

**Division of Health Sciences
Centre for Research into Aged Care Services**

The impact and influence of change on a residential aged care
community: an action research study

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Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

Signature:

Date:

Abstract

This study was an investigation of the complexities and challenges of change in a community-based aged care facility in Western Australia, to reveal the impact and influence of change on the community. It explored the impact of change on both the residents and the senior management team, as leaders of the organisation, and explored how change influenced the redevelopment process and future of the organisation.

There is considerable literature on organisational change including the impact of change on the structure, function, process, workforce and leaders of the organisation. There is, however, little literature on organisational change within aged care communities, particularly with an emphasis on the complexities and challenges associated with change within an organisation that is both a business and a home for its residents.

The study took the form of a participative action research study, occurring predominantly over two years (2002-2003) with some continuation into a third year (2004). The study had three phases and included two action research cycles and a critical reference group (CRG), comprising the senior management team (SMT) and researcher. It adopted a broadly qualitative methodology, using data from participatory observation and semi-structured interview; however, it did include quantitative and qualitative data from two 'quality of service' surveys for independent living residents and a staff satisfaction survey.

The findings of this study are presented as a narrative account of the experiences of the participants. The study reveals that change associated with the redevelopment impacted on residents' wellbeing, described by them as quality of life. The redevelopment process and associated change also emphasised the importance of communication and explanation with residents to understand elements of quality of life and to monitor and manage the impact of change.

The findings of the study highlight the challenge faced by community-based aged care communities classified by government, the industry and the wider community as

primarily not-for-profit, to balance financial accountability and social conscience. The perception of benevolence influenced the attitudes of residents and staff and made business accountability more difficult to explain and realise.

The study reveals that change also impacted on the structure and function of the organisation as it built its capacity for change. It reshaped the relationship between the Board and senior management team (SMT), which was reported as an improvement in communication, work relations and leadership effectiveness. The development of the leadership team, being the senior management team, was influenced by change and the change process enabled this team to become a competent, confident, cohesive senior team, with a preferred leadership style.

A further finding was the realisation of the value and appropriateness of the action research process. It provided tools and processes that were used to plan, act, analyse and reflect on the many aspects of organisational change and enabled the organisation, principally the SMT, to reflect on the impact and influence of change. The research process supported their development as leaders as well as the development of the team. The process of planning, collecting data, analysing data, reflection and action provided a structure and process that they continued to use in their management practices, as new situations continued to arise with the redevelopment process.

Acknowledgements

This thesis has been my journey but it has also been a team effort. While it has been an amazing learning journey for me, its completion was assisted by the support, encouragement and wisdom of the people who are acknowledged here. I thank them all.

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CHAPTER 1 INTRODUCTION AND OVERVIEW OF THE THESIS

This study set out to explore the impact and influence of change resulting from a redevelopment process, in a residential aged care community in Western Australia. The projected demographic changes of an ageing population and the resulting changes to government policy and funding, suggest that the need for aged care providers to transform their organisations will become increasingly important as they respond to increasing numbers of older people who are seeking accommodation, services and lifestyle choices. The study sought to understand the impact of these changes on the residents as well as their impact on the operation of an aged care organisation, particularly the senior management team. It also sought to understand how change influenced the redevelopment process and the structure, function and processes within the organisation.

1.1 Introduction

There is considerable literature on organisational change, including its impact on the structure, function, process, workforce and leaders of the organisation. There is, however, little literature on organisational change within aged care communities, particularly in relation to the impact of change on the residents and leaders within that organisation, or the complexities and challenges associated with change within an organisation that is both a business and a home for its residents. Therefore, this study provides new knowledge and understanding of the complexities of change in an aged care organisation and provides insight into ways of accommodating the needs of residents during a process of redevelopment.

The study is placed within a reality of planning for accommodation and services for a growing, ageing, non-homogenous population, while accommodating economic realities and the social conscience related to care of the older person. It also reveals the internal complexities faced by providers within the aged care industry who are seeking to meet the expectations and needs of the population of today, as well as plan for populations of tomorrow, constrained by a number of external issues related to funding, workforce characteristics and community expectations. As a case study of one aged care community, it sought to provide insight into the complexities and

challenges of organisational change within this sector, to inform other aged care providers and to be of interest to governments and policy makers.

A participative action research method comprising three phases and two action research cycles was employed, with each cycle involving several 'mini cycles' of planning-action-reflection. The study occurred predominantly over two years, 2002-2003, with some continuation into 2004. It adopted a broadly qualitative methodology, using predominantly semi-structured interview and participatory observation. However, the study did include quantitative and qualitative data from two 'quality of service' surveys for independent living residents (2002 and 2003) and a staff satisfaction survey, implemented by the organisation in 2002.

The study took place in a non-denominational, non-profit, community based aged care organisation in Western Australia, providing accommodation, services and community lifestyle for some 1100 residents, in low and high care centres and independent living units. The provider elected to remain anonymous and is referred to throughout the thesis as '*Choice Village*'. This provider had recognised a need for change and had elected to embark on a process of redevelopment over several years, to better equip it to meet the needs of its current and future resident populations. It was clear that such complex change would impact on the residents, many of whom had lived there for a long time. This was their home and, for many, other residents were their family. It was important to find out what was important to the resident population and to monitor the impact of change.

The key participants in the study were the senior management team, referred to throughout the study as the SMT. This group of senior managers, with the researcher, formed the Critical Reference Group (CRG) for the study. A second key group was the residents living in the low and high care centres and independent living units. Other groups involved to a lesser degree, were members of the Board, the area managers in all departments and the broader workforce.

The findings from the study have resulted in a greater understanding of the issues and challenges facing aged care communities as they respond to an ageing population and changing demand for services and accommodation. It has revealed

the impact of change on the residents and senior management team of an aged care community and how change influenced organisational structure and function, the model of care and service framework, and the leadership behaviour of the executive team. It has also revealed that an in-depth study of one provider has value for other aged care communities and a wider audience.

1.2 Ageing and aged care context

The United Nations designated 1999 as 'The Year of the Older Person', recognising and affirming what demographers and others had talked about for many years, that the world population is ageing at an unprecedented rate. Much as rapid improvements in life expectancy characterised the 1990's, the literature reports that fertility decline and urbanisation appear to have been the dominant global demographic trends in the second half of the twentieth century. The ageing population has now emerged as a worldwide phenomenon, absorbing the interest of researchers, governments, policy makers, service providers and the general community. It is, in one sense, a human success story as societies now have the luxury of an ageing population. But the steady, sustained growth of the ageing population brings many challenges.

After 2010, the number and proportion of older people will rise dramatically in most developing countries. This is aligned with a high fertility rate after World War II, reducing death rates at all ages, major reductions in the prevalence of infectious and parasitic diseases, improvements in nutrition and a decline in infant and maternal mortality (Kinsella and Velkoff, 2001). There is also increasing awareness that absolute numbers of older people are high and also increasing. This ensures that the older population will be an ever-increasing proportion of the population. This has produced a social phenomenon without historical precedent that will change the stereotypical picture of older people and challenge approaches to accommodation, social services, community structures, health services and the provision of aged care.

Shifts in population structures result in changes to service demand and economic requirements. With an increasingly older age structure comes change in the relative number of people who can provide support to those who need it. However, the

stereotype of an older population as a predominantly dependent group ‘draining’ the resources is not valid. Not all older people require support, but they will shape patterns of social relationships and expenditure in coming decades. Consideration needs to be given to a number of related issues. For example,

- The impact on families: the ability of family and relatives to provide care for older people who are living longer; the impact on adults who find themselves caring for their parents as well as their children and, sometimes, their grandchildren; and the ability of an older person to care for their ageing spouse.
- The impact on communities: the type of housing that will be required to support older people living in their own home rather than an institution; the demand for, and type of services, and the impact on local governments and community agencies; concerns regarding security and safety; and changing community attitudes towards the contribution and burden of an older population.
- The impact on the workforce: the change in retirement age and attitudes towards working longer; changing patterns of employment and nature of jobs and contracts; loss of knowledge and experience when cohorts like the ‘baby boomers’ retire; and characteristics of ‘family friendly’ workplaces in response to a demand for flexibility and variability in policies.
- The impact on aged care communities: accommodation options and choices; housing design and innovations, such as new technologies, the interphase between service sectors; changes in roles of professionals, and a range of needs among age cohorts of older people within any one population.

While all these issues are equally important and warrant inquiry, this study paid particular attention to the fourth, aged care communities.

There is an abundance of literature on the projected demographics of the world’s ageing population and a growing body of knowledge on the impact that this is likely to have on health and community services. This has provided us with broad population-based knowledge but not necessarily with an understanding of the specific needs of older people in the future, the impact of an ageing population on

accommodation and services, or the challenge that existing aged care providers have to address to maintain financial viability within a culture of social accountability. Further, there has been limited exploration of the impact that the ageing population will have on current aged care accommodation and services and how they will need to change.

It is many years (1988) since the World Assembly on Ageing adopted the Vienna International Plan of Action on Ageing (IPAA), subsequently adopted by the United Nations General Assembly. The plan aimed to guide the formulation and enactment of policies and programmes worldwide. It sought to strengthen the capacity of governments and society to address the dependency needs of ageing populations while, at the same time, promoting older people as active, vital resources and participants. The IPAA was one of a series of policy documents developed by the international community to promote lifelong development and improve the quality of life of all older persons. The IPAA also revealed that quality of life is important to older people, regardless of degree of dependence/independence or state of health (WHO, 2000).

Older people often have a positive view of their health even though they may have an illness or disability. Quality of life, however, means different things to different people. People's self-assessment of their health can also be a good predictor of their future health care use. It is therefore important to understand what elements contribute to a perceived concept of quality of life and to incorporate that understanding into care and service options. Those with an illness or disability may require some sort of assistance; understanding the nature of this assistance and what it means to the individual is critical in planning for appropriate accommodation and services.

Many older people live an independent, healthy life. There is a popular view in this discussion that claims that the ageing population is a major driver of the demand for health care, and thus of the annual growth, in national health spending. While this may be true for a cross-section of the population at any one time, it is not a reliable guide to what happens when a population ages gradually over time (Reinhardt, 2004). While the projected increase in the percentage of older people in the total

population, from 12.7% to about 20% by 2030, is not trivial in terms of health services, other factors need to be considered and the needs of a healthy older population also need to be considered. Aged care communities will find that it is important to acknowledge the needs of independent, healthy older people as well as those who need residential and community care.

Planning for future demand is recognised as important; however, this industry is so consumed by the day-to-day demands of the business that there is limited time and few resources for future planning. It is also relatively inexperienced in research and reluctant to 'expose' itself to the scrutiny of external researchers. The very nature of the industry and its potentially vulnerable population suggests a participative, developmental approach is needed. The aged care industry will benefit from research where the researcher works with the organisation to assist it to prepare for the future.

1.3 Rationale for the study

Aged care service providers play a central role in the delivery of health care services in many countries, including Australia, and form a significant part of the Australian economy. Hogan (2004) reports that:

“On any given night about one in every hundred Australians receive care in a residential care service or through a community care package. In addition, about four in every hundred Australians receive aged care services at home or in the community every year” (p1)

The ability of the government and the industry to deliver quality aged care is already affected by the ageing of the population and increased longevity of older people, especially those 85 years and over. The government revised aged care accommodation standards (to apply for 2008) for quality improvements, are also forcing redevelopment and refurbishment.

The aged care sector is more highly regulated and constrained than many other industries. These regulations serve an important purpose for the industry and the community but also bring a number of outcomes (Hogan, 2004): they diminish the

extent of competition among providers; they make it difficult for new providers to enter the market; they restrict consumer choice and reduce the consumer's ability to bargain over entry conditions; and they adversely affect enterprise mix and investment. Providers of aged care services identify other outcomes: extensive time consumed by documentation and reporting; concentration of the most highly qualified staff on non-clinical activities; nervous anticipation of 'spot visits'; and resource allocation that outweighs the benefit for consumers and providers. Boards and managers face many challenges in the future with its almost inevitable need for change.

Understanding the issues related to the provision of accommodation and services for an older population, including early retirees, is further complicated by an increasingly complex 'retirement industry'. An area of interest relates to the ability of retirement villages to meet the needs of the client group, as they grow older and their personal situation changes. Building standards for adaptable housing assists developers of retirement villages to support people to 'age in place' (Gray, 2002). To do this, such communities need to be able to provide a range of appropriately designed housing and flexible access to a range of services and support options. Such demand is resulting in significant change to organisations providing aged care communities, such as the research site for this study.

The growing complexity of an ageing population and the impact of government policy and expenditure, as well as the many social and operational issues being faced by providers of retirement accommodation and aged care, highlights the increasing likelihood of redevelopment and change. While research into the challenges associated with implementing large-scale organisational change is discussed in the literature, there is a paucity of research into the complexities of change in aged care. There is a clear need for research that provides a focussed, in-depth exploration of the complexities and impact of change within specific facilities and among communities of older people.

1.4 Overview of the thesis

This study adopted a participative action research method to understand both the complexities and challenges in a community-based aged care facility and the influence and impact of a process of change and redevelopment on the organisation and its residents. It involved interplay of people, interests and action throughout the action research process, an active, cyclical process of planning, action and reflection.

As an action research study, it aimed to give voice to the participants, in particular the residents and senior management team, and through them, to the organisation itself. It is their study, facilitated by the researcher and the research process, and the findings from the study come from the voices of the participants. The findings of the study are placed in the context of the wider ageing population and the complexities of the aged care industry. Therefore, this thesis reveals the process of inquiry as well as critical components of the study.

Chapter 1 is an introduction to the study. It explains the context and the rationale. From this the reader gains an understanding of the reason for the study, and of the research community.

Chapter 2 provides a background for the study. This includes an international ageing population, now emerged as a worldwide phenomenon, the Australian and Western Australian ageing population and the concept of healthy ageing relevant to the aged care industry. It then discusses important aspects of the Australian health and aged care sector, including policy, characteristics of the aged care sector and the retirement industry and the interface with other health service sectors. This chapter goes on to discuss issues for the workforce, one of the most critical issues for the industry. Finally, it presents reasons why there is need for change to meet future demand and expectation.

Chapter 3 explains the research method and design. It presents an explanation of action research, the application of action research in health care and the appropriateness of the action research method for the study. The discussion looks at the philosophical foundations to action research relevant to this study: naturalistic

inquiry and phenomenology. It then moves to a discussion of validity in action research and addresses credibility, transferability, dependability and confirmability, before discussing principles of ethics and confidentiality. The chapter then explains the research design: aims and objectives arising from the research question, and an overview of the study, including study site, participants, data collection and data analysis. Finally, there is a summary of the research method and design, and discussion of validity, ethics and confidentiality relevant to this study.

Chapter 4 is a detailed narrative of the three phases and two action research cycles. The narrative of phase one includes a period of reconnaissance, positioning the research team and an account of the components of the first action research cycle. The narrative of phase two explores and aims to further understand the issues associated with change and provides a detailed account of the components of action research cycle two. The chapter concludes with the narrative of phase three, a period of affirming and consolidating action.

Chapter 5 presents the findings of the study, the impact and influence of change as experienced by the participants in this study, in three parts. The first part describes the residents' experience and highlights the importance of wellbeing, expressed by the residents in terms of quality of life. This reveals that quality of life is expressed slightly differently by the three groups of residents, even though there are common elements across all categories. The impact of change associated with the organisational redevelopment on their quality of life is discussed. The second part provides the experience of the SMT as the leaders of the organisation and the change process. It describes the impact of change on them and how this influenced their development of this team. The experience is described as three steps: forming a vision, building a vision and creating a vision. The third part of the chapter focuses on the experience of the organisation, described in terms of building its capacity for change. The capacity for change involved letting go of the past, strengthening operations, creating a physical and functional community and creating a model of care and service framework that would support future growth and development. Finally, the chapter presents the key factors influencing change in aged care communities and summarises the findings of the study.

Chapter 6 is a discussion of the findings in relation to relevant literature on resident wellbeing, quality of life, empowerment, ageing-in-place and social connection. Literature on leadership, including values-based leadership and transformational leadership, is reviewed, as well as team development. Factors important to ensuring the organisation's capacity for change are then discussed. These include business capability, a model of care and a service framework, as well as balancing business accountability with social conscience.

Chapter 7 concludes the study. This is a discussion of the implications of the findings and the impact these may make on the key stakeholder groups and on the body of literature. It also makes some recommendations for future research.

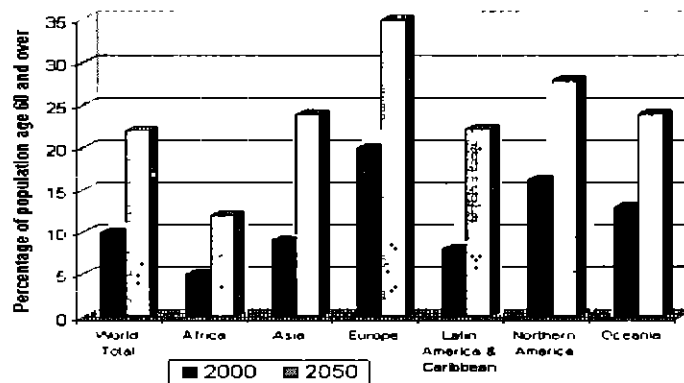
CHAPTER 2 BACKGROUND TO THE STUDY: PROVIDING FOR AN AGEING POPULATION

Chapter Two presents the background and context for this study. It discusses within demographic projections an ageing world population context, internationally, nationally and in Western Australia. The chapter discusses the concept of healthy ageing as the possibility for healthy ageing in future older populations has increased and is impacting on design of accommodation and allocation of services. A discussion on the Australian aged care sector includes a policy focus, aged care industry focus and retirement industry focus and highlights issues for aged care relating to articulation across other health service sectors. The chapter then looks at particular workforce issues relevant to this industry, as they have an impact on quality of life for residents in relation to staff satisfaction and are of particular interest in the industry. Finally, the chapter suggests how the industry is adapting to address the need for change.

2.1 An ageing world population

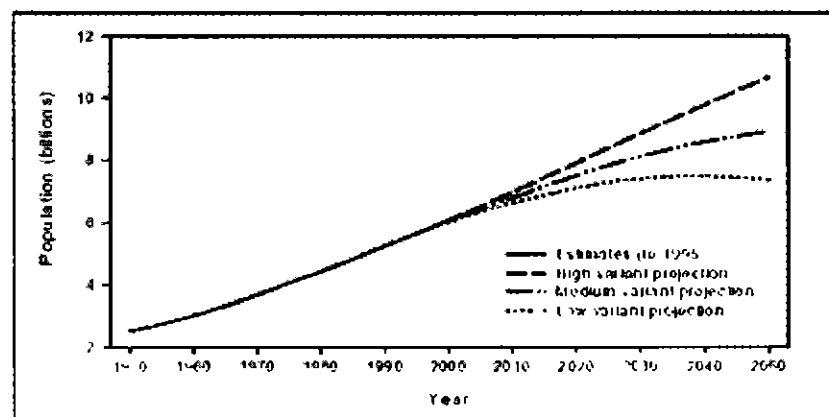
World demographic projections of an ageing population, including Australia, are well documented. The world is in a demographic revolution (WHO, 2000). Worldwide, the proportion of people aged 60 and over is growing faster than any other age group, with a growth of some 380% predicted between 1970 and 2025. It is predicted that by 2025 the world population of people over 60 years will be 1.2 billion. Decreasing fertility rates and increasing longevity will ensure the continued 'greying' of the world's population. Figures 1 and 2 provide an overview of world population ageing. Figure 1 reveals the demographic change that has occurred in world regions in populations aged 60 years and over in the period 2000-2005. Figure 2 demonstrates estimated growth of the world population from 1950, projected to 2050.

Figure 1: Percentage increase in population aged 60 and over by region, 2000-2005



Source: World Population Prospects, The 1998 Revision, Volume II: Sex and Age. The Population Division, Department of Economic and Social Affairs, United Nations Secretariat

Figure 2: Estimated growth of the world population projected from 1950 to 2050



Source: World Population Prospects, The 1998 Revision, Volume I: Comprehensive Tables (United Nations Publications Sales No. E99.XIII.9)

The WHO has identified a number of specific challenges for accommodation and services for an ageing population, in response to projections. The first concerns disability and the double burden of disease; there is an inevitable shift in disease patterns with an ageing population. While countries continue to struggle with infectious diseases, they are also faced with the rapid growth of non-communicable diseases, such as cardiovascular disease, cancer and depression. The second relates to changing of an outdated paradigm; old age has traditionally been associated with sickness, dependence and a lack of productivity. The ageing population calls for a

paradigm that views older people as active participants in an age-integrated society and as active contributors and beneficiaries. Thirdly, there are issues related to the feminisation of ageing; women live longer than men in almost all areas of the world but they are most likely to experience domestic violence, discrimination in education, work and health care and are more likely to suffer disabilities in old age. Older women who are alone are vulnerable to poverty and social isolation. Fourthly, the ageing population raises issues in ethics and inequities: advocacy, ethical decision-making and upholding the rights of older people must be at the centre of any planning. There is a range of ethical considerations facing an ageing population; for example, resource allocation, choices related to health and death, genetic research and manipulation.

It is important to recognise that the ageing population is not one homogenous group. This is particularly important when considering accommodation and services. It is useful to consider three cohorts: those aged 45-64 years (middle age), 65-79 (younger old) and 80 years and over (older old). These three cohorts tend to have different needs, expectations and priorities, conditioned by their early life experiences (PMSEIC, 2003).

The middle age group was born between 1939 and 1958. They are mainly post war baby boomers, born in large numbers soon after World War II. They will account for the population of 'older old' people (over 80 years) between 2026 and 2036. They have grown up with expectations that include comprehensive health and social services. The majority of women in this generation are now also in paid work outside the home, with consequent changes in family relations and financial expectations. More than one quarter of this cohort is likely to experience old age without the support of a long-term partner.

The younger old age group was born in the period 1924-1938. Most experienced childhood during the economic Depression or Second World War. The majority in this generation are homeowners, living in their own homes, with low housing costs that have permitted a reasonable standard of living on the pension. Many of them provide care for their own parents, their spouse, a sick or disabled adult child, grandchildren, or combinations of these. Their expectations and priorities are for

staying in their own home as long as possible, staying mobile and independent, actively participating in society, having high quality health care and continuing lifelong learning.

The older, old age group was born before 1924. They lived their formative teen and young adult years during the Depression and Second World War and will be reaching 80 years old from 2003. This cohort is currently fairly small, although the number of the older old is expected to increase rapidly in the next 30 years. They need support and aids to enhance their independence and mobility, and to maximise the option of staying in their own homes.

At times there is a tendency to present the ageing population and associated implications for accommodation and services in a negative light, implying that the ageing population will be less productive, less healthy and will produce an increasing demand on health and community services. There is also a tendency in some literature to presume that older people are no longer in need of health education and are unable to improve their health status and lifestyle. Howat, Boldy and Horner (2004) report on a process whereby health professionals identified health promotion priorities for older people in Western Australia. Health professionals identified physical activity, social isolation, mental health and medications as issues warranting attention by health promotion professionals and of interest to older people.

The World Health Organisation adopted the term 'active ageing' in the 1990's to express a vision of ageing as a positive experience.

“Active ageing is the process of optimising opportunities for physical, social, and mental well-being throughout the life course, in order to extend health, life expectancy, productivity, and quality of life in older age (WHO, 2001).”

The term 'active ageing' refers to continuing involvement in social, economic, spiritual, cultural and civic affairs, not just physical activity. It recognises that older people with illness or disability can still make active contributions to families, peers and communities. Their ability to make decisions about daily life and maintaining their independence is a primary goal for both individuals and policy makers.

While recognising advances in science and technology and the impact such advances have had on longevity and quality of life, the literature highlights the importance of not viewing the ageing population as one homogenous cohort – for both social and service reasons. Baltes and Smith (2002) caution against viewing ‘older people’ as all the same, and refer to the ‘young old’ and ‘oldest old’ as the Third and Fourth Age respectively. There are significant planning and service implications in this. It is the oldest old, those over 80 years, who form the fastest growing group of the elderly population in percentage terms. Baltes and Smith propose two ways to define the Third and Fourth Age: the first is a population approach and the second a person-definition approach. The population definition approach puts the third to the fourth age transition at about 75-80 years of age, so that our ageing population can be categorised as 65-80 years (third age) and 80 + years (fourth age). The distinction is important, according to Baltes and Smith, because the quality of life and general health status of these two categories can differ significantly. The person-definition approach looks to estimate the maximum lifespan of a given individual rather than the average population. Based on present-day evidence and excluding specific illness, an individual maximum lifespan is thought to vary between 80-120 years of age. In this view, individual transition between the third and fourth age could be 60 for some and 90 for others.

Third Age people (young old) can potentially look forward to a very good quality of life in later years. They have an increased life expectancy, substantial latent potential for better physical and mental fitness in old age, evidence of cognitive-emotional reserves and effective strategies to master the gains and losses of late life. It can be presumed that this cohort will engage in community activities and remain active contributors to, as well as users of, community resources.

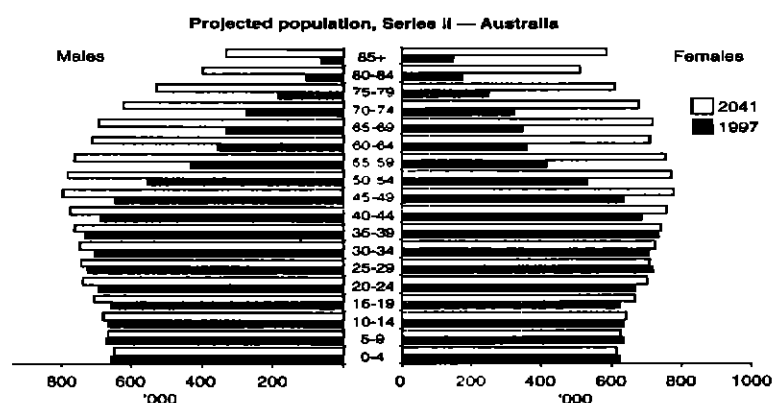
Fourth Age people (oldest old) will not have as good a quality of life, however. They will have losses in cognitive potential and ability to learn, a sizeable prevalence of dementia, high levels of frailty, dysfunction and multi-morbidity, and will consume resources rather than contribute. Baltes and Smith (2002) question if they will have a good quality of life at all. However, there will be more people in both categories and not all in the Fourth Age will live in residential care.

2.2 An ageing Australian population

Australia is also facing unprecedented ageing of its population. Some view it as 'doom and gloom' and the increasing number of older people as a great burden on society. Others see it as an achievement and ageing as an opportunity for full participation in society, a chance to live an active, healthy and productive later life. There is a demographic trend that shows an increasing number of older people and fewer younger people (AIHW 2002). By 2051, the population aged 65 years and over is projected to be at least double its present size, increasing from 12% of the population in 1999 to 24 - 27% in 2051. The highest annual rate of growth for this age group will occur in 2012 when the large cohort born in 1947, part of the post World War II 'baby boom', turns 65. The 85 years and over age group numbered 241,100 (1.3% of the total population) in 1999. This group is projected to reach approximately 1.3 million in 2051, and between 1.3 million and 1.6 million in 2101. In 1999, the 85 years and over age group was dominated by women, who made up 69%. In all series this proportion is projected to fall to 63% in 2021, 59% in 2051 and 57% in 2101, reflecting the increase in life expectancy of men and the narrowing gap in life expectancy between men and women. The population aged 15 - 64 years, which encompasses much of the working-age population, made up 67% of Australia's population in 1999. This proportion increases slightly over the first ten years of the projection under all the main series, to reach 68% in 2008. It then declines to 65% in 2021, 59 - 60% in 2051 and 58 - 59% in 2101 (AIHW, 2002).

Projections show that the ageing of Australia's population will continue as an inevitable result of fertility remaining at low levels over a long period, associated with increasing life expectancy. As growth slows, the population ages progressively, with the median age of 35 years in 1999 increasing to 40 - 42 years in 2021 and 44 - 47 years in 2051. Between 2011-2021 the 'baby boom' generation will enter the 65 years and older age group and it is projected that the rate of increase for people 65-74 years will be 28%, 75-84 years will be 17% and 50% for those 85 years and over (WHO, 2000). Further, the ratio of men to women will increase, with more women than men and the number of overseas-born older Australians from culturally and linguistically diverse backgrounds also continuing to increase.

Figure 3: Projected population profile Australia 1997 – 2041



Source: Australian Bureau of Statistics, 2002. Australian Social Trends Cat No. 4102.

AIHW (2004) presents a range of key statistics on the demography and health of Australians aged 65 years and over. It reports that many are living to old age, with life expectancies increasing at ages 65, 75 and 85 years. A large proportion of Australians in the age groups of 65-74 and 75-84 years live a healthy life without disease and disability. However, the prevalence of disease and disability increases with age, particularly chronic disease. As the population aged over 65 years becomes older, the level of chronic disability will increase and there will be a rising demand for support services, including palliative care. Specific population increases were reported. The largest percentage increases between 1991 and 2001 were in the 85 years and older age group, with an 85% increase in males and 67% increase in females; the population aged 65 years and over is projected to nearly double over the next 20 years. The majority of people in the age groups 65-74, 75-84 and 85 and older reported that they were in good health in 2001 and living at home.

Australia’s National Strategy on Ageing, subtitled “An Older Australia: Challenges and Opportunities for All”, was released in 2002 by the Federal Minister for Ageing, and supports the WHO position on active ageing. While recognising the positive contribution to the Australian community made by our ageing population, the strategy calls on all levels of government to take a leadership and facilitation role to ensure older Australians are able to lead healthy, active and fulfilling lives. The goals for healthy ageing are set out as:

1. All Australians have the opportunity to maximise their physical, social and mental health throughout life,
2. Population health strategies promote and support healthy ageing across the

lifespan,

3. Information, research and health care infrastructure is available to support the healthy ageing of the Australian population. (AIHW, 2001).

The paper recognises that ageing of the population is occurring at the same time as many ongoing social, economic and technological changes, which will further impact on the provision of appropriate health and community services. Examples of changes include patterns of disease and disability, family structures, work patterns, housing patterns and national and personal wealth. For many older people, quality of life is determined by the strength of their family relationships, links with the community and the extent to which they feel valued and respected. Life-changing events such as retirement, death of a partner or the taking on of a caring role for another are common for older people. Life-changing events can be made more difficult to adjust to if connections with a community are not strong. There are a number of issues that need to be addressed by governments at all levels. These include responsibility for personal safety, affordable housing and ready access to facilities and services. As well, there is a need to capitalise on the wealth of experience and knowledge from within the older population and to provide them with opportunities for new challenges.

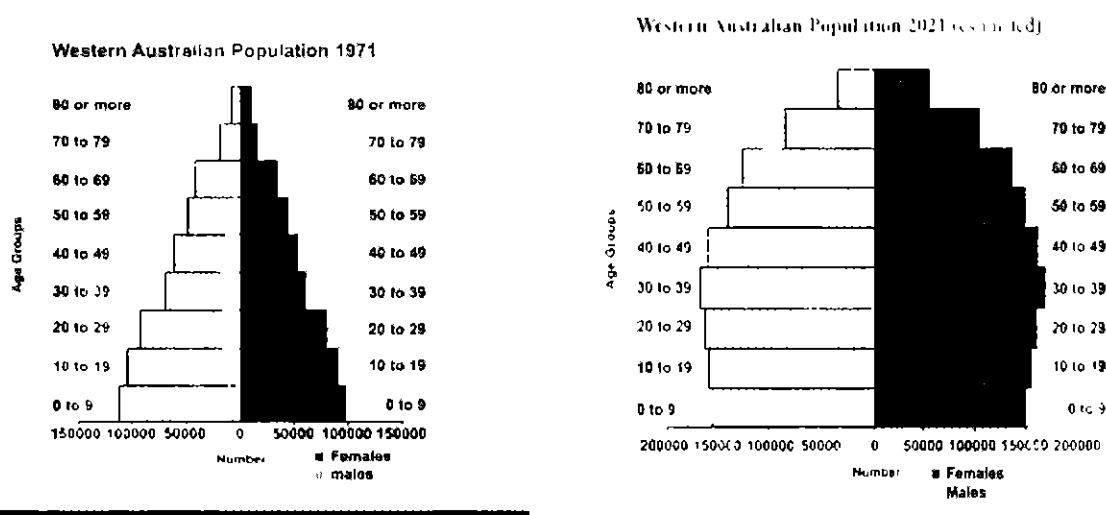
When examining the demographics of the Australian population, it is clear that a range of options and choices will need to be made available to people according to individual need and circumstance – one size will not fit all. An effective strategy will need to address this range, so that individuals are able to access what they need when they need it, to either:

- Promote independence and support an independent lifestyle;
- Maintain and support independence and where appropriate provide support; or
- Provide support in dependent situations.

2.3 An ageing Western Australian population

At a local level, the population of Western Australia is also ageing. Figure 4 shows a marked change in population numbers in all age categories 1971-2021.

Figure 4: Western Australian population projections 1971-2021



Source: Health Department of Western Australia, 2002.

The Health Department of Western Australia released a discussion paper titled, “Health and Quality of Life for Older West Australians” in 2002, which aimed to provide the foundation for the development of a whole-of-sector and cross-jurisdictional approach to the planning and provision of a comprehensive range of services to meet the health and aged care needs of the older population of Western Australia.

The paper builds on work done in previous years, including an extensive consultation in 1997, which highlighted a number of key concerns related to ageing:

- Negative stereotypes and myths about ageing still exist;
- Services need to be more readily accessible, flexible and better aligned with need;
- Information about services and policies is not readily accessible;
- Health services are not culturally appropriate and well coordinated;
- Family and carers are not adequately supported;

- Security of private homes and public places is not adequate;
- Access to transport to support an independent lifestyle is limited;
- Opportunities to be involved in employment and volunteering are limited;
- Access to education and training for carers needs to be improved.

This paper reports that the State's older population is not evenly distributed as a whole or within the metropolitan area. Whereas the total number of people in WA is expected to increase by 44% between 1996-2011, numbers will vary in different regions and according to individual community stages. Further, different cultures have different demographics, health conditions and lifestyle risk factors. There are a number of social and economic factors that play significant roles in the health and wellbeing of older people. They are:

- Participation in the community – high degrees of social involvement and economic security enable people to live independently and are important for health promotion behaviours.
- Economic security – with reasonable economic security there is less likelihood of financial anxiety and more opportunity for lifestyle choice and access to resources when they are needed.
- Independence and support – it is important for older people to have a strong network around them to help maintain independence and a quality of life.

The highest level of severe to profound disability is related to dementia, followed by mental health conditions, eyesight disease and stroke. Older people are more likely to develop some form of disability or handicap than younger people, are more likely to have a long-term health problem and are less likely to exercise (HDWA, 2002). Older people are also more likely to have a chronic health condition than younger people. By age 65, most West Australians have some form of chronic health condition, such as eyesight problems, arthritis, hypertension, high cholesterol, heart disease and deafness. Chronic disease risk factors also increase with age, as do co-morbidities (e.g. lack of mobility, diabetes). While population demographics are important and inform policy and planning, health status, health promotion and disease projections are also important.

2.4 The concept of healthy ageing

The ageing population discussion forms a powerful context in which to consider the changing health needs and quality of life of older people. The continuing increase in the number and proportion of older West Australians makes the health of older people an important public health issue. Attitudes and policies in relation to ageing are recognising that there is now the potential for more positive experiences. Health promotion is a broad concept that extends beyond prevention and incorporates partnerships between health care providers, individuals and the community. Evidence suggests that a substantial proportion of chronic disabling conditions associated with ageing are potentially preventable, or can be postponed, and are not inevitable. Illness prevention is an important component of health promotion and can be better understood if a distinction is made between the disease process as an intrinsic part of ageing and the disease becoming more common with age. Health promotion activities have not targeted older people as much as other age groups, believing that little can be done to improve their health. However, older people today, and increasingly more in the future, expect to live a healthy, long life - or at least one where illness and disability can be avoided or minimised (Victor, 2002 in Boldy, 2002).

Older people expect better health outcomes and increased access to resources and services in their later years, rather than sitting at home putting up with the 'aches and pains'. Further, ageing is a life-long biological, sociological and psychological process experienced by all individuals (Gray, 2002). Thus, the consequences of ageing are related to, but not synonymous with, chronological ageing. Traditionally, we think of ageing in relation to retiring, that is, when you stop paid work (often around 65 years), or with changes to health and the need for care (often around 80 years), while recognising a great variation in experiences, capacity and health status at all ages. There is a growing awareness that there needs to be a fundamental change in the way Australians' think about ageing and the needs of older people.

Gray (2002) projects some key characteristics of this phenomenon that suggest implications for service delivery.

1. While increased longevity and healthier old age does not reduce the demand for aged care services, improved health status and longevity may delay this demand.
2. Disability rates will increase as moderate to severe dementia increases with age. The number of Australians with dementia is expected to double in the next twenty years (Flicker, 2002).
3. More older people will live alone as a result of increasing divorce rates, smaller families and fewer older people living with children and may only be able to live alone if supported by informal carers, family members and/or volunteers.
4. By 2026, 1 in 4 people over 65 years will be from non-English speaking backgrounds.
5. While older people are currently concentrated in urban areas, there is an increasing number living in non-metropolitan areas, coastal towns and country towns. This represents a further challenge for service delivery.

Much has been written about the concept of 'healthy ageing' and the roles that various levels of government and organisations need to play to support healthy ageing. There is also growing recognition that a lifestyle approach across the lifespan is needed to achieve this. It is important to ensure that other sectors of the population are not isolated or neglected while there is an increasing emphasis on the needs of older people.

Old age and chronic disease does not always mean a need for health services, but in many cases it does. Old age, chronic disease and increasing risk factors, however, place increasing demand on health and community services, and an increasing desire for those services to be accessible, readily available and flexible. Access to acute (hospital) health services remains important for all people, including older people. However, it is becoming increasingly evident that many older people will be seeking access to health promotion activities and services that will support their continuing good health and independent living, preferably at home. It is likely that the demand for locally positioned, community-based services will increase and that the demand on local government to meet the health and community needs of older people will increase.

Advances in medicine and medical technology can provide us with the opportunity to live longer and in good health, staying mentally and physically active and able to participate in life until we die at an advanced age. Healthy ageing benefits individuals as well as society. It could bring about a choice (indeed an expectation) to spend longer in paid work, increase opportunity to contribute to the community and provide more time to spend with family and friends.

Some social factors will influence the provision of services (Gray, 2002). Increased longevity and healthier old age will shift the demand for aged care services towards the last two years of life. Disability rates will increase as moderate to severe dementia increases with age. The number of Australians with dementia is expected to double in the next twenty years (Flicker, 2002).

While the literature describes the global context of healthy ageing, there is a need to examine healthy ageing within particular ageing populations to see what older people think and how this relates to specific needs for accommodation and services. It is also important to examine how providers of accommodation and services for older people interpret healthy ageing through building design, physical and social environment and a framework for services.

2.5 Aged care in Australia

Over the last couple of decades Australia has developed a relatively modern aged care industry with a diverse range of independent living communities, residential accommodation and services, and community and home services. Increasingly, older people are seeking to maintain their independence, accessing the services they need, as required, and preferably while still in their own home. They are seeking diversity and flexibility of services and a range of accommodation options.

The Australian aged care sector covers services that support people living independently in the community through to residential aged care. It is underpinned by quality assurance mechanisms and guided by access strategies and processes. Aged care services in Australia are currently provided through at least thirty different funded programs with a range of eligibility and access points – community care, residential care, primary care and hospital care (Gray, 2002). The Australian Bureau

of Statistics (ABS) survey of Disability, Ageing and Carers reports that 40% of people of all ages with a major disability, who lived independently and need assistance, felt that their needs were not being met. It is still very difficult for older Australians to access the advice, support and care services that they need.

2.5.1 Policy focus

The Australian health care system is designed to ensure universal access to adequate health care at an affordable or no cost, as well as providing choice through private sector involvement. It is a blend of public and private sector (Gray, 2002). Private medical practitioners and other health practitioners provide primary and specialist care in the community and a mixed public (State controlled) and private hospital system provides comprehensive acute services. Commonwealth funding includes two universal national subsidy schemes – Medicare and the Pharmaceutical Benefits Scheme. In addition, Commonwealth, State and Territory and Local Governments provide public health services, community health services and ambulance services.

Assistance is provided to older people in a variety of cash and non-cash forms by all levels of government, profit and not-for-profit sectors, volunteers, family members and friends. Government expenditure is in the form of service pension, age pension, residential care subsidy, home-based care subsidy, medical services, hospital services and pharmaceutical services.

Policy related to services for an ageing population is influenced by political and government philosophy, public opinion and economic pressures and constraints. There have been several key developments related to services for older people during the last twenty years. The Aged Care Reform Strategy of 1986 attempted to address a lack of clearly defined policy goals or objectives, funding imbalance across the sectors, increased community pressure and consumer rights, and issues relating to assessment, monitoring and quality. Later, the introduction of outcome standards for nursing homes in 1987 and hostels in 1991, as part of a new government managed quality assurance system (the Standards Monitoring Scheme), was of particular relevance to residential aged care.

Further reforms were implemented in 1998 as a result of the passing of the *Aged Care Act 1997*, again with a number of initiatives that focused on residential care. These included an accreditation system for regulating quality in residential aged care, combining nursing homes and hostels into one system, a new funding tool based on resident dependency (Resident Classification Scale or RCS), as well as increased emphasis on community based care options. The success of these initiatives has been mixed and was met with considerable confusion and concern initially and increasing frustration and irritation in recent times.

In 1999, the International Year of Older Persons, the Commonwealth Government announced, as a key policy response, the development of a National Strategy for an Ageing Australia, with four themes. The focus was to expand coordinated forms of home-based care and respite services, with an increase in the number of Community Aged Care Packages (from 4,441 places in 1996 to 10,046 places in 1998). The intent was for General Home and Community Care programs to remain the major supplier of home-based care services, supported by the Domiciliary Nursing Care Benefit. This shift to home-based care is not suitable for many and does not decrease the need for additional residential care beds. There is increasing criticism that this shift in funding and the number of residential care beds (high and low care) that are available, is insufficient for the population's needs (residential beds per population) and that demand has already far out-stripped supply. The funding does not sufficiently recognise the increase in acuity and dependency of many residents and the increased complexity of care that is needed.

Although, with the passing of the Aged Care Act 1997, the user pays system within residential aged care has been enhanced, the majority of recurrent funding comes from the federal government, mainly via the Resident Classification Scale (RCS), a case mix funding tool. Other sources of income are resident accommodation bonds, daily fee charges and a variety of subsidies. The RCS covers the full spectrum of residential care needs and is used to assess funding requirements, regardless of physical location and level of care (high or low care). Funding under the RCS is based on the resources needed to address a resident's needs, which have been assessed and regularly evaluated. The scale is based on eight different levels of resident dependency and consists of 20 questions, each of which involves an

assessment (by facility staff) of the nursing/ personal care support required by each resident related to particular dimensions (e.g. personal hygiene). Each dimension is categorised into four levels of need. Weightings allocated to each level of need on each dimension are summed, and a resident's RCS category, which is numbered from one to eight, is calculated on the basis of his/her total score. The level of funding appropriate to each resident is then determined, based on his/her RCS category.

The Aged Care Act 1997, allows residents to pay two types of fee, care fees and accommodation payments, both dependent on the income and asset status of each resident. Care fees, made up of a basic daily care fee plus income-tested fees if relevant, contribute to the costs of personal care, meals, and cleaning and recreational activities. All new residents, regardless of their level of care, may also be asked to make an accommodation payment, which is primarily intended to provide facilities with a source of income for capital replacements, although it can be used for other purposes such as to retire debt relating to the provision of care. In high care facilities, this payment is known as an accommodation charge and is a daily fee that can be levied for up to five years. The amount to be paid is based on a prospective resident's assets, although criteria have been set by the government that allow the resident to retain at least 2.5 times the annual single age pension. In low care facilities, the payment is known as an accommodation bond, which can be paid as a lump sum, via periodic payments, or as a combination of a lump sum and periodic payments. In all cases, and as for high care residents, the bond, when paid, must leave the resident with assets of at least 2.5 times the annual single pension rate. Under certain conditions, the family home is excluded from the assets test. The service provider can retain an agreed proportion of this bond each year, up to a specified amount, for up to five years. They can use any interest earned, with any residual amount refunded to the resident's estate or resident on discharge (Department of Health and Ageing, 2002; Gray, 2002). More recently, the Aged Care Act 1997 is now under review and an new approach is being considered.

2.5.2 Aged care industry focus

Most residential care in Australia is provided by some 3000 certified residential aged care facilities. They are identified as private (25.8 %), not-for-profit/charitable (65.5%) and government (8.7%) (Commonwealth of Australia, 2003). Residential aged care accounts for about 78% of government aged care expenditure, identified as \$4.3 millions out of a total of \$5.5 millions in 2002-03, even though only a relatively small percentage of the population, about 5%, lives in such facilities. While the number of beds funded is monitored and licensed according to population projections, in 2002, 20% waited for three months for a bed in a high care facility and 34% for a bed in a low care facility Gray (2002). Gray reports that 20% of people 65 years or over had a problem or severe disability and required assistance with self-care, mobility and/or communication. Many more needed low levels of support/care on a regular basis to support a decent quality of life. AIHW (2002) reports that there were 43,606 admissions to residential aged care during the period from 1 July 2000 to 30 June 2001; 63% were for women and 42% for people aged 75-84. The number of respite days in residential care increased steadily from 337,020 in the year ending June 30 1991, to 985,905 in the year ending June 30 2001. This represents an 11.3% increase.

The Australian Government report “A National Strategy for an Ageing Australia” (Bishop, 1999) attempted to provide a framework for policy and services to meet the needs of older people in the future. However, according to the Myer Foundation report of 2002 titled, “2020: A Vision for Aged Care in Australia”, this has not established an effective platform for service delivery for the future. The Myer Report (Myer, 2002) predicts that aged care services of today will not be able to deliver either the quantity or quality of services that will be needed in the next twenty years. The ageing population will bring with it an increasing demand for care and an increasingly diverse range of needs. Further, the report suggests that governments alone will not be able to meet the costs unless there is a significant increase in taxation revenue as well as new sources of funding.

In 1999, less than 5% of Australians were in long-term care at any one time; this had increased to 7.3% by 2002 (Myer, 2002). The Australian Institute of Health and Welfare (2000) estimates the probability of admission to a nursing home as 33% over

the lifetime for those who reach 65 years of age, 61% for those who reach 80 Years and 97% for those who reach 90 years or beyond. As more than half the population now aged 65 years will reach 80 years of age, more women than men, accessing long-term care is becoming increasingly likely.

While the entire industry remains committed to quality services and quality of life for clients/residents, there is continuing debate about differences between private-for-profit and not-for-profit providers. Discussion centres on a perceived fundamental difference in organisational purpose between the two types of providers. The private-for-profit providers confer financial benefit to shareholders while the not-for-profit, which include community and church-and-charitable providers, confer benefits back to their communities. For some, this difference results in a different business focus and a different attitude towards profit. More significantly, it gives rise to different community attitudes and expectations.

The debate and discussion about accommodation and services for older people continues. The aged care system covers services that support people living in the community and in formal residential aged care. It is underpinned by quality assurance mechanisms and guided by access strategies and processes. Aged care services in Australia are currently provided through at least 30 different funded programs with a range of eligibility and access points – community care, residential care, primary care and hospital care (Myer, 2002). The 1998 ABS survey on Disability, Ageing and Carers reports that 40% of people of all ages with a major disability, who live independently and need assistance, felt that their needs were not being met. It is still very difficult for older Australians to access the advice, support and care services they need.

Older people living alone in their own home or with a family member can access home and community services following an assessment process. Usually, services fall within a 'low care' category and assume that the individual can manage on their own some of the time and/or have a carer to assist them. A higher level of dependency or more complex health issues may result in assessment for 'high care' services and placement, when possible, into a residential facility. Sometimes high care services can be accessed for someone living at home, particularly if they are

waiting for a place in residential care. The level of service tends to relate to the type of accommodation or housing.

The following summarises a list of types of service categories in Australia:

- High and low levels of residential care – Nursing Home (high care), Hostel (low care),
- Community Aged Care Packages (CACP) – extensive home care as an alternative to residential care,
- Home and Community Care Program (HACC) – home care,
- Day Therapy Centres – a range of services provided during hours of operation at a community facility,
- Flexible Care Services (mixture of services) – less dependent on accommodation, more on need,
- Multipurpose Services – providing a range of flexible aged care health and community services, configured to best suit the needs of people living in rural and remote communities,
- Extended Aged Care at Home (EACH) – services normally offered in a high care facility at home, and
- Respite Care – short-term residential care, some home based and some in the community.

Monitoring and quality assurance is very important for the provider, client population and the wider community. A new system for regulating quality was introduced in 1998 as part of the Aged Care Structural Reform package, requiring facilities to be accredited to continue receiving Commonwealth funding. While the previous Standards Monitoring System (SMS) was regarded as having a number of positive features that had led to an overall improvement in the quality of care (Australian Institute of Health and Welfare, 1995), continued concerns about certain aspects of it prompted the development of an alternate approach. The accreditation system that replaced the SMS is based on a framework with five components, each of which must be satisfied for a facility to be granted accreditation status (Aged Care Standards and Accreditation Agency, 1998). A facility must be able to meet the accreditation standards, ensure user rights, achieve building certification and

demonstrate concessional and assisted resident ratios. An independent body, the Aged Care Standards and Accreditation Agency (ACSAA), manages the system. This agency regularly assesses compliance against the accreditation standards and is responsible for assisting facilities to improve quality through education, training and information sharing, conducting support visits, and interim checks.

There are four standards, each of which is associated with various expected outcomes (44 in all). They are:

- Standard 1: Management systems, staffing and organisational development with 9 expected outcomes;
- Standard 2: Health and Personal Care with 7 expected outcomes;
- Standard 3: Resident Lifestyle with 10 expected outcomes; and
- Standard 4: Physical Environment and Safe Systems with 9 expected outcomes. (Department of Health and Family Services 1998).

Compliance with the standards is assessed according to a ratings system. Two higher award ratings, Accreditation with Merit and Commendable, can be awarded to a service overall, provided it meets specified criteria (Aged Care Standards and Accreditation Agency, 2001).

Monitoring is ongoing, with formal and informal assessments made according to the established, regulated standards. Many providers report satisfaction with the process and outcomes, however, the process is time consuming and resource intensive and, although the industry accepts a need for quality assurance, it seeks to have a more streamlined, less punitive approach.

The provision of aged care in Australia is complex and involves all levels of government and a range of providers from the public, charitable and community sectors. It is highly regulated and rigidly monitored. The nature of care that is provided varies across the sector according to allocation of funding and resources, degree of dependency of the individual and the support that is available from family, friends and the community in general.

The Australian Government's funding for aged and community care has increased over the last decade and is projected to increase further in the next decade, to \$6 billion in 2003-04 (Hogan, 2004). The ageing of the population and the increased longevity of aged persons are significant factors in policy development, funding and resource allocation. They are also significant factors for the aged care industry and becoming increasingly significant to the retirement industry and community services. Australians are well serviced in comparison to some other countries but the situation is becoming increasingly complex and the challenges for all countries are multiplying.

2.5.3 Retirement industry focus

The retirement housing industry in Australia is a relatively new partner in aged care and has begun to play an increasing role in providing support and services for older people, not just accommodation. Many people moving into 'retirement villages' are expecting to have access to some support and services, similar to those traditionally available in a low care facility.

There are hundreds of retirement communities in capital cities and an increasing number in outer metropolitan areas and rural towns. The design has changed over time and, in the last ten years or so, there has been a trend towards a 'village' concept with a better understanding of economic, social and environmental factors.

Retirement communities are offering all sorts of additional facilities and lifestyle options to attract people. These include: on-call security and emergency personal assistance; additional services such as meals, housekeeping and transport; personal care options through funded community care packages and individual services; and access to low and/or high care facilities and/or services, either on-site or adjacent to the retirement village. One attraction with this is that a particular individual can receive care, while the partner can still live independently nearby.

The industry has moved far beyond just providing housing and seeks to develop sites based on principles of social interaction as well as appropriate housing design. One such principle is explained by Lawton (1991) as 'person-environment fit'. This approach outlines four domains of quality of life sought by older people –

psychological wellbeing, behavioural competence, objective environment and perceived quality of life. Lawton identifies a number of characteristics that an individual will consider in a retirement village: health support, companionship, independent dwelling characteristics, dwelling affordability (cost), village amenities, village facilities and village location. Gardner (2001) applied the Lawton Ecological Model in his study of accommodation options in later life and reports on a range of factors that contribute to and detract from a decision to move to a retirement village. Stimson (2001) reports three 'pull factors' (reason for moving to a retirement village) identified as: first, built environment and affordability; second, location; and third, the ability to maintain an existing lifestyle and familiarity. Retirement villages are becoming an integral part of the total 'package' of accommodation and service options that are available, where the move is towards increased availability of health and community services regardless of the type of accommodation. This might mean anything from high care services in a retirement unit or 'home', to low care services in a caravan. While accreditation and quality assurance mechanisms are still developing within the industry, standards for accommodation and services are apparent.

2.5.4 Interface with other health service sectors

The interface between hospital and residential care services is a major area of concern for all sectors, as well as for older people. Coordination of health care has not been easy to achieve. Gibson (2002) reports that while expenditure in all sectors continues to grow in real terms, this growth is most rapid in the community care sector and least rapid in the hospital sector. While residential care places have increased, this has not kept pace with population growth or demand. This has resulted in specific interface problems, where older people are referred to as 'care awaiting placement' cases, or 'bed blockers'. For the hospital sector this is further complicated by pressures to achieve shorter shorter lengths of stay, increased presentations of older people at emergency departments and subsequent increased admissions; 12% of the population over 65 years accounts for one-third of hospital admissions and half of the total bed occupancy. Gibson (2002) reports an increased emphasis, and more funding, on acute surgical and medical episodes of care, and a decreased emphasis on palliative care, rehabilitation and restorative care.

In Australia it is not easy for older people to move across the service sectors. A number of difficulties have been recognised:

- services are funded through many different government packages;
- assessment of client need is duplicated among service providers;
- role boundaries among professionals restrict the ability to provide services in a more flexible and cost effective way; and
- myths associated with ageing and 'presumed' dependency exist within the community.

Some older people living in their own home or perhaps with a relative, who are admitted to an acute care service because of a deterioration in their health status or treatment of a specific complaint, find that they cannot be discharged home and have no choice but to be admitted to a residential facility. The waiting list for residential care is considerable in all States and the process of assessment for admission is arduous for the individual and their family. The hospital cannot keep them indefinitely and there is increasing pressure over time to discharge them out of the acute system, because of increasing demand for hospital beds.

A similar concern involves the interface between different home and community care services, often coordinated and funded by different agencies. Services can be funded by different levels of government, may be public or private providers, and may have different eligibility criteria. The assessment processes for a particular service may be repeated and the information is frequently not shared between agencies. The situation can become very frustrating and time-consuming for everyone.

The preferred outcome is for the services to be 'consumer driven' but this is not always the case. What is best for an individual, or just what they would prefer, does not always match with what is available or what they are assessed as eligible for, or 'need'.

Attempts are being made across many countries to improve this situation and there are some common principles behind this push for more integrated care (Bergman et al , 1997) These common principles include:

- Standardised assessment and entry criteria,
- A reduction in the collection of repeated information from different providers,
- Funding equity,
- Improvements in communication between professionals and across sectors,
- Agreed standards,
- Encouragement of case management and coordination between providers and professionals,
- Promotion of independence and ‘best’ health, with a focus on what you can still do for yourself rather than what has to be done for you (wellness focus),
- A focus or goal of ‘active living’ rather than inactivity while waiting for death (health promotion).

A number of issues related to the interface between service sectors warrant inquiry.

Those with particular relevance to this study are:

- Flexibility in the allocation of aged care places to meet individual need, not accommodation type;
- Changes to government funding;
- Measures to address recruitment, retention and training for the workforce;
- Reporting process needing review and refinement;
- Innovative approaches to accommodation and service delivery;
- Articulation between service sectors; and
- Adoption of a healthy ageing focus across the sector.

2.6 Significant workforce issues

The workforce is the highest budget item within the aged care industry (Hogan, 2004). Workforce costs and issues in aged care impact on a provider’s capacity to provide appropriate staff and services for residents. There is a national staffing crisis in health care in Australia (AIHW, 2001). Specifically, this relates to a lack of appropriately skilled staff, current roles that no longer address the nature of the work and difficulty attracting and retaining staff. Rural areas are further disadvantaged. Education providers find it increasingly difficult to prepare a workforce that can

meet the needs of the aged care industry. Nursing workforce information in Australia indicates a serious shortage of both registered and enrolled nurses working in aged care (AIHW, 2001; Stein, 2000). Between 1994 and 1997, employment of nurses in nursing homes fell by 10.9% with decreases in both private (13.2%) and public (8.7%) nursing homes. This was in spite of an increase in the number of nursing home beds and in the proportion of patients needing the highest level of nursing care. The future role of the registered nurse, considering that he/she is currently the primary provider of care in residential aged care, is in need of review.

In contrast to the shortage of registered and enrolled nurses in residential aged care, the number of persons in non-registered care positions (personal carers) has increased markedly from 16,700 in 1991 to 35,941 in 1996 and continues to do so. This trend is evident across Australia and is accompanied by some concern over role boundaries and responsibilities. Personal Carers, also known by different titles, e.g. Care Aides, Care Workers and Nursing Aides, are an integral, valued part of the workforce in residential aged care and are being called upon to expand their role as the overall nursing shortage continues.

The effective management of human resources within an organisation is critical to effective management (Horner, 1995). Residential aged care involves some unique management challenges. For example, the manager is responsible for a business that is also the residents' 'home'. The manager is also responsible for staff who may, on the one hand, be employed as health professionals and carers but who, at the same time, build personal relationships with residents and endeavour to create an informal and home-like environment. Organisational rules and regulations are essential, but flexibility is critical. There are a number of other key workforce issues for service providers that impact on their ability to provide a required number of appropriately qualified staff.

2.6.1 Casualisation

Australian statistics compiled over the last decade indicate that the number of casual health care employees in Australia has doubled and now exceeds 25 per cent (Lowry, 2001). Casual employment contracts are common in aged care. Employers often cite

pay and penalty rates as the main reason for employing casual staff. For the employee, flexibility of hours of work and greater ability to accommodate other demands such as those of family or part-time education, are likely to be the main attractions.

However, casual workers are often treated as if they are forced to work, are undervalued, assumed to be less committed/less involved, are given fewer opportunities for training or advancement and are assumed to have lower expectations of what an organisation will offer them. For example, Lowry's (2001) study of 454 casual workers employed in 22 recreation clubs in NSW found that nearly two-thirds: were involuntarily casually employed (it being the employer's decision to keep them as casual); desired full- or part-time work; received little training; had little opportunity for career progression; received little performance evaluation or recognition; had difficulty integrating into the organisation or work team; and felt there was inequity in the treatment of casual, part-time staff versus permanent staff. As Lowry points out, ignoring casual workers may impact negatively on the quality of working life as well as the quality of service provision.

2.6.2 Work friendly environment

The work environment is critical to employee satisfaction. Work-friendly (family-friendly) practices are defined as any benefits or working conditions that an organisation may have in place that assists an employee to balance the domains of family and work (Bardoel and Tharenou 1998). Lane (2001) describes work-friendly practices as 'the little things that count'. Presently, there is a lack of conceptual models to identify key factors important for implementing work-friendly practices. Research by Bardoel and Tharenou (1998) suggests that organisational size and human resources management influence the extent and type of work friendly practices. Large organisations, for example, are more likely to adopt policies pertaining to individual support (e.g. personal counselling, relocation assistance, career opportunity), leave options, child/dependent work options and individual growth.

In Lane's (2001) study of a large manufacturing organisation, employees were asked to describe what they expected of an employer of choice. The following key factors were cited: generous paid maternity leave (16 weeks); employer salary sacrifice options to be able to purchase more annual leave (for school holidays); children's room/resources for emergencies; sabbatical leave without pay but without penalty; and access to services to "maximise" off-work time. These services included dry cleaning picked up and delivered to work, access to mobile care service options, and access to advice for tax returns done during work time. Classes on site/advice on health, fitness, relaxation, subsidised gym membership and flexible education options (for example, PCs available for study purposes) were also suggested. Whilst these results are not based on data collected from a health care organisation, they have some relevance in the sense that, as in residential aged care, the workforce in the above study was predominantly female.

Equally relevant to this issue is the fact that there has been a significant increase over the last five years in the number of nurses (including aged care nurses) choosing to work for 'agencies' rather than individual employers. Flexibility has been identified by agency staff as being a significant benefit of this form of employment. This flexibility includes the employee's choice of shift, ability to say 'no', choice of facility and avoidance of 'extra' activities that are often a component of contractual employment.

Choo (1999) argues that the ageing population is changing the nature of the workplace and is influencing the working environment. 'Baby boomers' are the emerging cohort of older worker and they have different attitudes to work and expectations of the work setting than many of their predecessors. They view benefit packages, a pleasant working environment and training opportunities as the norm to which they are entitled. They are very conscious of their rights as employees and expect to be treated equitably. For older women in the workforce, a major concern is having the time to attend to elder care (rather than child care), emergency care, long-term care and juggling family responsibilities with work responsibilities. Choo cites a US study that sought a solution to the lost productivity of having employees taking time off for elder care. Employees were provided with access to a resource and referral service rather than having to track down information themselves. The

employer saved US\$266,000 in lost productivity. This finding demonstrates the need to create working environments that support employees by providing the little but important things that make a difference to the quality of a person's working life, at the same time as building commitment to the employer.

2.6.3 Recruitment, retention and staff turnover

Employers report a number of recruitment challenges. Successful recruitment strategies have been identified marketing the organisation as a great place to work, providing a learning environment (opportunity for training, viewing mistakes as an opportunity to learn rather than an opportunity to judge and punish, encouragement for innovation and creativity), involving employees in the recruitment process and strategic planning to anticipate need rather than reacting to a crisis in a knee-jerk fashion.

Strategies to retain staff market the employer internally, reminding employees of the values associated with employment and their employer. Organisations need to continue to market themselves to their employees and not rest on the fact that they are 'on board'. This means working to understand the workforce, the needs and values of employees, strengthening relationships between managers and all levels of staff, finding ways to balance work and personal pressures, and seeking out ways to recognise and reward performance. If employees are rarely rewarded, they will expect something significant. However, if they are rewarded on a regular basis they will accept the smallest acknowledgement. On the other hand, the workload issues that have been recognised as the most significant challenges to employee retention rates are non-client (resident) tasks, feeling worn out, lack of opportunities to 'regenerate' and having to cover shifts for other employees (Choo, 1999).

Staff turnover has been a topic of concern for many years. The literature serves to underscore the complexity of accounting for voluntary turnover in organisations and has collectively demonstrated that a host of factors potentially influence an individual's decision to leave. These factors include: dissatisfaction with the work, supervisory/management style, unmet expectations regarding pay, promotion or training, personal factors and other employment opportunities. The literature also

demonstrates that when employees decide to leave, their decisions are not typically one-off but rather mark the end of a more complex process. While decisions to leave an employer are generally triggered by a single event, or a specific dissatisfaction, they usually involve a series of cognitive and behavioural considerations – in other words, a process of reflection. It is during this process of reflection that there is an opportunity to prevent someone leaving the organisation for ill-considered or un-reflective reasons (Campbell and Campbell, 2001).

Although the cost of turnover varies between organisations, it is usually underestimated. The typical salary cost of voluntary turnover ranges from 0.5 to 2.5 times the annual salary of the job/position, where turnover expenses include separation costs as well as those related to replacement, orientation and training. Gray, Phillips and Normand (1996) identify direct and indirect staff turnover costs. Direct costs are recruitment, publicity, review and preparation of job descriptions, advertising, processing and short-listing applicants, interviewing, health screening, relocation, redundancy, orientation and agency staff fill-in or overtime. Indirect costs include reduction in service and cancellation of services or closing of beds. The average efficiency loss over the first six months of employment was estimated to be at least 30 per cent, and possibly as high as 50 per cent (Gray et al). However, staff turnover is not all bad and voluntary turnover can increase productivity, provide opportunities for other staff and bring new knowledge and skills to a work team as and when new staff members are recruited.

Lack of professional recognition of nurses working in aged care is a significant issue for both nurses and management. In a workshop convened by the Nurses Board of Western Australian (NBWA) to address nursing shortage issues in aged care, lack of professional recognition was identified as a dominant theme (Hardcastle 2000). Similarly, a study of the recruitment and retention of qualified nursing staff in aged care identified the generally low status of aged care nurses compared with other health professionals as a major issue (Nay and Closs 1998). These, along with other factors such as workload, the nature of the clinical role, lower rates of pay compared with the hospital sector and the lack of career pathway, have reduced the attractiveness of the sector to nurses, leading to an increased role for non-registered carers.

While those who choose to work in aged care report great satisfaction with both the nature of the work and the relationships they develop with the client population, it is demanding work (Hardcastle, 2002). The industry faces recruitment and retention problems and providers need to be better supported to provide staff with education and training to enable them to feel confident and competent for the role. It is important to explore how clients relate to staff, what clients value in staff and how clients can inform organisations in terms of environment, accommodation, roles and responsibilities and work practices.

2.7 Adapting and changing for the future

Demographic data alone is not sufficient to predict the quantity and nature of accommodation and services that will be needed in the future. A percentage of the population potentially in need of services has been identified as having a mild, severe or profound restriction in communication and in activities of daily living, such that they require assistance from another (Cluning, 2001). Surveys conducted by the Australian Bureau of Statistics (ABS) have identified that just over one third of the total population aged over 70 years comes within this definition of handicapped or frail aged. The number of people aged 65 years and over who require at least some assistance with the basic activities of daily living is estimated to have increased from 0.25 million in 1981 to 0.5 million in 2001 and is projected to increase to two million by 2031 (AIHW, 1999a: 208). It is evident that there will continue to be an increasing need for aged care services for the older population. It is also clear that there will be changes to the supply of unpaid informal care from families, relatives and friends, as many of these people will also be ageing. High rates of females in the workforce, high rates of divorce, an increase in the number of single-parent households, increase in the number of job changes and an increase in the number of people working longer, will all affect the structure and function of informal carer networks and the availability of a volunteer workforce.

However, a large percentage of older people are not universally disadvantaged and at risk. Many are financially independent and live healthy and empowered lifestyles. Today, you are no longer old at 65 years. With improvements in general health, with prevention and major advances in medical treatments, old age does not necessarily

mean dependence and a poor lifestyle. Many older people consider themselves to be in good health, although perhaps a little less healthy than in previous years. Some believe that they can continue to improve their health and quality of life as they get older (Cluning, 2001). Health, wellbeing and independence of older people can be enhanced by the actions of older people themselves, by a society that recognises and values the wisdom and experience of older people, by strategic planning and positive action by governments and policy makers, and by partnerships between practitioners and service providers.

Although the projected increase in the older population is not a trivial matter for accommodation and health service policy, the more pressing challenge is to determine what planning and change is needed now, to ensure all older people the opportunity of high quality accommodation and health services, and quality of life in the future. For the industry sector most involved in accommodation and services for older people, there is increasing pressure to better understand the complexities and challenges they face and the process of change that needs to be implemented. This challenge and the process of change, is the focus of this study.

2.8 A summary of the background to this study

The impact of an ageing population is likely to be seen in changes to government policy and funding for aged care providers, as governments seek to respond to changing demand for accommodation and services for healthy older people as well as those in need and unable to manage on their own. The impact is also being felt by the aged care industry. It is clear that the aged care and retirement industries are facing change and many have embarked on significant redevelopment projects. It is also clear that many are struggling to address issues of structure and function, including financial accountability, as part of their redevelopment, while continuing to meet the needs of their resident populations without compromising quality of life.

CHAPTER 3 RESEARCH METHOD AND DESIGN

This chapter provides a detailed description of the methods used to investigate the input and influence of change on an aged care organisation. It presents a rationale for the use of action research as the principal means of inquiry, and then describes the procedures used throughout the study. Finally, it explores issues of ethics and quality that ensure that the research was carried out in a rigorous and acceptable manner.

3.1 Research method

Action research was selected as the method because of the need to provide in-depth, detailed understanding of the processes of change in an aged care organisation. A participative approach enabled the participants to be involved in a research process and outcomes that could have a long-term benefit. The research environment and process provided a structure for participative learning and realised new knowledge, with benefit for the organisation for the future.

3.1.1 Action research

Action research is one approach within a range of critical methodologies that have a central interest in exploring the relationship between knowledge and action, where knowledge relates to power and power to change.

‘Action research is a systematic, participatory approach to inquiry that enables people to extend their understanding of problems or issues and to formulate actions directed towards resolution of those problems or issues’ (Stringer and Genat, 2004, p4).

The roots of action research lie in the first half of the twentieth century, with the term credited to Kurt Lewin (1890-1947), a social psychologist. Lewin was interested in constructive solutions to social conflict with a particular interest in problems of poverty and exploitation in minority groups. His approach to action research (Lewin, 1948; Lewin and Lewin, 1942; Lewin, 1946) is well published and cited by scholars

and students. Lewin drew on theories of progressive education, advanced by philosophers like Dewey. He was particularly interested in people learning to solve their own problems through self-education so they would enable themselves to improve their situation. It was his belief that people are more likely to act on decisions made democratically within a group than they are on decisions made without involvement. His later work involved experiments that aimed to increase productivity among people in factories, where he implemented a group process of inquiry and learning. Lewin suggested the idea of action research as a cyclical process, a series of stages including activities such as fact-finding, planning, action, reflection, evaluation and refinement of a problem.

Lewin also has his critics among contemporary writers. Waterman et al (2001) explain some of the criticisms in 'Action Research: a systematic review and guidance for assessment'. Carr and Kemmis (1997) asserted that group decision-making was a technique to gain cooperation rather than a fundamental principle for social action. Adelman (1993) asserted that Lewin had not developed theoretical structures to assist in the critique of oppressive power bases in manager-worker relationships.

Hart and Bond (1999), however, see the influence of Lewin's work in industrial and organisational research where the researcher acts as a consultant and works with the organisation to resolve a problem and evaluate change that results. Gunz and Jacob (1996) report Moreno (1892-1974) as another forefather of action research. Moreno, a social philosopher, helped to promote a social science approach with subjects as active not passive participants, and viewed researchers as social investigators not observers. The integration of theory and practice, with researchers acting as participants, is evident as a key characteristic of action research today.

Stenhouse (1975), Elliott (1991) and Nofke (1994) were key supporters of action research in education. Through his work in curriculum development, Stenhouse supported the notion of teacher as researcher, where action research coupled with change and became relevant in everyday classroom situations and problems. Elliott also worked in curriculum development and encouraged reflection by teachers as a means of understanding practice. The relevance to education is continued by

Kemmis and McTaggart (1997), who promote a collective form of action research and a group process to affect change.

Carr and Kemmis (1997) outline action research as critical education science and argue that the 'objects' of action research, i.e. the things that action researchers research and aim to improve, are their own educational practices, their understanding of these practices and the situations in which they practice (p 180).

“It engages the action researcher in extending the action research process to involve others collaboratively in all phases of the research process.” (p182)

The field of action research is varied and in practice choices may be made as to how implementation is interpreted. However, there are five broadly shared features: participation and democracy, knowledge-in-action, practical issues, human flourishing and emergent developmental form (Reason and Bradbury, 2001). There are varying definitions of action research within the literature, all of which capture these key features in some way. The following definition is one of the most comprehensive and is particularly relevant to this study.

“Action research is a period of inquiry, which describes, interprets and explains social situations, while executing a change intervention aimed at improvement and involvement. It is problem-focussed, context-specific and future oriented. Action research is a group activity with an explicit critical value basis and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked” (Waterman et al, 2001 p 11).

There are a number of forms of action oriented research which place the emphasis on the developmental orientation to gain knowledge during the inquiry process, including action learning, action science, action inquiry and cooperative inquiry (Reason, 2001). Within the learning process, emphasis is placed upon collaboration between individuals, development of skills of reflective practice and open inquiry, as

part of work life. Developing commitment to reflection and learning is viewed as an essential component of good organisational management and integral to the development of what is now often referred to as a 'learning organisation' (Reason, 2001). Two criteria appear as fundamental to action research within this definition and are critical to this study: the cyclic process and the research partnership.

The cyclical process of action research facilitates reflection and contributes to learning. Reason (2001) identifies two objectives of participatory research. The first is to produce knowledge and action that is directly useful to a group of people. The second is to empower people to construct and use their own knowledge for their benefit. This raising of consciousness represents a process of learning through inquiry and reflection.

The relationship of action research to organisational learning is recognised by many. Susman and Evered (1978) and Livesey and Challender (2002) propose that the focus of action research is organisational development. Checkland (1999) takes the view that action research is about change and how to achieve it, and this quality makes it different from other research. The action research cycle of action and reflection results in the development of strategies that facilitate both the learning process and the learning outcomes.

The action research cycle incorporates problem identification, planning, action and evaluation (feedback and reflection), often leading to new problems, planning, action and evaluation. Within each cycle there may be a series of small or mini-cycles around contributing issues or factors and with sub-groups of individuals. This means the overall process needs to be flexible and fluid to allow for movement in different directions and to accommodate a change in direction if required. The nature of the cycle and the flexibility provides a framework for understanding and resolution of issues 'along the way' and the application of new knowledge into practice. This can lead to innovation and change, encouraging and facilitating the implementation of change within a supported, reflective environment.

Action research emphasises the concept of co-researchers and stresses the notion of participation as fundamental to achieving more democratic research processes and

realisation of practical, relevant outcomes. Research is 'done with' not 'done to' participants. The researcher does not presume a position of power nor participate as an expert, but rather as an equal partner in a process of discovery. Knowledge and power is balanced; the researcher may have knowledge of the process but the participants have knowledge of the setting. Changes in position may occur as participants gain more understanding of the situation and participate in finding solutions. Action research calls for reflection and analysis of knowledge and action by all participants and, consequently, has an educational function. This new knowledge and understanding can be liberating and enabling as individuals and the whole group learn through exploration. Learning is shared within the group during reflection as individuals gain insight into particular issues or situations.

3.1.2 Action research in healthcare

The interest in action research and its application in education continued into health care research, where the lack of involvement of practitioners in research was also recognised. Action research was promoted as a means of involving practitioners. Hart and Bond (1995) recognised that a large amount of research in health care was carried out by nurses and promoted action research as a relevant extension of the way nurses work in partnerships with clients and colleagues. Health practitioners often work as part of a team, with patients/clients, colleagues from different professions, families, community groups, and administrators. Health care practice often involves a process of planning, review, reflection and action within a collaborative relationship, with an overall aim of improving health outcomes. Action research provides a disciplined approach and a set of tools that can be readily applied to many different health settings and with different patient/client groups. Outlines of action research projects across a range of health care settings are listed.

Chenoweth and Luck (2003) describe a quality improvement study that 'focussed on evaluating and improving discharge planning at a large metropolitan teaching hospital'. They report that,

“ Action research was found to be a means of developing trust, respect and cooperation among the participants which, in turn, facilitated a system-wide

appreciation of this complex and important aspect to healthcare services and allowed participants to identify those aspects requiring change". (p72)

Linderman et al (2002) report action research as "a means for potentially improving the links between research and practice, and in improving educational effectiveness to enhance resident/patient care in aged care settings." (p10) The authors describe the application of action research in two projects: improving nutrition and physical activity, and in falls prevention.

Meyer (2000) reports on the use of qualitative methods in health related action research where they can be used to foster better practice across inter-professional boundaries and settings where practitioners can review practice. The author outlines three important elements: the participatory nature of action research, democratic impulse and contribution to social science and change.

Coghlan and Casey (2001) state, "nurses are increasingly engaging in action research projects to improve aspects of nursing practice, education and management and contribute to the development of the profession" (p674). A study that looked at action research from the inside, explored the nature of the challenges that face action researchers in nursing. The authors conclude that action research presents opportunities for personal learning, organisational learning and contribution to knowledge.

Action research has also been used to achieve organisational collaboration in the non-profit sector, involving six independent voluntary agencies working in the HIV/AIDS field in the UK (Harris & Harris, 2002). The writers identify three aspects of the action research method as particularly helpful in facilitating organisational change. First, feedback of interview notes to participants and sharing of accounts led to better understanding and enabled decisions to be made about the change process. Second, written reports became the basis of group discussion and further helped participants to reflect on their views. Third, the development of possible organisational models or scenarios demonstrated real outcomes from the collaborative process.

Stringer and Genat (2004) encapsulate the potential of action research in health care when they say,

“The systematic processes of inquiry available through action research extend the professional capacities of health practitioners, providing methods that improve the effectiveness of interventions and augment professional practice in ways that enhance outcomes for clients” (p1).

3.1.3 Philosophical foundations

Action research is based on a philosophical stance that focuses on the way knowledge is acquired, interpreted and what outcomes can be expected. It is grounded on the foundations of naturalistic inquiry and phenomenology. Through the systematic participatory approach of action research, the lived experiences of participants are explored to find meaning and understanding that, with reflection, can translate to learning that is a basis for action.

3.1.3.1 *Naturalistic inquiry*

Naturalistic inquiry provides the methodological grounding for action research by focusing on participants’ meaning and understanding rather than looking for causal relationships. Naturalistic inquiry, often referred to as qualitative research, uses a diverse set of tools to study social and cultural phenomena and to explore meaning. People interpret their experiences in different ways and make meaning according to social and cultural norms and experiences. Where a group of individuals develop similar patterns of behaviour with similar experience and learning, they may develop a better understanding of the world in which they live and work. Naturalistic inquiry aims to explore the world of others and bring meaning to the combined worlds of interacting individuals. Stringer explains,

‘ It is this understanding that is at the heart of action research – the need to clarify and understand the meaning implicit in the acts and behaviours of all people involved in events on which research is focussed, and the need to use those extended understandings as the basis for resolving the problems investigated” (Stringer and Genat, 2004 p22).

By comparison, objective science or positivism is often more focussed on quantitative research. It operates according to an agreed set of assumptions and beliefs about how we acquire knowledge and seeks to describe features of our world and relationships between features. Positivism uses a specific set of tools to measure variables and to determine the nature and extent of relationships between variables, often seeking to find causal relationships (Grbich, 1999). The accurate definition and measurement of variables and relationships, the aim of much objective science, has provided a powerful body of knowledge, particularly in biological and physical sciences. Research into social or cultural contexts, which are the foundations of human social life, are often studied more effectively with the help of naturalistic inquiry.

3.1.3.2 *Phenomenology*

A phenomenological perspective underpins an action research orientation by seeking meanings inherent in participant lived experiences. Phenomenology stems from the work of Edmund Husserl (1859-1938) and seeks to find how individuals understand and interpret 'things' or phenomena. Other writers, including Grbich, (1999), Jean-Paul Sartre (1960, 1963), Maurice Merleau-Ponty (1943, 1962) and Martin Heidegger (1962, 1982), seek to identify, understand and describe the subjective experiences of respondents. The emphasis is on identifying and describing the participants' 'lived experiences' (Grbich, 1999) through rigorous analysis, rather than a subjective interpretation by a researcher. In research, everyday experiences are studied from the point of view of the participants as they describe their view of their world. An interpretive approach to qualitative inquiry describes and gives meaning to events and situations as described by the participants and enhances our understanding or comprehension of experiences.

“Taking an interpretive approach, action research:

- identifies different definitions of the problem;
- reveals the perspectives of the various interested parties;
- suggests alternative points of view from which the problem can be interpreted and assessed;

- identifies strategic points of intervention; and
- exposes the limits of statistical information by furnishing materials that enable the understanding of individual experiences” (Stringer and Genat, 2004).

Phenomenology suggests that if researchers put aside prevailing, accepted understandings of phenomena and revisit individuals’ immediate experience of them, it is possible that new meaning will emerge or that current meaning will be reinforced (Crotty, 1998). It requires that usual (previous) understandings are set aside and a fresh look is taken at things that we ‘know’. Sadler (1969) in Croftly (1998) describes phenomenology as ‘an attempt to find a fresh perception without prejudice or acculturation’ (p80). Phenomenology may question what we take for granted and is viewed as a critical methodology, involving critical reflection and reinterpretation.

Benner (1994) supports the use of interpretive phenomenology to study what is described as everyday aspects of the world, where the researcher seeks to understand the world of concerns, habits and skills presented by participants. It uses a stringent set of disciplines to give the best possible account of the text, guided by an ethic of ‘understanding responsiveness’, so that the researcher does not read into the text what is not there. The interpreter does not place his or her own world onto the text, rather, listens carefully and hears ‘the voices’ and concerns within the text to give a full account.

3.1.4 Validity in action research

Validity is a critical issue in research and enables the inquirer to persuade the audience (including self) that findings of an inquiry are worthy of attention (Lincoln and Guba, 1985). Processes for testing validity of an experimental study are well formulated. Experimental inquiry is judged by its ability to demonstrate the extent to which variables in outcomes are attributed to controlled variation in independent variables, so demonstrating causal relationship (internal validity). Further, this causal relationship can be generalised across alternative measures of the cause and effect

and across different types of persons, setting and issues (external validity). It views reliability as a precondition for validity, where reliability implies dependability, stability, consistency, predictability and accuracy. Assessing the validity of qualitative research, including action research, requires quite different processes as the methods are subjective in nature and local in scope.

Researchers have identified a number of assumptions underlying the term 'validity'. Denzin and Lincoln (1998) in Stringer and Genat (2004) interpret validity in action research as, "a text's call to authority and truth" (49). Waterman et al (2001) further suggest that action research needs to be judged according to its own terms: participatory work, aimed at change, and movement between reflection, action and evaluation. Badger (2000) claims that action research is not amenable to critique by the strategies used for other methodologies. He explains,

"the design of action research is led by the research problem rather than the requirements of a particular methodology, and may be affected by the dynamics of the situation itself." (p 201)

Action research seeks to construct an understanding of a dynamic, complex social world, situation or agency and, being essentially qualitative and naturalistic, it reveals subjective experiences of the participants and how they assess meaning in their world or situation. Taking a set of criteria proposed by Lincoln and Guba (1985), Stringer and Genat (2004) suggest validity is demonstrated through trustworthiness and is established by attaining credibility, transferability, dependability and confirmability. Stringer and Genat (2004) view validity as a question of quality and address issues of validity when they say,

"the truths emerging from naturalistic inquiry are always contingent (i.e. they are 'true' only for the people, the time and setting of that particular study). We are not looking for 'the Truth' or 'the causes', but 'truths-in-context' (p 49).

They go on to explain that there are no objective measures of validity, so the underlying issue is trustworthiness, 'the extent to which we can trust the truthfulness

or adequacy of a research project' (p50). Lincoln and Guba (1985), as outlined in Stringer and Genat (2004) suggest that trustworthiness can be assessed according to a set of criteria that includes credibility, transferability, dependability and confirmability.

3.1.4.1 Credibility

Credibility is the naturalist's substitute for the experimental inquiry's internal validity (Lincoln and Guba, 1985). It minimizes the extent to which the researcher's personal views intrude on the study. Careful adherence to particular processes and activities that increase the probability of credible findings, demonstrates rigour. Credibility is established through prolonged engagement, persistent observation, triangulation, diverse case analysis, participant debriefing, referential adequacy and member checking.

Prolonged engagement is the investment of sufficient time to achieve an in-depth understanding of the context, to acquire knowledge and establish trust with participants. It also allows the researcher to recognise personal and participants' (unintended) distortions and misinformation. Persistent observation during prolonged engagement further demonstrates credibility. It requires repeated, extended observations to establish adequacy, accuracy and appropriateness of data. The researcher also needs to record the time spent in the research context, along with the number and duration of observations and interactions.

Triangulation is a technique to improve the probability that findings and interpretations will be found credible. Quantitative and qualitative approaches can be used to collect data, and multiple sources and methods provide a rich resource for building understanding and progressing to resolution of a research problem. Diverse case analysis using material obtained from a variety of types of participants ensures all perspectives are considered and is demonstrated through sampling procedures.

The credibility of a study is further enhanced where records show opportunity for participant debriefing. This applies to the research facilitator and participants. Participant debriefing provides opportunity for reviewing appropriateness of

activities, clarification of descriptions and interpretations and sometimes an opportunity to deal with emotions and feelings that might emerge. The credibility of a study is also enhanced by a direct relationship between terminology and language of the participants, referred to by Stringer and Genat (2004) as referential adequacy. Events, activities and other phenomena are expressed in the language of the participants and used in the account of a study, expressed as the findings.

Reflection is a critical factor in qualitative research. It is the process of considering how the researcher's own actions, beliefs and values have affected the situation that is being studied and its interpretation. The use of a reflective journal throughout the study not only captures the researcher's thoughts and reflections, it also provides a record of a process of critical analysis embarked on by the researcher.

Finally, a process of member checks enhances credibility. It enables participants to review raw and analysed data and reports to ensure validity. Opportunity to reflect on interview notes during and at the completion of interviews is an important process, as is ongoing interaction with participants in a study to provide opportunity for feedback and reflection on data analysis and reporting. Towards the end of a study, participants' involvement in reviewing text from the study and discussion of findings provides further opportunity for member checking.

Stringer and Genat (2004) argue that credibility of an action research project may be further enhanced by participation of stakeholders (p53). Engaging people as participants in the research minimises the impact of the likelihood that the researcher will interpret events through their own interpretive framework. Bray et al (2000) report on the merits of participative inquiry as a means of establishing validity, in which participants collaborate (work together), cooperate (accommodate each other) and actively engage in a process of inquiry to answer questions of importance to them.

3.1.4.2 Transferability

Naturalistic inquiry can only apply results directly to the context of the study. Lincoln and Guba (1985) argue that it is not the naturalistic researcher's task to

provide an index of transferability, but rather a responsibility to provide the database that makes transferability judgements possible on the part of the potential applier (p316). Nevertheless, to enable people to take advantage of knowledge that arises from research, researchers seek to provide the possibility that results from a qualitative study might be transferred to another study. Detailed description contributes to trustworthiness by enabling the reader to understand the context and people participating in a study. Full explanation of research method and design, data collection approaches and analysis, along with the findings of a study, may assist others to recognise possible similarities and learning relevant to their situation.

3.1.4.3 *Dependability and confirmability*

A study is dependable when research procedures are deemed adequate for its purpose. Details of the research process are made available to participants and other audiences in the form of an inquiry audit. This includes processes used to define the research problem, data collection and analysis and construction of reports. The audit also provides details of the raw data compiled throughout the study. The inquiry is compiled chronologically and categorised according to source. Dependability and trustworthiness of a study is enhanced by the accuracy of such information.

3.1.5 Ethics and confidentiality

The relationship between the researcher and researched are the key issues in research ethics. Examples of unethical research behaviour include: deception about the purpose of the research, creating distress for participants through the research process, studying people and their behaviour without permission, violating confidentiality and falsifying or presenting results out of context (Grbich, 1999, p 71).

Polit and Hungler (1978) refer to three common ethical requirements - voluntary participation, freedom from physical or psychological harm and distress, and anonymity or confidentiality of information (p32). While universities, agencies and some organisations have explicit guidelines about ethical conduct and procedures for

researchers, researchers may not be sufficiently aware of the potential for harm among research participants, if the research process itself consumes the researcher.

Action research and the process of inquiry that includes extended periods of contact and the development of relationships based on trust, must pay particular attention to the need for confidentiality, care and sensitivity. Conversations during the research process may reveal personal, private information and the researcher must have procedures in place to reassure the participants and provide ways to deal with information that is obtained. Presuming confidentiality of all information is a good principle, as is sensitivity towards participants as individuals as well as members of a group.

A duty of care towards participants accompanies any research inquiry (Stringer and Genat, 2004). This requires secure storage of all data and documents for the length of the study and beyond, being alert for discomfort during inquiry and establishing strategies for referral or action if a situation arises where a participant demonstrates distress or need for follow up.

Formal ethics protocols are well known and common protocols include obtaining permission for inquiry, informed consent, explanatory notes and a description of the purpose of the study, evidence of the status of the researcher and an outline of the research process.

3.2 Research design

A participative action research approach was employed in this study. Action research processes of planning, data collection and analysis, reflection and action were employed to illuminate the complex dynamics of the change process within an aged care organisation. The provider had elected to embark on a redevelopment process and wanted to monitor and understand how the change that was associated with this redevelopment would impact on the organisation and its residents.

3.2.1 Aim

The aim of this study was to explore the impact of change resulting from an organisational redevelopment process in a community-based residential aged care community and, in particular, the impact on the residents and senior management team (SMT), the leaders. The study sought to provide information for the SMT about the complexity of the challenge associated with organisational change within an aged care community that would enable them to manage the change process more effectively.

3.2.2 Objectives

The objectives of the study were to:

1. Explore the impact of the redevelopment process on the residents within the aged care community.
2. Examine the changes to the structure and function of the organisation as a result of the redevelopment process.
3. Explore the impact of the change process on the leaders of the organisation and the influence of the change process on their development as leaders.
4. Inform the organisation how to better meet the challenges of change.

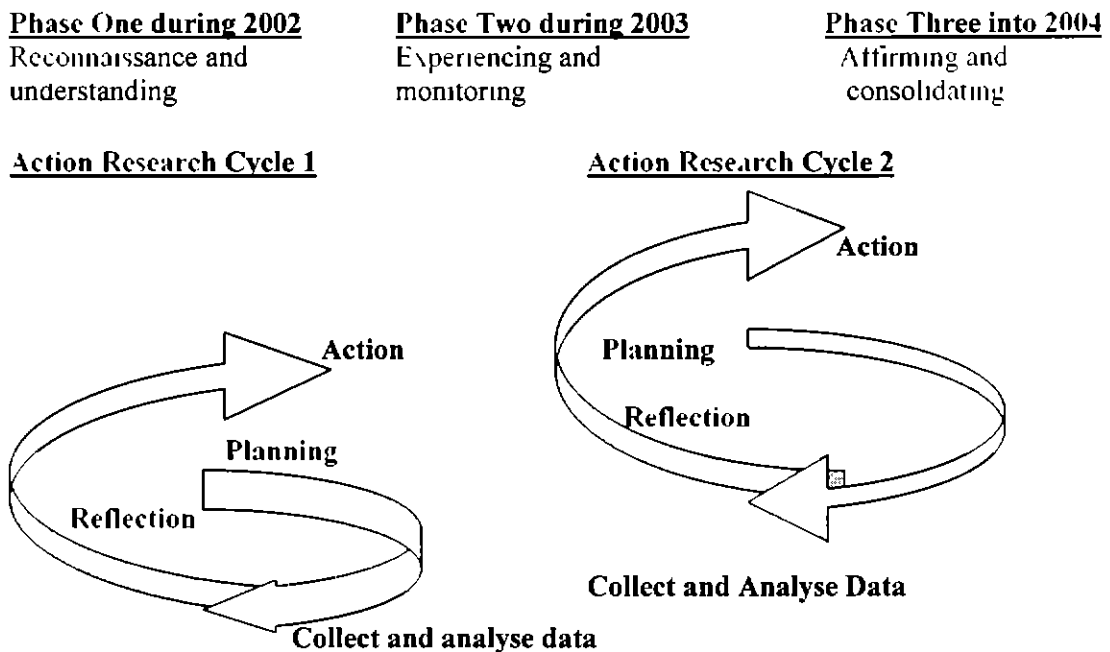
3.2.3 Study overview

The study occurred predominantly over two years (2002-2003), with some continuation into a third year (2004), incorporating three phases of activity, including two action research cycles. A research team consisting of the researcher and eleven members of the senior management team (SMT) formed the critical reference group (CRG) and participated as equal members of the research team. The participative, sustained commitment called for by this study was additional to the regular workload of the senior managers so the research process needed to be flexible and adapt to the work environment and work priorities.

Figure 5 presents the three phases of the study during 2002-2004 and the associated action research cycles. It shows that action research cycle one occurred

predominantly in the first phase of the study, in 2002; action research cycle two was predominantly in phase two, beginning in 2003. However, the action from this cycle progressed into 2004 and became the third phase of the study.

Figure 5: Study phases and action research cycles



While there were clear stages within each cycle, there were also a number of ‘mini cycles’ of planning-action-reflection. The researcher (self) first gained entry to the organisation, establishing interest and involvement, building rapport and trust and establishing the senior management team (SMT) and researcher as the critical reference group (CRG) for the study. I attended senior management team meetings at least monthly and, often, every two weeks, and completed the first of three interviews with members of the SMT.

Phase Two occurred during most of the second twelve months (2003). It built upon feedback and reflection from phase one and involved the second action research cycle. Again, there were a number of ‘mini cycles’ of planning-action-reflection within the cycle when participants became aware of further issues and questions, explored future plans and determined action. Participation in SMT meetings, additional planning meetings, interviews with residents’ representatives, interviews with a sample of staff, and further interviews with individual members of the SMT,

provided a comprehensive body of data. A management development plan, the development of a new model of care and service framework and adoption of a community-focussed and whole-of-site development plan, were all outcomes of the action research process.

Phase Three of the study began towards the end of the second twelve months and continued into the next year, until the cessation of this study in mid 2004. While this phase did not involve an action research cycle, there were several 'mini cycles' of planning-action-reflection. Activities within this phase evolved from the reflection and resulting action of the second phase, with the researcher as more of a participant observer than earlier in the study. In this phase the leadership team confirmed its future direction, strengthened its capability and began a structured process of implementing organisation-wide change. A workshop involving the CRG, Board and residents' representatives, affirmed the organisation's future plans. There was a more detailed exploration of the new model of care for service delivery and advancement of the site development plan, particularly planning for a new combined high and low care centre. This phase also revealed a change in management focus from quality processes to quality outcomes. It culminated in the creation of a new senior position, to facilitate organisational development and support a change management plan involving residents and staff.

3.2.4 Study site

Choice Village was established as a residential aged care community in Perth, Western Australia in 1960, with the first resident units being completed in 1961 with funding donated, raised or provided by Commonwealth and State governments. The number of units increased over time, to provide independent accommodation for low to middle income older people. Residential care was introduced in 1969 and, as a non-profit, non-denominational provider, all resources were owned and shared by the community. Records indicate that the organisation was an early leader in the provision of accommodation for older West Australians over more than four decades.

History indicates (Cleaver, 2002) that this was the result of the dedication and considerable hard work of many people but, in particular, the vision and commitment

of one man who led the organisation as foundation Chairman for 37 years, ending in 1997. The journey of its development includes major milestones, hardships and successes.

In 2001, at the commencement of this study, the organisation had grown to provide 284 high and low dependency residential care places for older people unable to live alone plus approximately 750 units for older people still able to live independently. It employed 350 people, mainly in the care centres but also in the administration of the organisation. The organisation was led by a community Board and an executive team of Chief Executive Officer, Care Support Director and Care Director, plus a team of senior managers with responsibility for finances, hotel services, admissions and lifestyle and information systems, high and low care centres, village care and education. A support team provided services to both directorates, in human resource management and safe practice and environment. Staff were employed as direct carers (registered nurses, enrolled nurses and personal carers), in hotel services (catering and meal service, domestic service), site support services (maintenance, gardening) and in administration (reception, clerical services, business services).

3.2.5 Participants

Following initial exploration of the research site, it became clear that there were two groups who were most affected by the redevelopment: the residents and the senior management team, including the Chief Executive Officer (CEO) and Executive Managers of each department/area. These two groups became the primary participants in this study. Secondary participants included staff working in the organisation and members of the Board.

3.2.5.1 *Residents*

As participants, the residents provided an internal, consumer view of the impact of change. There were three categories of accommodation with varying resident populations. In 2002, there were 742 residents in Independent Living Units (ILU), 120 residents in the Low Care Centre and 164 residents in two High Care Centres. In this study, a purposive sample of residents from each of the three areas of

accommodation was interviewed, using a two-stage process. Inclusion and exclusion criteria were first determined in consultation with care staff in each of the three areas and then, with their assistance, a sample of residents was identified in each of the three areas and invited by the researcher to participate in an interview. This process is described in detail later in this chapter. In a total of twenty-six interviews (semi-structured conversations), residents were engaged and encouraged to tell their story.

Additional information was obtained from participation at events, observation and listening to residents at meetings, movement throughout the community, and informal interaction with residents. In 2003, time was also spent interviewing members of the residents' advisory council as representatives of the larger resident population. The four resident representatives who were interviewed provided a cross-section of accommodation sections/options on site: a high-rise apartment, a two storey villa, an original two-bedroom single story unit who had been moved in the previous year and an original unit who had not been moved in the previous year. Residents were able to talk about their perceptions and points of view, but also reported on perceptions of other residents, captured within their role as resident representative. Although they had only held the role officially that year, all had been involved in activities, on committees and held positions of office across the community.

In 2002 and 2003, a 'quality of service' survey was sent to all residents in the independent living units. Questions about the redevelopment, change and the management of change were included in the survey. Residents were also invited to provide additional comment on questions or on any other aspect of the village or redevelopment. Analysis of this quantitative data and the valuable additional comments provided additional information. Routine resident satisfaction audits completed with residents in high and low care centres were also reviewed. These audits were part of a regular quality assurance process. Collection and analysis of data from the resident sample in each action research cycle is outlined in detail in Chapter Four.

3.2.5.2 *Senior Management Team*

The SMT were identified as the primary leaders of change and most directly involved in the redevelopment process. With the researcher, this group of eleven, the executive and senior management team, became the critical reference group for the study (CRG). In 2002, at the commencement of this study, the organisation's executive was the Chief Executive Officer (CEO), Care Support Director, and Care Director. The executive, plus managers of functional units, formed the senior management team (SMT) and were responsible for all aspects of day-to-day operations. Each individual had knowledge and experience of his or her individual portfolios, along with many years of experience in health care, particularly aged care. The CEO and two other members of the SMT had joined the organisation in 2001 but other managers had been employed for some time.

While the CRG remained engaged throughout the study, membership of this team changed. Early in 2002, a new Manager of the High Care Centres was appointed and, a little later, a new Manager of Hotel Services. Both of these appointments changed again during the study, the former early in 2003 and the latter early in 2004. In addition, the position of Care Director was vacated early in 2004 and not refilled. A new position was established, Organisational Productivity and Development Officer, and an appointment was made early in 2004. Contact with this group was continuous and data was collected during informal conversations, via three planned, semi-formal interviews with individual members, at social gatherings, from regular team meetings, and during organised focus groups and forums. Additional meetings were also held with the CEO and this provided an ongoing link to the Board.

3.2.5.3 *Workforce*

The workforce was approximately 350 at the time of this study. The majority of staff working at *Choice Village* were employed to provide care and services for residents living in the high and low care centres. Most were employed as personal carers (care attendants or care aides) and provided personal care to the residents, or as hotel services attendants and involved in meal services and other domiciliary services such as cleaning. There were also a large number of Registered Nurses and some Enrolled

Nurses working in the care centres, along with allied health staff. Clerical and administrative staff were also employed throughout the organisation, located in the care centres and administration Centre. There were also a small number of maintenance and gardening staff, however, some services were contracted to external providers. Some staff held more senior departmental coordination positions in each of the major areas and they, along with the SMT, guided the work of the organisation and the delivery of services to the resident population.

Staff were not primary participants. In 2002, during the first phase of this study, a staff questionnaire was circulated to all staff and the findings from this are summarised in Appendix V. This was not repeated formally in the second phase in 2003, however, staff were kept informed of the study through newsletters and involved in staff development and education activities, initiated within the regular human resource initiatives. Departmental coordinators were also interviewed as part of the first action research cycle.

3.2.6 Data collection

Interviews were the principal means of collecting data to understand people's experiences. Other data collection techniques involved observation, survey, workshop, research record and reflective journal. Use of a range of data sources gave strength to the study by expanding the scope of inquiry and this triangulation of data contributed to the rigour of the research process.

3.2.6.1 *Interview*

The researcher completed twenty-two interviews with residents during the first phase of the study, four during the second phase and thirty-three interviews with members of the SMT over all three phases of the study (interviews with eleven individuals on three separate occasions). The researcher also completed ten interviews with other senior staff from each department during phase two and attended regular (4-6 week) interviews with the CEO throughout the study.

Interviews with residents

A purposive sample of residents from the low and high care centres were selected for interview during action research cycle one, from a staff initiated, de-identified list of all residents in the three centres. To obtain a range of situations within the population, inclusion and exclusion criteria were identified by the CRG. First was the Resident Classification Score (RCS), which indicated the degree of dependency (care need) as 1-8, where 1 indicated maximum dependence and 8 indicated minimum dependence. Residents in a low care centre are more likely to be assessed as categories 5-8, while residents in a high care centre are more likely to be assessed at 1-4. At this time, there were only category 1-3 residents in the high care centres and 5-6 with a few at 7, in the low care centre (no residents categorised at 8). Second, cognitive level was considered, guided by the assessment/experience of staff. Ratings were: (i) can participate in an interview alone; (ii) can participate in an interview in part: (iii) cannot participate in an interview. For residents in category (ii) and (iii) category (iii) was not relevant to residents in low care and the most relevant family member was invited to either represent the resident or be present at the time of interview. Third, language was considered and the decision was made to exclude residents who did not speak and understand English without an interpreter. This process provided a stratified, purposeful sample of sixteen high care residents and sixteen low care residents, as identified in Table 1.

Table 1: Resident sample from high and low care centres

Location and potential population	Resident cognition	Resident classification	Resident classification	Resident classification	Resident classification
High Care (126)		High Care 1-2	High Care 3-4	Low Care 5-6	Low Care 7-8
	(i) participate alone	4	4		
	(ii) participate in part – family member invited (iii) cannot participate – family member invited	4	4		
Low Care (102)	(i) participate alone			4	4
	(ii) participate in part – family member invited			4	4
Total		8	8	8	8

At the time of selection, there was a total resident population in high and low care centres of 266. There was a population of 162 residents in the high care centre, reduced to 126 following exclusion by cognition and language criteria. In the low care centre, there was a population of 120 residents reduced to 102 residents, following exclusion by language and/or personal circumstances.

Within the randomly selected high care sample, residents were selected from single and double room accommodation, single-storey and two-storey buildings, recent arrivals and long-term residents, gender (male and female) and those with physical and behavioural disabilities. Within the low care sample, all residents were in the one high-rise building. There was representation from bed-sitters, one-bedroom units, men and women, long and shorter lengths of stay, and those with physical and behavioural disabilities.

All residents in the sample were sent a letter of introduction to outline the study, introduce the researcher and explain the organisation's support. Material was sent with a return envelope and contact details. Where appropriate and necessary, a letter was also sent to the next-of-kin. All residents in low care who elected to participate telephoned the researcher. Residents in the high care centres who chose to participate telephoned or got a staff member to telephone for them. In some cases, the next of kin (partner or son/daughter) telephoned to arrange a time for a meeting. Their response, plus affirmation of agreement to participate at the time of the visit, was considered informed consent.

Staff also provided a de-identified list of 667 residents who were living in the independent living units at the time. To obtain a range of situations within the population, with particular interest in residents who had been moved in the past twelve months, inclusion and exclusion criteria were determined. First, age in 2002 grouped as (i) under 70 years, and (ii) 70 years and over; second, housing situation, grouped as (i) required to move during the 2002/2003 stage of the redevelopment of the site, and (ii) not required to move during the 2002/2003 stage of the redevelopment of the site.

This provided a stratified, purposeful sample of 32 residents, comprising eight from each of the four categories for interview, illustrated in Table 2. Single residents and those living with partners were not differentiated but, in the case of a couple, differences in responses were noted during interview. The sample included men and women, types of units (bed-sitter, one bedroom, single storey, two-storey villas and apartments) and time at the village.

Table 2: Resident sample from independent living units

Resident Population	Aged under 70 in 2002/03	Aged 70 and over in 2002/03
Required to move in 2002/03	8	8
Not required to move in 2002/03	8	8
Total	16	16

All selected residents were sent a letter of introduction to outline the study, introduce the researcher and explain the organisation's support. Material sent included a return envelope and contact details. Residents who chose to participate telephoned the researcher and arranged a time for interview. Their response, plus affirmation of agreement to participate at the time of the visit, was considered informed consent. Not all residents chose to be interviewed and eighteen interviews were completed with residents in 2002. Interviews were conducted with residents from each of the categories identified in Table 2: aged under 70 years, aged 70 years and over; required to move and not required to move. If residents did not respond directly to the researcher, there was no way of knowing why they had elected not to participate.

All interviews took the form of guided conversations (Stringer and Genat, 2004). Every opportunity was given to the participant to steer the conversation in the direction of their choosing to reveal their perspective, not to focus on revealing answers to particular questions or provide particular information. The establishment of trust and comfort with the situation was critical to the outcome and time was spent establishing rapport and interest. A questioning technique common to action research involves stages, and commences with broad or general questions. For example, in this study, interviews with senior managers began with, "tell me about your role in this organisation", followed by narrower questions that shifted the conversation to more defined areas, for example, "how has your role changed in the last year?"

Sometimes prompt questions were introduced, for example, “*tell me about the residents’ care schedule.*” Other techniques used included encouragement to continue and talk more on a particular topic of issue, for example, “*tell me more about how you felt about that*”, and the use of example questions, “*can you give me an example of how trust is demonstrated within the team.*” In most cases, interviews continued for forty-five minutes to an hour. With residents, some went longer.

Interviews with residents started with questions about their family, activities or personal situation: “how long have you lived here?” and “when did you come to the organisation?” When appropriate, questions about the garden, personal effects and photos were included. Consent to participate was always confirmed in case the situation had changed since the appointment had been made. Questions moved to more specific areas of inquiry and, at times, included areas of interest/concern to the resident.

During action research cycle two, in the second half of 2003, the resident representatives on the Resident Advisory Council were invited to participate in an interview. Four residents from this group of six agreed to be interviewed in their homes, with interviews lasting between forty-five minutes and one hour. The same processes of explanation and consent were adhered to. Interviews were taped and transcribed and the text verified with participants.

Interviews with senior managers

Thirty-three interviews were completed with members of the SMT over all three phases of the study (interviews with eleven individuals on three separate occasions). The SMT were major participants in this study and all managers had agreed to individual interviews to provide opportunity for discussion and appointments were made with each individual and were in their office. Their agreement to participate was again confirmed and any questions answered. Verbal agreement to participate in an interview was viewed as informed consent. As part of the ‘understanding how we are going’ phase during research cycle one, opportunity was provided for the manager to tell some of the history of the community as it related to their role as manager and how the role had changed. Opportunity was also provided to talk about

their perception of the performance of the SMT, past and present, and to describe how they were developing as a team.

With senior managers, the process commenced with general discussion about length of employment, experience and description of the role. Second and third interviews with members of the SMT were slightly more directed, as the group had determined the focus of their inquiry and it was possible to seek a more in-depth understanding of particular issues.

Additional interviews with the CEO provided an opportunity to discuss any issues associated with the study or the direction of the inquiry. They also provided an opportunity to reaffirm continuing support for and agreement with the study.

Interviews with senior staff

Senior staff who were working as team leaders within their departments were invited to participate in an interview during the second action research cycle. Eleven staff were interviewed: two from hotel services, including catering and cleaning; four from the care centres; two from within administration; two from the support staff for residents in the village; and one from the education department.

Staff were interviewed in their office or work area at a convenient time. Consent was obtained and the aims and objectives of the study explained before commencing the interview. Interviews were semi-formal and took the form of a guided conversation, as previously explained.

3.2.6.2 *Participant observation*

Participant observation provided an additional source of data and an opportunity for familiarization with the community environment and informal resident contact. It also provided an opportunity to make note of particular characteristics, situations, events and people, while framing questions and focussing on reflection. Interaction with this community continued over a period of two and one-half years with frequent on-site attendance for meetings, interviews and other activities. A desk was provided in the general office. Therefore, there were many opportunities to listen and talk

informally with people in the office, the staff room or as they moved throughout the building. Following an orientation to the site early in the study and security identification, it was possible to walk freely throughout the site and within facilities. A log of all contact with the community was kept, including dates, time and purpose of the contact, as part of the research record. Notes were made in a research journal and these notes also became part of the research record.

Attendance at resident events, meetings and activities was encouraged and this enabled interaction with residents in a variety of settings and situations. When possible, time was spent talking informally to residents in recreational situations such as the coffee shop, lounges, and activity centres. Contact with the SMT was regular and continuous throughout the study. This included fortnightly management meetings plus additional meetings when appropriate and relevant to the study, such as organisational planning forums and site development planning sessions. A log of all SMT meetings became part of the research record and included dates, times, purpose and outcomes.

While interviews and participative observation were the primary research tools, the total body of information was enriched by additional data. The nature of the action research cycle and the process of 'look-think-act' (Stringer and Genat, 2004) caused a response to opportunities when they arose and modification to data collection methods. During this study, other opportunities for data collection presented, in particular, survey and workshop.

3.2.6.3 *Survey*

Survey was a means of capturing information from a large population and particularly useful for collecting data from the large resident population and staff in the first phase of the study. While surveys are a relatively inexpensive means of acquiring information in a limited time frame, they often have a low response rate and the information that is obtained is restricted by the questions asked.

Residents' Survey

Surveys were circulated to residents in the independent living units during cycle one and cycle two. The process of developing the resident survey involved the SMT and researcher working together to determine the purpose and focus of the survey, formulating areas of inquiry and deciding question type, selecting language and length, while mindful of the age of the respondents. The draft survey was then piloted with a sample of residents.

In cycle one during 2002, 695 questionnaires were distributed and 392 returned, a 56% response rate. The CRG decided to include questions relating to the proposed development and change in the community. A survey of 77 questions grouped in various sections across a range of areas was designed by the CRG, particularly the staff working in this area. In most questions, respondents were asked to select one of four responses across a range from (1) strongly agree to (4) strongly disagree, plus there was provision for additional comments in each section. The survey was developed in consultation with staff and residents, and piloted with a small sample of residents. It was distributed to all residents in independent living units with a letter of introduction/explanation from the CEO and a stamped, self-addressed envelope. Residents could return their survey personally to the administration centre, where they were collected centrally, or mail directly to the University. Participation and completion was determined as informed consent, although separate consent forms were provided. Returns were anonymous; however, residents were invited to provide contact details if they wanted particular questions answered or had issues to discuss. Quantitative data was analysed with the statistical package SPSS. A copy of the survey instrument can be found in Appendix I.

A second 'quality of service survey' was repeated towards the end of 2003 to obtain information from a large population of residents. A copy can be found in Appendix III. The CRG reviewed the content, quantity and quality of questions and decided to expand the section on change and redevelopment. They also decided to ask about 'additional services' as part of the exploration of a model of care. A survey of 53 questions grouped in various sections across a range of areas was disseminated to residents in independent living units. In 2003, 665 questionnaires were distributed and 238 returned, a 36% response rate. Overall, satisfaction remained high among

the respondents for most of the categories. The findings from the 2002 and 2003 survey are summarised in Appendix IV.

Staff survey

In previous years, a staff survey was implemented every year, with the primary focus on education needs and the primary population, clinical staff. The CRG agreed to a staff survey during action research cycle one as a means of finding out how staff felt about the changes that were occurring. As this was to be an expanded version of previous staff surveys, time was spent determining additional areas of inquiry. There was considerable discussion to determine language appropriate for all categories of staff with varying levels of literacy and comprehension and capturing desired information, while encouraging additional information. Again a draft was piloted with a sample of staff and some changes were made to the survey.

The CRG felt that there were a number of important categories of questions that needed to be included. Following considerable discussion, a six-part questionnaire with eighty-four questions was compiled, piloted and distributed. The pilot was across a range of categories of staff and from this it was determined that it would take between 20-30 minutes to complete. The questionnaire was distributed in a blank envelope to all employees with a letter of explanation from the CEO, a consent form, and return-paid envelope. Questionnaires could be returned to central collection points or posted to the University. This addressed any concerns of objectivity and confidentiality. All returned questionnaires were viewed, entered and analysed only by the researcher. The copy of the survey can be found as Appendix IV.

3.2.6.4 *Workshop*

In the first phase of the study, the critical reference group participated in workshop activities in addition to regular team meetings and these formed part of data collection within the action research cycle. The first workshop enabled the CRG to reflect on and discuss the data from the first cycle. This included the resident

interviews and survey, a staff survey and initial interviews with members of the SMT. This reflection informed the planning for the second action research cycle. The second workshop involved the CRG in a discussion of various models of service delivery and enabled them to explore how this information might be applied in this organisation. This included a presentation by the researcher on the outcomes of a period of study leave spent overseas and the knowledge and experiences of the researcher, including relevant literature. This process informed the development of a 'new' model of care and service delivery framework.

In the second phase of the study, the CRG participated in four leadership development workshops as part of the second action research cycle. The first two were facilitated by an external consultant and were part of a leadership development process initiated by the CEO. A third became part of a data analysis process to identify, discuss and reflect on epiphanies, that is, illuminating experiences, as well as themes, revealed from the analysis of interviews with members of the SMT. The fourth involved reflection on a proposed new site development plan and how it reflected the vision of a 'community', and discussion on proposed building developments. These workshops informed the planning for the third phase of the study.

In the third phase of the study, members of the Board, the senior management team, resident representatives and the researcher convened for a day workshop outside normal business hours. At this time the combined organisational group sought to affirm the proposed 'community' plan, a model of care and service delivery framework and further stages of the site redevelopment. In addition, this workshop provided opportunity to reflect on the research process, the impact of the study on the organisation and its benefit.

3.2.6.5 *Research record*

A research record provides an accurate source of information for feedback and reflection. A journal was kept of all contact with the community throughout the study, including date, time, purpose and outcome of the contact. This record also provided details of phone calls, transfer of information, documents and memos. Organisational documents were filed over the length of the study – annual reports,

newsletters, notices and other reports. A data log was compiled of date, time and length of interviews, as well as dates associated with survey dissemination, analysis and reporting.

The researcher participated consistently in regular meetings throughout the study. Field notes were kept of all SMT meetings and included a summary of discussions and decisions. Data from the analysis of leadership development exercises were also made available to the researcher. Further review of these notes, and additional comments, became part of the total record of the study. The notes from organisational meetings were at times useful during reflection by the research team at subsequent meetings. Minutes were kept as a formal record of all SMT meetings and were available for review by any member of the team.

Taping of SMT meetings was considered and discussed; however, the nature of the meetings and number of people made this difficult. The group agreed to accept the formal minutes of the meeting as a record and used them as a source of reflection and discussion at subsequent meetings. Notes were also made on organisation records, reports and other documents that were made available. This included reports of three reviews completed by external consultants contracted in the twelve months previous to this study. Notes from these reviews were typed and kept as part of the research record.

3.2.6.6 *Reflective research journal*

A personal research journal recorded reflections on field notes, interactions and events throughout the study. It was used to 'capture' thoughts and personal reflections, questions, issues and concerns. The journal was reviewed and reflected upon throughout the study and, at times, informed discussions with supervisors.

3.2.7 Data analysis

The study resulted in a large quantity of predominantly qualitative data from interviews, participative observation and workshops, plus quantitative and qualitative data from resident and staff surveys. Data analysis involved a process of examining

and reflecting on all the data to identify epiphanies, illuminating experiences and features and elements of participants' experiences. This organised process of distillation made sense of the large body of information and achieved greater insight and clarity into the specific topic of interest, question that had been asked, or problem that had been identified.

During the analysis of data, every effort was made to incorporate the language of the participants. This was supported with transcripts of interviews, extensive interview notes (affirmed by participants), research journal records, minutes of meetings and personal notes. The process of data analysis for the combined body of data culminated in the findings of the study, summarised in Figure 6 (modified from Stringer and Genat, 2004). Figure 6 explains the development of three primary data sets from residents, the organisation and SMT. The findings of the study are described in Chapter 6 as a collective account, incorporating data from the three primary data sets.

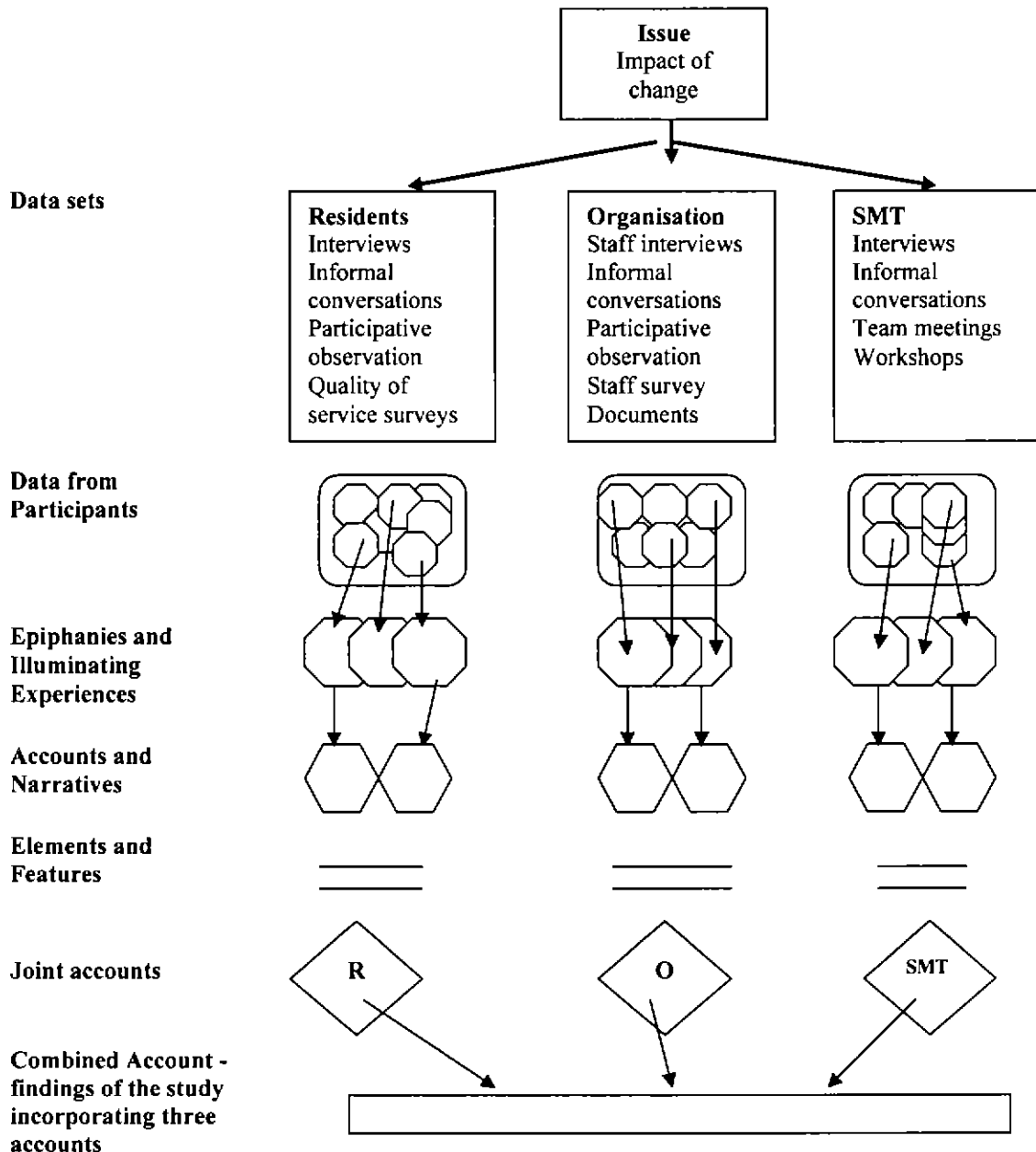
Within the context of an action research process, the CRG engaged in a collaborative process of data analysis. Rather than seeking to find objective theories to explain the data, this study viewed the data as the 'voice' of the participants, residents and SMT, and focussed on better understanding their perceptions and experiences through their words. This process was based on the work of Denzin (1989) and is described as interpretive analysis, where the researcher seeks to identify 'epiphanies', or illuminating experiences, to reveal meaning. Stringer and Genat (2004) explain,

“Epiphanies may be positive or negative, may vary in intensity and emerge instantaneously or more gradually. They are moments of truth that change or give meaning to people's lives and therefore provide a means to move towards descriptions and interpretations of lived experiences, more clearly representing the life-world of the people studied (p93).”

Reflection on the data sought to reveal the most significant experiences the person(s) had revealed in relation to the issue being studied. Information was verbal and non-verbal, with verbal descriptions as illuminating as non-verbal expressions of emotion or agitation. Significance was obvious, even dramatic at times, or only revealed after

long periods of reflection. Epiphanies and significant events varied among participants and ranged in complexity. The process of unpacking the data into epiphanies or significant events provided the language and meaning of the participants, and subsequently, enabled understanding of significance. The language was used in the narratives.

Figures 6: The process of data analysis



Following this process of reflection, the participant verified epiphanies or significant events that were highlighted: *what is most significant for you in all this?* The

individuals then confirmed both the epiphany and the significance. Epiphanies are not always momentous events and are sometimes described as a revelation, a sudden insight, an 'aha' moment when meaning is revealed. Alternatively, an epiphany can be associated with an actual event.

The next process of the analysis involved writing narratives about the data, telling the story of the participant using the agreed epiphanies to illustrate points of view. This next level of unpacking produced a series of descriptive statements to create the features of the experience for each participant. Some individual epiphanies were strong enough to stand alone while others, when combined, revealed a stronger explanation of an experience. Some were common to more than one participant and, when gathered together, described a significant experience or defining moment for the group.

The language of the narrative came from the interview data but could also be identified within other sources. It also came from other processes of reflection or other interactions. The interaction with this group provided other examples of situations and events that were important to individuals. For example, within this study the CRG met to reflect on what had been identified as a series of verified epiphanies, unpacked from previous individual interviews. Although the language was different for individuals, there were common experiences within the group. They were telling similar stories but using different language. Together, the group discussed individual epiphanies from within the narratives used to describe experiences that they felt they had as managers, even though they identified them with different language. Individual narratives or accounts were then analysed for features and elements to enrich the narrative.

In this study, this process was repeated to produce narratives from interviews with and observations of individual residents, senior staff and members of the SMT within each research cycle. Elements and features were then distilled from within the narratives and rewritten as three group accounts: one for residents, a collective account capturing data about the organisation, and one for the SMT. The collective account, the findings of this study, revealed the impact and influence of change. The impact of change on residents is described as one resident account, across the three

sub-groups of residents. The impact of change and how it influenced the development of the organisation is described as key themes. The impact of change and its influence on the development of the senior management team as leaders, is again described within themes.

3.2.8 Validity

Validity is established through prolonged engagement, persistent observation, triangulation, diverse case analysis, participant debriefing, referential adequacy and member checking. This is illustrated in this study with the following examples. This study commenced in 2002 and continued into 2004, a period of prolonged engagement and persistent observation that ensured an understanding of the community in which the study was placed and the development of a research relationship. The relationship of the researcher to members within the organisation became one of trust and acceptance. Conversations were open and revealing and participants had the opportunity to reflect and debrief when necessary. Building trust was a developmental, time-consuming process. Trust ensured that confidences were honoured, individual contributions were valued and participants were involved in, and able to, influence the research process.

A record was kept of all contact with the organisation throughout the study, including date, time, purpose and outcome of the contact. The record also provided details of phone calls, transfer of information, documents and memos. Organisational documents were filed over the length of the study – annual reports, newsletters, notices and other reports. A data log was compiled of date, time and length of interviews as well as dates associated with survey dissemination, analysis and reporting. A research journal recorded minutes and notes from meetings, workshops and forums with staff and residents.

Qualitative and quantitative data was collected from a range of sources using a variety of approaches to demonstrate triangulation of data. For residents, it included: conversations during interviews with residents and, at times, their next of kin; participation in resident meetings and attendance at functions; data from resident surveys; and participative observation of residents during daily interaction at the

coffee shop, recreation venues and meeting places. For interviews, a sampling process was used to include a range of residents across all three categories of accommodation and within categories to capture examples of residents with varying levels of need, length of residency, age category and involvement in change within the organisation. This demonstrates effort to ensure diverse case analysis and that all perspectives were considered.

For staff it included: data from past staff surveys and reports; analysis of data from an organisation wide staff survey, conducted in the first research cycle of the study; and interviews with eight staff who held leadership positions within departments. In addition, senior managers participated in three semi-structured interviews during the course of the study. The researcher participated consistently in regular team meetings throughout the study, also in focus groups and seminars with managers and Board members. Data from the analysis of leadership development exercises conducted by an external consultant were made available to the researcher.

During the analysis of data, every effort was made to incorporate the language of the participants. This was supported with transcripts of interviews, interview notes (affirmed by participants) recorded in the research journal and minutes and notes from meetings.

Regular meetings were also held with the CEO throughout the study, to monitor progress and affirm continuing participation and assistance if needed. Material was jointly prepared for collaborative presentations at external forums on the establishment of the 'research partnership' and its mutual benefit. Organisational documents were also made available to the researcher for review, along with notes from meetings and outcomes of organisational reviews. Opportunity to reflect on interview notes and other data collected during the study facilitated a process of member checking and provided opportunity for feedback and discussion.

This study revealed learning that may be useful for other aged care communities but the results cannot be transferred directly. Detailed description of the process and findings will enable the reader to understand the context and people participating in this study and to recognise possible similarities to other situations, populations and

aged care communities. During the study, other aged care communities expressed interest in the research process as well as the study and opportunities were taken to share learning in public forums.

3.2.9 Ethics and confidentiality

Ethics and confidentiality in this study were ensured through attention to voluntary participation, anonymity and de-identification of documents when requested and signed agreements. Initial processes included:

- The approval of the study proposal by relevant university committees.
- An explanation of the purpose of the study and status of the researcher was approved by the Board and agreed to by members of the SMT, following discussion.
- Following approval, an article introducing the researcher and providing an explanation of the study was circulated in newsletters to residents and staff.
- A confidentiality agreement was signed with the organisation.
- A preliminary plan for the study, explaining the process of action research and formation of a critical reference group, was discussed with members of the SMT. Members agreed to the study, their involvement and the role of the researcher as individuals and as a team.
- Confidentiality of all information was established with the SMT and strategies for the storage and management of data and records were explained and agreed to.
- Organisational documents were only reviewed on site.

Attention to ethics and confidentiality was maintained during the study through:

- An explanation of the study, letters of invitation and consent forms were developed for resident involvement in interviews. Letters were sent to residents and to next of kin where appropriate.
- Residents or next of kin made contact with the researcher if they wished to proceed with an interview. Verbal consent was reaffirmed at the time of interview.
- Tapes from resident interviews were transcribed independently.

- Residents were provided with a summary of feedback from the surveys and further individual inquiry was encouraged.
- Questionnaires for the two resident surveys were posted directly to residents with post-paid return envelopes and returned anonymously to a central collection point, or posted to an external address. Data were reviewed, entered, analysed and stored external to the organisation.
- Questionnaires for the staff survey were circulated directly to staff with post-paid return envelopes and returned anonymously to a central collection point, or posted to an external address. Data were reviewed, entered and analysed and stored external to the organisation.
- All interview records and notes were kept by the researcher.
- Staff were invited to participate in interviews and chose to make appointments for interviews; verbal consent was confirmed at the time of interview.
- Residents and staff were informed of the stages of the research process throughout the study.
- All participants were de-identified; residents and staff involved in interviews were referred to by code.
- No real names were used in any of the accounts of the study.
- All journals, records, documents and tapes were stored securely by the researcher and will remain stored according to University policy.

3.3 Significance of the research process

Research roles have traditionally been described as ‘researcher’, controller of the research, and ‘subjects’, the objects of the research (Stringer and Genat, 2004). This implies a power relationship where the researcher holds the power and the subjects are powerless. In action research, the intention is that the researcher holds no more power than any other member of the team. The research participants are collectively engaged in creating their outcomes through participation, where the outcome has meaning for them. Explanation, the outcome of a positivist worldview, is not reality itself (Baldwin, 2002).

“Unless people participate in the construction of knowledge, the knowledge has no meaning for them” (p289).

Particular aspects of the role of the researcher in action research have been identified. They are: adaptation to changes in the research process, the ability to adapt to changes to schedules and work pressures among participants, the necessity for strategies to deal with large amounts of ‘personal’ and sometimes sensitive information from participants, the process of enablement and learning that occurs among participants and the balance between expert and researcher.

Action research in this study involved planned research cycles that involved identification of a problem or analysis of a situation through a process of reflection, planning and action that often resulted in change; then monitoring the effect of that action and revisiting the initial problem or situation to see what effect had resulted (Waterman, 2001). This process led to the identification of new problems or situations that might shift the process into a different cycle of inquiry and action. This evolutionary process and the ability to respond to a ‘live’ process of inquiry, required flexibility and fluidity and the research plan varied over time. While this may be viewed as a great strength of this method (Waterman, 2001; Robinson, 2001; Gloster, 2000; Stringer, 2003), it also presented a challenge for the researcher.

The action research process in this study also facilitated a learning process for the members of the SMT, who embarked on a process of individual and group inquiry as they learnt about the impact of the change process. The action research process also enabled residents to speak out on issues, to contribute their viewpoint and become more involved in the change process. From involvement as members of the Board and the Residents’ Advisory Council, to informal contributions through interviews, meetings and written feedback, residents expressed their concern to the organisation.

The research process also provided opportunities for members of the SMT to reflect and comment on the research process as well as the outcomes. As part of the process of member checking, it was important to also provide opportunities for reflection on the experience of being part of the research as participants and the value of the research to the organisation. This occurred initially during regular meetings towards

the end of the study, during the third phase. At this time, however, members of the SMT indicated a desire to comment individually. Following discussion, it was agreed that individuals would reflect on three areas:

1. The value of the research for the individual and the senior management team,
2. The learning from the experience of being involved in an action research study, and
3. The value of the research for the organisation.

Residents who had participated in interviews were kept informed of the progress of the study and invited on several occasions to make contact with the researcher for further information and/or involvement. Follow up did occur on a few occasions and visits were arranged or conversations held over the telephone. At the workshop that occurred during phase three of the study, the residents' representatives discussed the value of the study and commented on their involvement. One resident asked,

“Are you coming to interview me again? I really enjoyed those sessions with you.”

Another commented,

“It has been really good to be able to give the residents feedback about this at our meetings. We are really interested to see how this has all happened, to see how the study has fitted in. It made us feel more involved with what was happening when you interviewed us.”

The value of the research for the individual and the senior management team

The following comments from individuals indicate the value of the study to them and the SMT.

“Working in administration can make you organisation/systems oriented, dealing with major decisions. The study reinforced the human aspects of our industry. It helped me to see how important it was to listen to the residents.

Sometimes we assume what is best for the residents and cannot understand when they reject change, even if it is for the better.”

“The study has validated the change process used. The feedback and information generated and provided has assisted greatly. The study has also helped to strengthen the relationships between the senior managers as well as the SMT and the Board.”

“The study has helped us to see what we are doing compared to other places, where we stand and where we can go. It has also helped us to see the way in which our change has affected the stakeholders and the improved outcomes over time. Residents are more informed and more comfortable speaking out and we are better at listening.”

“It has helped me to focus on our goals and strategic plan and because I was involved, without forgetting our illustrious and interesting past. It was also valuable to participate as part of the senior management team and I enjoyed our one on one conversations.”

Other comments reveal value in a learning process that occurred as the study progressed, both with the method and the process of reflection.

“I really enjoyed talking through the information and having the opportunity to hear what residents had said (to you). I think the process of reflection was really valuable for me.”

“The process made us stop and think more than perhaps we might have done. With our meetings so busy, it is always hard to make time to stop *doing* and just think about things. Because you were part of our meetings, we were able to think about other things as well as use your knowledge and experience in lots of ways.”

For the members of the SMT who joined the organisation during the time of the study, it appears that the study provided them with additional value.

“Being a new member of the team, it has been really useful to read about the study over previous years and know where the provider has come from and how this can inform the plans and strategies for the future.”

The learning from the experience of being involved in an action research study

The aged care industry has limited experience in the research process and finds it difficult to allocate resources for activities other than direct care and operational matters. Individuals indicated that involvement in this study was a new experience for them, both in research in general and action research in particular.

“My studies have exposed me to research but not action research. I really enjoyed the participative nature of the study, being involved. I didn’t feel like it was your research but rather ours. While the process was rigorous, it was still friendly, sort of informal at times and I really enjoyed the feeling of being within it.”

“It has reinforced my belief that an organisation is a sum of its parts and it needs to understand where it has come from before it can move forward. It is important to involve everyone. In the same way, the process has reminded me that the slightest change in situations causes a ripple effect throughout the whole community and can have consequences for everyone. The research process helped me to see the whole picture of what we were doing.”

“One of the main challenges has always been the problem of ‘change’ and change management, both for the residents and staff. The framework of this study helped me to clarify this concept and to see how that can be handled better.”

“Probably the most significant experience for me was to enable me to focus on incremental adjustments (clarified as steps along the way) required in relation to the process of change, by listening to the feedback to actions and having the opportunity to reflect on information and situations.”

“I saw the organisation journey back to base when the Board and SMT revisited the vision and mission. The process provided an opportunity to listen to others and to test my thoughts against others. It was a real learning process for me.”

The value of the research for the organisation

Comments on this question highlight the role of the researcher and illustrate the combined researcher/expert role that often occurs in action research.

“Your knowledge and experience was invaluable to the organisation. You had access to and shared with us so much that we would not have had (access to) during the study.”

“The independence of the research process, you as an outsider, validated what we were doing and gave access to research expertise that we did not have. But I never felt like you were directing it, just coming along with us.”

“We were able to access all sorts of information during the study and to learn from the research experience. I really believe we have made some better decisions, because of the study.”

During one SMT meeting, a member commented,

“At first I wasn’t sure if this (the study) was going to be much use, even get in our way. But over time it became clear that we were really lucky to be involved. Aged care providers rarely have money for research and it was very interesting to see how this study evolved over time and how we seemed to drive what was happening. I was surprised to see this, it was kind of our study.”

Finally, one manager commented,

“I guess I didn’t really understand how this would impact on us. I think that the research has brought some clarity to what we have been doing and to some of our decisions and the rationale behind our decisions. A great deal has happened during the length of the study and I think we have a better picture of how we have changed because of it (the study). I think the story of our journey is as important as the journey itself.”

There were no negative comments identified by the SMT in relation to the research process. It is worth noting, however, that one member of the team who had expressed some personal comments that were less positive, left the organisation during phase three of the study. As has been discussed earlier, the research process of feedback and reflection results in considerable discussion and sharing of ideas. Similarly, the interview process revealed personal reactions and responses and may also have been uncomfortable for this individual. The SMT progressed through a period of considerable growth and development, some of which was facilitated by the research process.

3.4 Limitations of the study

This was a case study of *Choice Village*, one community-based aged care community with a unique population of residents, organisational history, structures and operations. While the findings are not generalisable to other aged care communities, they may have relevance to others if that community can relate to the context and situation of the study and the participants.

Demands of the business in this industry and commitment of finite resources, limits opportunity for other activities such as evaluation and research. The organisation had little experience with research, and particularly a study of this kind, but no lack of enthusiasm and interest. The research process had to adjust at times to organisational demand and activity and accommodate different levels of experience among participants. This made the research process and the role of the research, at times, problematical, as it adjusted to the demands of a busy group of participants.

This community has a large resident population. While only a sample of residents were involved individually in this study, their views were considered to be illustrative of the larger population in this community. The findings of the study that relate to the resident population should not be generalised to the broader Australian community of older people or to specific communities that have different contexts.

3.5 Summary of chapter three: research method and design

The discussion on the research method and design demonstrates how action research, with its participatory approach and enabling orientation, provided both the framework and process of this study. In particular, it highlights how action research was effectively applied in health care, specifically aged care, and how this application was particularly appropriate for participants with little experience of research but a strong desire for learning and a commitment to change.

The research design reveals how this study sought to explore the complexities and issues associated with change in aged care faced by *Choice Village*. The detailed description of the methods used to investigate the impact and influence of change shows the rationale for action research and the application of the action research process. The comprehensive process of research phases and cycles, incorporating the four phases of the action research process, facilitated a continuous process of inquiry and realised significant learning for the participants. The comprehensive range of data collection methods (interview, participant observation, survey, workshop, research record and reflective research journal) provided the researcher with a substantial body of information that was then analysed and synthesised. The data analysis process is described and summarised in Figure 6 (page 86) to show how the body of data was distilled to reveal the key findings.

Application of the philosophical foundations of naturalistic inquiry and phenomenology enabled the participants to engage in and influence the research process. The establishment of the research partnership that developed between the SMT and researcher, highlights the need for a long-term commitment as well as the need for flexibility and the relevance this has for participants who already have demanding roles and responsibilities.

The research method and design also reveals the importance of the application of the principles of validity, ethics and confidentiality in research and the strategies that were utilised to protect the participants. The complexities relating to the well-being of the participants in this study, the residents of *Choice Village*, highlights the importance of attention to these principles. This has particular relevance in this study, where some of the residents were vulnerable and less able to look after themselves. Some residents may perceive that change increases their vulnerability. The impact of the research process is further evidence of the appropriateness of the research method and design and illustrates the value of the study and the action research process for the organisation and research partners.

CHAPTER 4 NARRATIVE ACCOUNT OF THE STUDY: EXPLORING CHANGE

The complex dynamics of change associated with the redevelopment processes within *Choice Village*, the focus of this study, required continuing and reiterative processes of investigation, incorporating multiple cycles of activity. Information (data) was gathered from a variety of sources and used as the basis for ongoing planning and development by the SMT, responsible for initiating and monitoring these changes. This chapter is a narrative account of the detailed processes in which the CRG engaged in continuing action research cycles of investigation, involving planning, data collection and analysis, reflection and action. This process provided the means by which the SMT could identify the key issues involved in the process of change, and gain greater clarity in determining actions to be taken to progress the redevelopment. The account of the study is told in part as a first person narrative, to capture the impact of the study on the researcher as well as reflect the realities of the highly interactive action research process.

4.1 Phase one of the study: reconnaissance and identifying the issues

Phase one of the study consisted of an initial reconnaissance, to position the research team and establish the research process for the study. The first action research cycle was completed during this phase.

4.1.1 Reconnaissance

A period of reconnaissance occurred in the first phase of the study to create a research environment and engage the participants. The relationship between members of the aged care community and me, as the researcher, became one of trust and acceptance, where conversations were open and revealing. Building trust was a developmental, time-consuming process that demonstrated that confidences would be honoured, participants would be involved in and influence the research process and that participation would be valued equally. It also required that I respect and acknowledge the workload demands and pressure on members of the SMT, all of whom had agreed to commit extra time and energy in the process of the study. I was

accepted as part of the senior management group in terms of the research process that was seen to be a learning resource as well as a strategy for the SMT to explore the impact of change on the organisation.

Fortnightly meetings of the SMT commenced and, over time, I gained an understanding of the community's history, current situation, challenges and issues and future aspirations. The executive and senior managers welcomed the study and my involvement, as did the residents and other staff, and this environment made initial contact with the community a very positive experience.

Following my initial inquiry, it was apparent that the history and the organisation's position within the industry was well documented. It was also apparent that it was in a period of transition and at the end of a fairly turbulent period of a couple of years. A number of key issues were being tackled, including: old, out-of-date accommodation at risk of not meeting future building standards, a changing resident population in response to demographic trends, workforce shortages and complexities, and increasing operational financial pressure from external influences.

I commenced a process of familiarisation with the community, residents and senior managers in the beginning months of the study. During this time, organisational documents and records were provided for familiarisation and, after an orientation, time was spent on the site observing and meeting with residents and staff. To assist me to gain a deeper understanding of the community and current situation, the senior managers agreed to individual interviews. These interviews were more like 'conversations', during which participants talked about their position within the organisation, length of employment and other experiences within this industry. They also provided an opportunity to talk to individuals about the proposed study, research process and role of research. Thoughts and feelings were shared willingly, along with experiences, some of the history of the organisation, how they felt about the current Board and management structure and some of the challenges that they felt they were facing.

The outcome of the reconnaissance enabled the SMT and me, as researcher, to establish a good research foundation for the study, a commitment to the research

process and an agreement to form a critical reference group (CRG) comprising the eleven members of the senior management team and me, as researcher.

4.1.2 Positioning the researcher and the research team

The research team in this study was the critical reference group (CRG) comprising the SMT and researcher and a collaborative partnership developed over the length of the study. The time allocated to SMT meetings was routine and occurred at regular intervals and I was informed of changes to meetings and additional meetings and events. While I was able to negotiate particular sessions, the managers and their other daily commitments sometimes dictated times. Opportunity for interaction with residents was also 'in their time' and required some flexibility. The needs and situations of particular residents changed from the time of appointment to time of visit, on occasions, and the conversations were 'diverted' at times by the residents' needs. This required a degree of flexibility on my part, along with rigour, routine and discipline, particularly as the study continued over a considerable period of time.

During the course of the study, residents and staff shared a considerable amount of organisational and individual information. Action research can have a liberating, enabling effect on participants and provide an opportunity to address issues, express concerns and reveal information. By definition, a successful, participative process creates a sense of safety and facilitates sharing. The researcher is in both a privileged and difficult situation at times. While the study revealed rich and valuable data, at times the quantity and nature of the information was overwhelming. I needed to have processes in place to de-brief, discuss, rationalise and, if necessary, 'let go' of information. The use of a research journal was an effective strategy to record data as well as deal with difficult information. The opportunity to share information with a trusted outsider was, at times, therapeutic and necessary.

The action research process also facilitates learning and individuals often feel the need to share new learning. This was particularly relevant among members of the SMT in this study, who 'grew' with the research process. On several occasions, a conversation with me proved to be a rehearsal for a subsequent conversation with someone else and a chance to 'practice' dialogue. This study created considerable

interest among other aged care providers, in both its nature and the process of cooperative collaboration and participation. Members of the CRG were asked to participate in forums where relevant industry information was being shared. As the study progressed, the SMT became 'proud' of their progress and looked positively on opportunities to talk about their redevelopment.

Although I may have had knowledge of the subject of the research inquiry, I came to the research process as a participant, not expert. I had considerable knowledge of the aged care sector and, in the past, had worked with other providers during periods of growth and development but, in this situation, my role was not one of expert. One manager commented on one occasion,

“You must feel we are making such slow progress at times. I'll bet you can see what we need to be doing.”

While I did not agree with this, there were times when I did feel that I could 'see' a possible action or outcome that the participants did not. This tension between roles indicates a change in relationships, as the researcher is not the expert and is not the director of the investigation. The role is more one of facilitation or consultancy, and certainly not one of control. My knowledge and understanding of issues was valuable and at times I was asked to find literature on a particular issue or to share something I had read; but my knowledge was of equal value to theirs and together we applied this to issues and situations. An example occurred during the exploration of different models of service delivery, when the SMT wanted to know about possible options and choices and develop something that was appropriate for the organisation and, particularly, the resident population. I was able to bring literature and recent overseas experience, and together we compared models and sought to find ways to apply this information to 'their' ideas of a model.

4.1.3 Action research cycle one

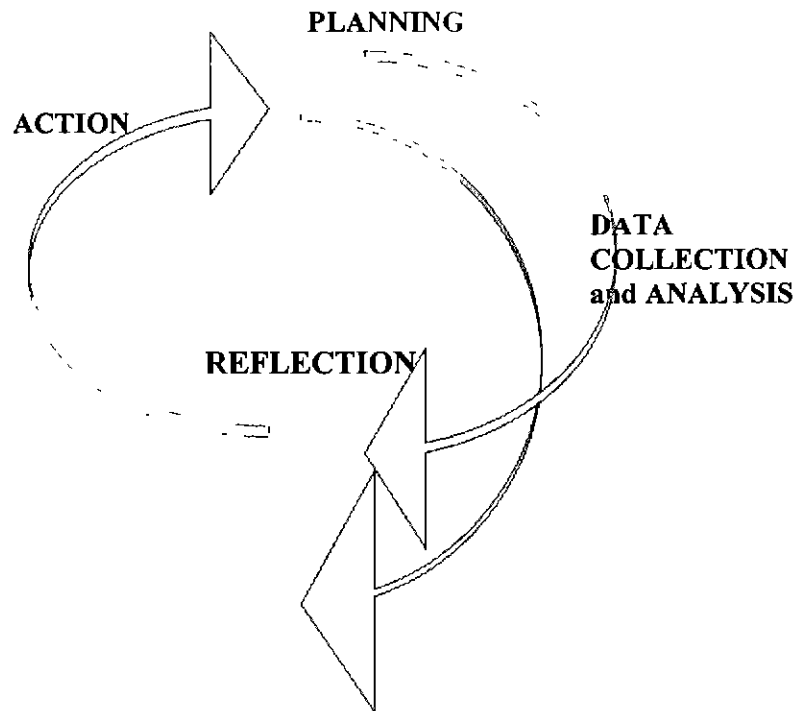
The first action research cycle, to 'look, think and act', occurred in phase one of the study and involved the following components: planning, collecting and analysing data, reflection and action. The critical reference group identified that this cycle was

a time of *understanding how we are going and becoming aware of the issues*. Phase one and action research cycle one is summarised in Figure 7.

Figure 7: Phase one and action research cycle one

Phase One – (i) Reconnaissance

(ii) Action research cycle one



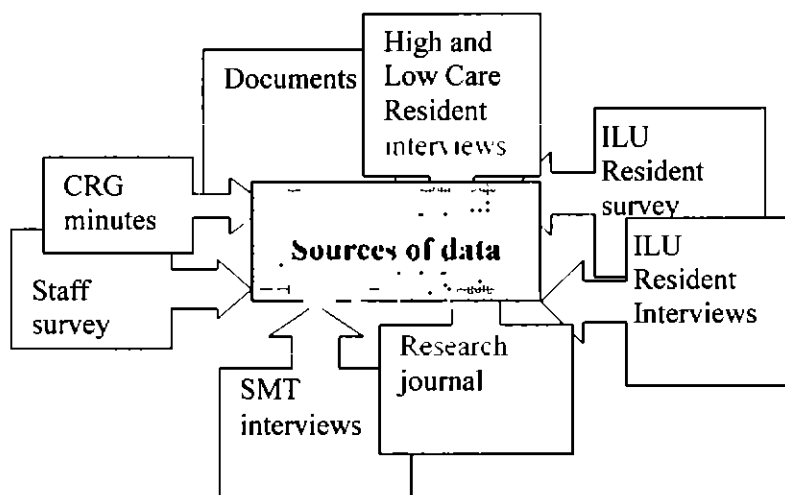
4.1.3.1 Planning

To begin to understand the impact of change from the redevelopment, the CRG planned two areas of research activity in this cycle. The first was to find out how residents were feeling about the change and to understand the residents' issues and concerns. This understanding would inform the development of a strategic plan and an operational plan to progress the redevelopment process. The second was to review the strengths within the SMT, as individuals and as a team, and to identify areas for learning. Length of membership in this group varied and included some members who had joined very recently and some who had been there for a long time. Some managers didn't appear to know each other particularly well and there was limited team cohesion. They also sought to find out how individual managers within the SMT felt the group was going, individually and as a leadership team, and to identify areas and a process for their development.

4.1.3.2 Data collection and analysis

A range of data was used by the SMT to identify and explore issues emerging from the change process. These different sources of information contributed to the ongoing reflections of the CRG and informed the continuing process of redevelopment of the organisation. The impact and influence of change on residents was revealed in interviews with a sample of residents in the low and high care centres and independent living units, and from the survey completed by residents in the independent living units. Information was also gained through CRG meetings and minutes from those meetings, interviews with managers and the staff survey. The impact and influence of change on the leaders of the organisation, Board and senior managers, was revealed in individual interviews, CRG meetings and minutes, and to a lesser degree through the staff survey and organisational documents. Analysis of this information and reflection on the findings contributed to the ongoing development of the strategic plan, operational plan, site development plan and leadership development process. Figure 8 presents a data map to summarise the sources of data for cycle one.

Figure 8: Data map for cycle one



Interviews with residents living in low and high care centres

Interviews with residents provided an opportunity to find out how they felt about the changes. Where possible, interviews were recorded and tapes were subsequently transcribed. In some cases, residents were not comfortable with taping and, on a few

occasions, the external environmental noise made taping unsuccessful. In all cases, introductory questions were planned ahead of time to engage participants and extensive notes were taken during interviews. Notes were referred to during interview, for example: *"Can I check with you here? With that question, this is what I have written down (read out). Is that what you said/have I got that right?"* At times there was a pause when notes were reviewed and verified by the resident. At the completion of the interview, all notes were read and clarification sought on points, additional comments and corrections. Each resident was asked, *"Have I missed anything or is there anything else you would like to say?"* Residents were invited to call if they thought of something else they would like to say or if they had queries. One resident did call after the interview and offered further comments on a particular area of inquiry.

As not all residents identified within the high care sample elected to be interviewed, responses from the sample of residents in high care were limited. Factors influencing response were identified as: resident or family member's perception of their ability to participate (time, health, other activities and commitments); perceived interest or relevance; and family or next-of-kin interest and/or availability. Time between receipt of letter and time of appointment for interview also seemed to be important, with residents forgetting about an appointment or changing their mind. Eight interviews were completed with residents in high care from a sample of sixteen (50%). Those who were interviewed did, however, cover the range of residents.

Responses from residents in low care also varied. Factors influencing response were identified as: interest, availability and competition with other activities, holidays and, in one case, change of mind. Ten interviews were completed with residents in low care from a sample of sixteen (62.5%). The transcribed interviews and notes from all interviews were read and reviewed on several occasions for clarification. For each, epiphanies and illuminating experiences were highlighted in the notes and coded to the appropriate resident. Draft individual narratives of each interview were written and then analysed for elements and features to highlight 'voices'. Analysis to this point was used to demonstrate to the CRG the data analysis process, as a learning tool, as members of the group had not had experience in this.

Interviews with residents living in independent living units

Interviews were conducted with a sample of residents living in the independent living units. Where possible, these were taped and transcribed and preliminary analysis was completed after the interview. Individual coded narratives were then further explored by the CRG, looking for elements and features. Individual issues and concerns were noted and discussed and, if appropriate or possible, strategies to address issues were suggested. For example, one resident felt that they had not seen the proposed site plan, so plans were posted in public places and attention drawn to them in the next newsletter. The difference between data from each resident group was explored and highlighted.

At this stage of the analysis, there were data sets for the three different groups of residents – high care, low care and independent living units. Within the data sets, individual epiphanies, elements and features had been highlighted, as well as noting what was common across each group of residents. Narratives for the three groups of residents were then written, noting common elements and themes. Analysis revealed that greatest awareness of change and concern about issues across the community came from residents in the independent living units and, to a lesser extent, the low care centre. Residents in the high care centres expressed least concern about change but, still, there was much to be learnt from their responses.

Survey of residents in independent living units

A survey of residents in the independent living units was an additional way to gather information from this large population and to find out about the impact of change. Response rates were 56% in the 2002 survey and 36% in the 2003 survey. The SMT were disappointed with the response rates and identified several reasons for this: difficulty with language or size of text, questions were not understood, resident was disinterested or saw no relevance to the questions and, resident was satisfied with services and saw no reason to participate.

The majority of questions sought to determine agreement/disagreement with statements, where 4 = strongly agree, 3 = agree, 2 = disagree, and 1 = strongly disagree. Analysis revealed a general level of satisfaction across all categories. Questions were grouped into categories. In summary, questions one to eleven aimed

to determine satisfaction with aspects of '*administration services*'. Questions twelve to twenty seven aimed to determine satisfaction with '*other village services*', including personal assistance, security, maintenance and gardening. Questions twenty-eight to thirty six aimed to determine level of satisfaction with '*contracted services*', including medical, podiatry, pharmacy and hairdresser. Questions thirty-seven to forty-six aimed to determine level of satisfaction with the '*complaints resolution processes*'. Questions forty-seven to fifty-six aimed to determine satisfaction with '*recreation/lifestyle services and facilities*' across the village. Dissemination of information among residents was important too and questions fifty-seven to sixty aimed to determine satisfaction with the residents' '*monthly newsletter*'. The large majority of residents (92 %) indicated that the newsletter was 'informative and easy to read' and they knew whom to contact to submit information. Questions sixty-one to sixty seven invited comments and suggestions for '*additional services*', additional clubs and activity groups and improvement to recreation facilities and services.

Some residents in the village attended the dining room in the low care centre for meals. Questions sixty-eight to seventy aimed to determine use of the dining room by village residents. The final questions, seventy-one to seventy seven, sought information about the 'effect of change' over the past twelve months. Residents were asked to comment on: the impact of change on their lifestyle, how well changes had been explained and managed, concern about change and the impact of change on their future.

There were 'additional comments' (qualitative data) from respondents and these were reviewed, noting questions, suggestions and comments. Residents chose to: submit specific questions, make individual complaints, praise and express satisfaction with their situation, highlight personal issues and concerns and share ideas and suggestions. Common issues and concerns were highlighted and areas of satisfaction were noted. If a resident who asked a question provided their contact details, they were visited.

Following a review of the results, the CRG agreed that residents had responded positively to the opportunity to complete the survey and the feedback provided

valuable insight into 'village life' and resident satisfaction. However, it was recognised that not all residents had responded and feedback was related only to the questions that were asked. Some residents talked further with administrative staff about the survey and some of the questions. Some revealed that they found it too long, arduous and, for a few, 'an invasion of privacy'. This survey was specifically for village residents. While there was realisation that, of those who responded, the majority 'were satisfied' with services and not concerned by the changes over the previous twelve months, there was no room for complacency. Some individuals were obviously still concerned and fearful of the future and worried about the 'new village'

A summary of the results of the survey was compiled and published in the newsletter, including examples of some of the comments. The group continued to work through the results, including the qualitative data, and established an action list, where possible, to address issues that had been raised. A summary of the findings from this survey can be found in Appendix III.

Staff survey

A staff survey had been implemented every year for several years, with the primary focus on education needs and the primary population, clinical staff. As part of this first phase, the CRG decided to expand the previous survey and implement this as a means of collected information from a large population. They felt that there were a number of important categories of questions that needed to be included. Following considerable discussion, a six-part questionnaire with eighty-four questions was compiled, piloted and distributed. The pilot was across a range of categories of staff and from this it was determined that it would take between 20-30 minutes to complete. The questionnaire was distributed in a blank envelope to all employees with a letter of explanation from the CEO, a consent form and return-paid envelope. Questionnaires could be returned to central collection points or posted to the University. This addressed any concerns of objectivity and confidentiality. All returned questionnaires were viewed, entered and analysed only by the researcher. The copy of the survey can be found as Appendix IV.

As for the resident survey, staff were asked to indicate the extent of their agreement/disagreement with a number of statements. The questionnaire was in several sections and aimed to determine satisfaction across a range of areas, including: work situation, culture of the organisation, staff health and well-being, change in the organisation in the past twelve months and education/training needs. The final section sought demographic information, including level of education, gender, age category, language, employment history, experience in health and aged care, number of years employed in this organisation and staff classification and hours.

The staff response rate was 26%. This was disappointing as the SMT was hoping to get a better response than in previous years, when the response rates ranged between 25-35%. Reasons why people did not respond to the survey were considered: they may have felt that they did not have time; they may have doubted that there would be worthwhile outcomes; they did not see the relevance of questions to their situation; they feared that they would be identified; they may have had a bad experience in the past; they may not have been able to read and/or understand the language; or they were disinterested.

Responses were received from all categories of staff, but some were better represented than others. The response rate was best from administrative (45%), support, including maintenance and gardeners (65%), senior management (100%) and allied health (100%) categories. It was lower from direct care staff, including registered nurses (35%), enrolled nurses (20%), personal carers (20%) and hotel services staff (22%). Alternative methods of obtaining more extensive information in the future were identified by the CRG as important.

A summary of demographic data provided a limited profile of the workforce. The workforce picture was summarised as: predominantly female, with the majority aged between thirty-one and sixty years; the majority worked part-time or casual rather than full-time; the majority spoke English as their first language, but 19% spoke one or more other languages; many had been working in aged care for more than six years (45%); and 32% had been working for this employer for more than six years. The majority of responses came from staff working as 'personal carers' and 'hotel

services' (cleaner, laundry, catering, kitchen) staff. Most worked Monday to Friday (53%) but 35% worked a combination of shifts.

Questions about change in the organisation in the past twelve months revealed that while staff agreed that there had been quite a lot of change, the majority of respondents felt positive about the change. They knew the reasons for change and felt that it had been managed well. Change had not had an impact on their workload nor reduced their job satisfaction.

It was agreed by the CRG that this survey did not provide sufficient or representative data from the entire staff population for them to feel that it had a good understanding of the views of the staff at this time. Alternative methods needed to be considered and the staff needed to be worked with more closely to really determine their views, and probably in groups or staff categories, with individual managers. Managers began to develop area-specific staff education plans to facilitate this. A summary of the findings from the survey can be found in Appendix V.

Individual interviews with members of the SMT

The SMT were major participants in this study and all managers had agreed to individual interviews to provide opportunity for discussion. Appointments were made with each individual and were in their office.

Many managers made direct comparisons between the new and old CEO and relationships between SMT and the Board. Managers identified areas of growth and areas needing development. Managers were asked to describe change that they had experienced and how it impacted on their role, and to identify challenges that were ahead for residents, managers and the provider. Each interview took between forty-five minutes and an hour.

As part of the process, it was agreed that a collective list of epiphanies would be presented back to the CRG, to be examined by the group for features and elements. This was a further learning process and part of the 'to find out how we are going', focus of the phase. Over a number of sessions, the group explored a list of extracted epiphanies from individual interviews and discussed their meanings. In some cases,

individual statements did not have the same meaning for others. However, the group did not find it difficult to identify common meaning or to see that the words might have been different but there was similar meaning. There were common elements. The CRG selected and explored the following epiphanies and their meanings

Epiphany: *'We are not all in the same corner' related to,*

Meaning: *support for each other; trust, be there for each other, connections, cohesion, judging and blaming, tension between individuals, commitment, honesty, go extra yards.*

Epiphany: *'I am seeing the vision more' related to,*

Meaning: *more than just talk, clear direction, plans, action with the words, see where we are going.*

Epiphany: *'Bullying has been organisational behaviour' related to,*

Meaning: *Board control and influence, interfering, judgement and blaming, under valuing, 'stress', controlling behaviour, manipulation, lack of control.*

Epiphany: *'The business direction is the right way to go but be mindful of the people' related to.*

Meaning: *people need to own the change engage employees, information, where is the enthusiasm and excitement, involve the staff.*

Epiphany: *'There is an organisational divide' related to,*

Meaning: *we are not one community, care centres and administration don't know what each other does, staff divisions, sub-communities among residents, division within management team.*

Epiphany: *'Residents stay in the village too long', related to,*

Meaning: *residents feel guilty if they can't cope in their unit, lack of understanding by staff in care centres of needs of residents in the units, families want them to stay out of the care centres until really need them, boundaries between care needs very blurred.*

Epiphany 'We have put some science behind our decisions', related to,
Meaning. not a cottage industry anymore, need good business practices, strategic plan to guide the organisation, leadership, financial accountability.

Epiphany: 'Issues are being dealt with not ignored', related to,
Meaning: communication is more honest within the team, staff are speaking up with issues, problems are being dealt with, sound business practices.

Epiphany: 'Start less and finish more', related to,
Meaning: lots of new ideas but lack follow through, moving too fast in some things, slow down and finish things, get the planning right first, walk before we run.

Epiphany 'Staff don't own the change', related to
Meaning. staff not involved enough, we are doing it but not engaged in it, need to devolve more, need to explain things more, look after everyone.

In total, the above ten statements (epiphanies) and associated meanings were accepted by the group. They captured the current feelings within the team, sense of cohesion and areas of concern. They also revealed the team's perception of the change process and impact. The SMT were able to realise and reflect on past behaviour within the team and the wider organisation. They were also able to reflect on the importance of managing the change process effectively and monitoring its impact on residents. These statements informed the action taken by the SMT.

CRG meeting minutes

The SMT met regularly to address operational matters and discuss issues and events. Formal minutes were kept for all operational meetings by a minute taker within the group and subsequently circulated to members. Formal minutes and notes from meetings were referred back to at subsequent meetings. I kept personal notes that highlighted items of discussion, perceptions, reactions and outcomes that formed part of my research journal. On some occasions, my notes were used to guide progress of the group, for example, 'where did we get up to last time?'

Reflective Research Journal

A reflective research journal is a means of gathering data over a long period of time and provides a source of data, personal notes and individual reflection. I made personal notes in the journal at regular times throughout the study which assisted in analysis and reflection.

Organisational documents

Minutes, organisational reports and historical documents were also a useful source of data and provided further information about the history of the organisation, past reviews, plans and decisions. These were made available to me, notes were made and recommendations noted. At times, these notes were discussed with the CEO and checked for accuracy and completeness.

4.1.3.3 Reflection

During this cycle, the CRG reflected on what had been revealed through analysis of the varied sources of data in terms of the impact of change on residents, the organisation and the SMT. Analysis of the data revealed that quality of life was important across all three groups of residents, and that change did impact on perceived quality of life.

Quality of life was important to residents in the high care centres even though their personal health status was compromised, resulting in loss of independence and increased need for care and support. Elements of quality of life differed for all three groups of residents. For residents in high care centres, it was expressed as personal needs, assistance with activities of daily living and communication with family and staff. It was apparent that residents in high care centres felt isolated from much that was going on throughout the community and did not appear aware of many of the changes brought about by the redevelopment. Change was still important in relation to staff change or change in routine. Family members seemed more aware of community change but were more concerned about the wellbeing of the resident.

Quality of life was also important for residents in the low care centre. Assistance was important but so was independence, and a good quality of life required a balance

between both. Residents in the low care centre were far more aware of changes and had much more to say about what was going on and what was important to them. Regular information about what was happening was very important. The social fabric of this population meant that lack of information or misinformation could evolve into a serious situation with many rumours and unrest. It was also clear that this group of residents were active members of the community and involved in activities and social events. They saw the community and the people as both family and friends. They wanted to know what was happening, what was planned and how things would change, even if they were not directly affected.

Residents in the independent living units (the village) also identified the importance of quality of life. They were much more aware and concerned with events in the community. Some had strong opinions although some seemed less interested than others. Many had been in the village for many years and had experience with the 'old' regime and were quick to make comparisons. Of those who had been moved, or were to be moved, there were mixed feelings and quite a bit of resentment. There was evidence of anger about the redevelopment among some, but appreciation among others. Some seemed still very focussed on the past while some looked forward to the future.

Further reflection revealed that a number of external events had influenced residents during 2002. Public external forums relating to the redevelopment of the adjacent prison were an example of how a group of residents could influence the larger resident population. The release of a book on the history of the organisation had an impact on some residents who saw it as a criticism of the 'new' regime or a way to 'relive' old experiences and situations. The CRG reflected on how this response could best be managed. Negotiations with residents to relocate as part of the first construction plan appeared to have been effective but it was clear that more needed to be done. Communication was revealed as very important for this group of residents too and it was clear that many residents wanted to become more involved in planning for the community.

The data also provided an insight into the impact of change on the leaders of the organisation. The data revealed changes to the Board membership and function

during this time and how the relationship between the SMT and Board had changed and improved. The need for better flow of information between Board and resident population was an important theme within the data. Reflection on data from staff was less rich because of the poor response rate; however, managers were seeking feedback from staff in their areas about the proposed changes. Change associated with new managers in two of the areas seemed to have been significant. The SMT decided that it was important to explore some of the data from the survey with staff and staff were invited to attend a one-hour focus group. Every effort was made to get representation across the whole workforce. Staff kept notes during the focus groups and a record of issues and resolutions was circulated to other staff via their newsletter. The SMT decided that it was important to work more closely with staff on the outcomes of these groups and to set up forums to discuss the redevelopment and how it would impact on staff roles and services.

The senior managers revealed the impact of change at both an individual and group level. There was consensus that 'things were better' in general in the organisation. The changed role of the Board, their relationships with members of the Board and the leadership of the CEO were identified as significant. The data indicated that the direction of the organisation was clearer and individuals had more confidence in the future, but there was concern about operational issues, policies and processes. There was a shared awareness of the need for team development.

There was also reflection on the research process and the involvement of the critical reference group. As a process, this phase had moments when the team was more 'researcher led' than collaborative, due to level of understanding, work load and demands, and lack of experience. However, at other times, they were 'driving' the process and taking the lead in discussions. The data also revealed that change to the model of care underpinning services was needed and the SMT felt that they needed more information on models of care and service frameworks to progress the redevelopment and change process.

In summary, data from a range of sources was used by the CRG to identify and explore issues emerging from the change process and the redevelopment. Data contributed to ongoing reflection by the CRG and informed the redevelopment.

4.1.3.4 *Action*

In the final stage in this cycle, the CRG decided what action was most needed, based on the information from the reflection process. The action that was needed aimed to: build the trust of the residents, develop the senior management team further and get the future direction clear. The CRG decided on several strategies as outcomes of the first action research cycle that led to the planning stage of the second action research cycle.

1. Review the current site construction plan and consider variations;
2. Review the proposed relocation plan for residents from independent living units as part of the redevelopment plan and improve communication;
3. Facilitate the election of a Residents' Advisory Council with representation from this group on the Board;
4. Form a leadership development plan for the senior management team; and
5. Explore the literature for new models of care as a framework for services across the site.

4.2 Phase two of the study: exploring and understanding the concerns

Phase two of the study occurred during 2003 and built on the outcomes of phase one. It consisted of further exploration and monitoring and realised greater understanding of the impact of change on the organisation and its residents. The second action research cycle was completed during phase two.

4.2.1 Action research cycle two

The action determined from the findings of action research cycle one led to the second action research cycle. As in cycle one, it involved a cyclical process of planning, data collection and analysis, reflection and action. These stages are discussed in detail.

4.2.1.1 *Planning*

Within the CRG, reflection on the findings from the first cycle in 2002 influenced organisational planning for 2003. Planning was needed for further site redevelopment, resident involvement, leadership development within the SMT and the formation of a new model of care.

Dissatisfaction with the initial construction plan for the site had been expressed within the SMT and this issue continued as a concern in 2003. Concern centred on the site design and its insular focus on housing, with little regard for the development for the needs of residents, the whole community or the financial implications for the organisation. To address some of the financial implications, the Board had decided to build a complex of new units and apartments on a section of the site that was vacant land, the sale of which would assist to finance the redevelopment. This did not address other resident concerns revealed during the first research cycle and, eventually, a decision was made by the Board to completely reject the first development plan and commence a process that would result in a new plan for an aged care community, involving accommodation, care centres, environment and facilities, to be implemented in stages over the next several years. This decision demonstrated recognition of the impact of change on residents, elements of quality of life and accommodation preferences as expressed by residents in interviews.

A number of actions relating to the business of the organisation emerged as outcomes of the first phase of the study. Realising the importance of continuing development of the Board's expertise and role, the CEO initiated a process to further develop governance processes. A review of organisational policies and procedures was needed to establish the business foundations for the future. One of the most significant responses to feedback from residents was a Board agreement to a process to elect residents to form a Residents' Advisory Council. Two residents would then become members of the Board, to provide a process of communication and feedback between the Board and resident body.

Reflection on the data from the first cycle by the SMT also resulted in the recognition of the need for a leadership development plan as a priority. The SMT

commenced a process of exploring different options and identifying priority areas of learning. The critical reference group (CRG) had also agreed to explore alternative models of care to guide the development of the service framework for the organisation for the future. It was recognised that this would include the implications for the workforce, their roles, profile and education. During this planning phase, the following research activity was agreed to:

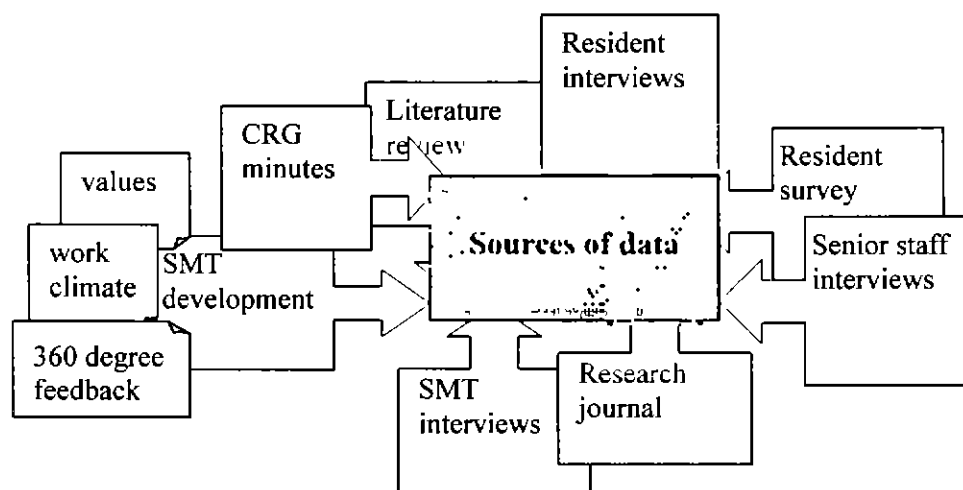
- Interview a sample of the elected Residents’ Advisory Council representatives as a sample of informed residents most associated with the change process;
- Repeat the survey of residents in the independent living units;
- Interview senior staff in each department as a sample of staff most associated with the change process;
- Repeat the interviews with individual members of the SMT; and
- Develop a model of care to guide a framework for services.

Again, it was agreed that I would interview the SMT, residents and staff and assist with the resident survey.

4.2.1.2 Data collection and analysis

Again, a range of data was used by the SMT to identify and explore issues emerging from the change process. These different sources of information contributed to the ongoing reflections of the CRG and further informed the continuing process of redevelopment of the organisation. The data map for action research cycle two is summarised in Figure 12.

Figure 9: Data map for cycle two



Resident interviews

The Residents' Advisory Council of eight residents was formed mid 2003 to provide a voice for the resident population. Monthly meetings were held across the site in different locations, to encourage participation from all areas of residents. Although participation at meetings varied, membership quickly increased as the process and flow of information improved. The representatives soon became a conduit for the resident population, Board and SMT. Four of these residents were interviewed.

Several themes were evident. In relation to the physical environment, there was concern that the units that had been vacated as part of the original redevelopment plan were still vacant and had become a symbol of change, a visible 'scar' within the community. Concern related to the impact on the income of the organisation from a lack of rent, but more so, the message that this was sending to the residents. Empty units were being neglected, so the environment around them was suffering (unattractive, run down). People living near empty units felt that they had lost neighbours and were missing the companionship (lonely, on their own, missing contact). This was viewed as a mistake and poor planning (why didn't they get it right, changed their mind). Finally, empty units presented a visible comparison of what was in the past (we never had empty units in the past) and evidence of how things were changing.

Communication was another theme and there was the view expressed that the SMT was explaining the need for change well. There was praise for the open, honest communication, frequent release of information, forums and opportunities for discussion and questions. It was reported that many residents were not worried about what was happening and did realise the need for change. There was also recognition that some residents would never be happy, "they have been hard to please all their life and they haven't changed" and, of these, some were still the most influential and vocal. There was a sense of, in general it is all okay, but this is a big place and "you can't please all the people all of the time", and "some people go out of their way to make trouble."

A common comment was made that, compared to 2002, things had 'quietened down'. The impact of the external influences, in particular the adjacent prison

development, was less and improvements such as landscaping and new buildings, had added value and were more attractive. The building of the new units was supported, even though there was concern from some residents that these new 'expensive' units would bring a different kind of resident to the community and create a 'rich and poor divide'. New residents might not mix with some of the existing residents or may be younger and still working. The anxiety, disruption and division among residents in 2002 had passed and "you can feel we are a community again." Attendance at residents' meetings was increasing and involvement in community functions had also increased in 2003. In the words of one resident,

"We have so many residents at our monthly meetings now that we have had to move to a bigger venue and turn on morning tea."

The formation of the Advisory Council brought strong praise and their involvement on the Board was welcomed. There was praise for the changes to the Board membership and function, and acknowledgment of members trying to be more visible and involved. There was also praise for the CEO and management team and realisation that they were trying really hard to meet the needs of residents. The needs were changing within the existing population, with some long-standing residents much older, and the demand for residential care was increasing within this population. The need for additional services to help keep people in their homes longer was identified as important.

Finally, the data revealed a more connected community and one that was less anxious and worried about change and the future. Reaction to the leaders, the Board, CEO and management team, was positive and supportive. There appeared to be a greater acceptance of the direction the community was heading in and an understanding of the need for change.

This was not my only contact with residents. Informal interaction continued – at functions and events, across the site during activities and at central locations. My informal conversations with residents continued and some residents who had participated in interviews in phase one made contact and were happy to talk

informally 'about things', as they said. A record of all interactions and events was kept and notes made and reviewed.

Resident survey

The 'quality of service survey' was repeated towards the end of 2003 to obtain information from a large population of residents. Information from this survey revealed that residents felt that they had been kept informed of building developments, had opportunity to contribute ideas and were aware of what was going on, on site. The majority felt that their future was safe and secure and that their needs were being met and would continue to be in the future. Finally, residents were asked to comment on the design of the 'new units' that were under construction in 2003. Comments varied, with some liking the designs and some thinking the units were too big. However, the majority indicated that they had not really paid much attention and did not feel the units were relevant to them.

Again, there were many individual comments, with a total of 123 residents providing personal comments and some questions. These were read and discussed and, if a resident could be identified, questions were followed up. No particular themes were evident from within the comments and topics varied. Several residents took the opportunity to praise the CEO and SMT and to indicate how happy they were. "Thank you for all your help. I am very happy here and have nothing to complain about", wrote one resident. Others took the opportunity to express considerable dissatisfaction with many things and particular dissatisfaction with changes to the Board. "This place has gone to the dogs (no longer any good). Why can't it just stay the same?" commented one resident.

Senior staff interviews

Managers had been working with senior staff within their departments as part of the staff education initiative and feedback from the 2002 staff survey. Interviews with these staff revealed valuable information about the impact of change on residents and staff, and some of the implications for the workforce in the future. This group of senior staff, representing all departments, were also working with other staff to keep them informed of change and the redevelopment process.

Leadership was one of these themes. Staff expressed confidence in the leaders,

“We have got the right leaders now” and “we are travelling in the same direction”. Leadership was recognised as both important and a strength. Comparisons were made between the past and current leaders and examples were cited of how the organisation had been floundering in the past with commitment but little direction. The strength of the SMT was referred to and the fact that they seemed to have clear goals and a good plan, was identified as important.

One senior staff member who had worked there for many years explained it this way,

“There have always been good people working here but in the past, we weren’t given a chance to do anything other than just work each day. No one told us anything and we didn’t know anything other than our job. Now we can see a plan and purpose, know where we are heading and we are included in some decisions. I can see a real difference.”

The need to let go of the past was another theme, expressed as, “there is no point hanging on to the past, it is time to forget and move on”, and “there were problems in the past but that is over now”. This was summarised by a staff member who explained their situation in this way,

“Some of us have been scarred by events in the past, and it has taken time to get over that I have had to really give these guys a chance and trust that I won’t get hurt again It is time to forget all that and move with the organisation because the future is looking really good.”

Equipping the organisation for the future, was also a theme. Staff talked about the changes to work processes and how that was affecting their work. For example, “I think we got by a bit before, whereas today you have to be sure of what you are doing and have all the processes in place”. One participant explained the importance of equipping the organisation,

“This place was going along just fine, but none of us really knew anything about the business. What we realise now is that, without changes, it was at risk and the worst part of that is, the people we are here to serve, the residents, would suffer. We had to change and get the business right.”

Concern for residents’ quality of life was apparent. Residents were identified as important, expressed as, “we only have jobs because there are residents, we should never forget that”, and “this is their (residents) home and we have to make it the best we can for them; I love the contact with the residents, it makes my job so much more than just work”.

A community of this size provided a cross-section of many different people. The staff recognised the challenges that sometimes present and admitted that some of the residents were a bit hard to get on with at times. But they were clear that the provider and the business was for the residents and that their quality of life was the most important thing for them. One made this comment,

“I sometimes think of them as family. When I go to the counter I sometimes think this could be my mum or dad and I might be the only person they can ask if they don’t have a family close by. They deserve that I give them the best I can; that is what I love about this place.”

While this was only a small sample of the staff population, they indicated that because of their position and relationship with staff in the departments, they felt that they were aware how staff were feeling and were able to comment on general perceptions.

Interviews with members of the SMT

Ongoing exploration of the impact of change on the leaders led to another round of individual interviews. Appointments were made with each individual in their office. Again, their agreement to participate was confirmed and viewed as informed consent. As part of this phase, the prompting questions used were: *Tell me about the past year for you; How have things changed for you this year; What has been happening in the SMT this past year; How do you think the organisation is managing the change?*

A similar process of checking interview notes was used. Participants were more aware of the process. Interview notes were reviewed for epiphanies and illuminating experiences and a preliminary narrative written for each interview and returned to participants for their verification. All narratives and notes were then analysed for common features and elements across the group.

The CRG felt the group analysis process used in cycle one had been successful and they were keen to 'try it again,' with more experience this time. A draft list of epiphanies that had been identified were presented to the group and explored for meaning. It was clear this time that they needed much less prompting and were able to participate and manage the discussion far more. A list of group epiphanies and their meaning was compiled, to explain how they felt as a group at this time.

Epiphany: 'We have to live our values' related to,

Meaning: walk the talk, get out there and be real leaders, show we mean what we say, demonstrate by our behaviour, show by example.

Epiphany: 'Get the mix and balance right' related to,

Meaning: recruit the right people to the Board, balance business expertise with experience, develop everyone's potential, know what we need and go out and get it, raise the bar and work to get over it.

Epiphany: 'Balance the means with the mission' related to,

Meaning: balance business expectations with social accountability, set realistic goals that can be achieved within our capability, don't promise what we can't deliver, take a hard line when it is needed, show the reality of the business with commitment to caring, we are a more commercial entity with a product to sell.

Epiphany: 'Values based leadership' related to,

Meaning: trust in and respect for each other, authentic trust within the group – don't have to question, translate the values into leadership behaviour, the team is not cohesive and the divisions show lack of trust,

Epiphany: *'There is no room for passengers' related to,*

Meaning: *every manager has to pull their weight, come up with the goods, work together to get outcomes not against each other, this is a tough business with little room for mistakes, the quality of people's lives (staff and residents) depends on us getting it right, if you can't make it, have the sense to move on, progress staff and manage the non-performers.*

Epiphany: *'Trust is a work in progress', related to,*

Meaning: *we have come a long way but there is still work to be done, our team is still fighting amongst itself, there is a breakdown in trust within the group at times, we are still not all heading in the same direction, don't expect progress all the time.*

Epiphany: *'Residents are moving away from a welfare state of mind' related to,*

Meaning: *be grateful for what you were given and don't ask for more, made to feel they should be grateful and they owed someone a favour, more assertive and more selective about where they live, speak their mind more.*

Epiphany: *'We had to mature quickly so we have missed a few steps along the way, related to',*

Meaning: *the pace has been frenetic at times, we need to constantly recharge our batteries, we find mistakes along the way, lack of follow through at times, change has been continuous.*

Epiphany: *'Communication chokes at level two of the organisation', related to*

Meaning: *the SMT doesn't devolve the information through their areas, it all happens at the top, need to engage the staff more, presume people know but we forgot to tell them, so much is happening we forget who we have told, must make time to reflect and review what we are doing.*

The group accepted these statements and associated meanings as a true reflection of how the team was feeling. The statements revealed growth within the team but also highlighted continuing issues of trust and perceived conflict between organisational values and management behaviour. They emphasised the importance of a team approach to leadership. Other statements highlighted progress in communication with residents. The importance of communication associated with the change process

was also expressed. These statements informed action taken by the SMT in the next phase of the study.

Senior management team workshops

The SMT recognised the importance of ongoing leadership development to assist them to provide the leadership the organisation needed for the redevelopment and to manage the change process. The SMT engaged in three specific activities during this second action research cycle as part of their own development program. Each exercise became a 'mini cycle' of action-reflection and contributed to the understanding of the impact of change on the leaders. They engaged the assistance of an external, objective facilitator to assist them to complete the three exercises. The three exercises were: Translating Organisational Values Into Behaviour; Work Group Climate (completed on three separate occasions); and a 360 - degree Performance Feedback process.

The process and outcomes were discussed by the SMT during meetings and used by the group to facilitate discussion. The findings revealed information on individual leadership capacity, team cohesion and team development, all relevant to the SMT's performance and, in some ways, indicated the impact of change on the group. Each exercise is explained.

Translating organisational values into behaviour

This first exercise involved an exploration of the corporate values and identification of behaviours that would demonstrate to others the application of those values in practice. The exercise was called, 'Living our Values.' Individuals were asked to identify behaviours that would illustrate a commitment to each of the values within the mission. Following considerable discussion and debate, the group agreed to several behaviours for each value. The outcomes of this exercise are presented in Figure 11.

Figure 10: Translation of values into behaviours

<i>Treat others with dignity means we will –</i>
Recognise and respect the value of every individual
Approach people with warmth and genuineness
Respect and value cultural diversity and cultural differences
<i>Demonstrate integrity means we will –</i>
Be open and honest in our communications with all
Be consistent and take personal responsibility for our decisions and actions
Set the highest ethical standards when interacting with staff and residents
<i>Respect others means we will –</i>
Make it safe for people to say what they genuinely think and feel
Be positive and supportive of others
Give and receive feedback in a constructive way
Genuinely listen to and appreciate the perspectives of others
<i>Achieve excellence means we will –</i>
Continually strive to improve the quality of the services we deliver
Be recognised by our customers as being responsive to their needs
Measure and improve our performance
Do the absolute best we can with what we have got
Be open and responsive to improvement suggestions
<i>Value teamwork and unity means we will –</i>
Work together to define and achieve agreed goals regardless of organisational boundaries
Encourage and develop teamwork, consultation and cooperation
Support the continuing education and development of teams and team members
Share challenges and successes and recognise the contributions of others
<i>Value community means we will –</i>
Promote a safe, friendly and caring environment where residents and staff feel welcome and valued
Encourage and support involvement in and ownership of the community by individual community members
Develop a culture of trust, security and well-being through people helping people

These behaviours became indicators for the group and guidelines for performance.

Participants responded to the exercise with comments like,

“I like how this gives us something to refer back to when we want to check how we are going as a team.”

Another commented,

“We need to be able to show that we are all heading in the same direction and that our behaviour is visible to residents and staff.”

Work group climate

This activity was completed twice during this cycle. It involved a short survey asking individuals to rate the team's performance over different '*work group climate*' dimensions of trust, innovation, goal clarity and inspirational leadership. Each dimension had several elements and each element was rated from 1 (strongly disagree) to 5 (strongly agree). The mean and standard deviation were calculated for each dimension. The first time was mid 2003 and the exercise was reported as a good litmus test for the team. The second time was late in 2003, towards the end of this cycle. It produced different scores that proved to be a catalyst for change in the membership of the team.

For the group, the reaction to this change in scores between the two exercises was almost more interesting than the scores themselves. After the first attempt, the group indicated that they felt positive about the rating of the dimensions and the overall 'group climate' score. However, the reaction was different the second time. They were looking for improved ratings in all dimensions, with particular interest in 'trust', to demonstrate the growth of the team and increased connectedness, believing it would demonstrate that the team was working together better with 'honest' interaction. Trust in the second attempt had only altered minimally from the score for the first attempt and could not really be considered an improvement (Mean had moved from 3.58 to 3.48; SD from 0.37 to 0.67). More importantly, the scores for each dimension, seemed to imply that some individuals were disinterested, lacked commitment and felt disillusioned and/or disconnected, or as one manager said, 'sat on the fence'. The group discussed the scores and their concerns among themselves and with the consultant who had facilitated the process. I was invited to attend the sessions associated with this.

During subsequent discussions with individuals, several expressed some concern about the perception of lack of commitment to the second attempt at the exercise. Reactions were polarised. One individual told me that they were feeling very tired at

this time of the year (December) and 'jaded' and didn't have the energy to put in the thinking that was required. Another told me,

"I know people are really tired, but so is everyone and that is no excuse for not committing to the exercise. If they are not committed to this, what else aren't they committed to?"

In terms of leadership behaviour and team performance, another told me that they were feeling really concerned about one member of the team and felt that they had made their scores and judged the team (unfairly) by their feelings about this individual. They said,

"I don't trust (the person) and it really worries me, so I guess I judged the team in the same way."

This exercise, along with other events within the organisation that related to the management team, appeared to bring some matters to a head late in 2003 and one executive manager subsequently resigned from the organisation.

360- Degree Feedback

The third activity was a structured 360-degree performance feedback exercise that involved obtaining feedback on an individual's performance from those 'above and below, as well as others at the same level within the organisation. Using a prescribed form, individual managers invited feedback on their performance from 12 colleagues – other managers and staff. The feedback was confidential, processed externally by the facilitator and reported back to each individual privately. Response to the process and the results varied among managers but, overall, a positive response to the exercise was reported and there was recognition that this was another step in their process of building their strength as a team. One commented,

"There was some good stuff, but I think the process is flawed, because some people didn't respond and give me feedback. So I don't know what they think and I have to wonder why they didn't respond. The feedback I got might be biased."

The SMT indicated that they would have been quite uncomfortable about such an exercise in 2002 but felt better able to cope in 2003. They felt that this was an indication of the team's growth and development. The exercise also provided opportunity for individual counselling with the consultant on the feedback and this was considered to be very valuable.

In summary, these three workshops provided a process of personal and group development and analysis. Several outcomes were reported: individual growth and development, polarisation of some individuals in the team, clarification of areas of conflict and interpersonal friction, confidence to confront issues and change to team membership. The SMT identified that the team was more capable, confident and cohesive and that communication was more honest.

Model of care

Data from the first cycle revealed that the current model of care and associated service framework needed review and redevelopment to meet the needs of residents then and in the future. A process to 'building a model of care' was embarked on and occurred over several months. This became another 'mini cycle' for the group. The group worked through several steps: circulation of information for reading before the session, general discussion about the information, reflection on application to the community, identification of areas for further inquiry/decisions and planning for the next step.

The first step was to understand what they meant by a model of care. It was agreed that this would explain for the organisation the relationship between types of accommodation and nature and type of services available for residents, and identify staff characteristics and roles needed to deliver services and provide care.

Significantly, it would inform: the environmental design and construction plan, the relationship of the provider to the wider community, articulation with other service sectors and, perhaps, other providers.

The second step was to identify those factors that would influence a model of care. There would be external environmental factors and internal environmental factors. External factors included: demographics of the older population in the area;

identified ‘wants and needs’ of the target population, now and in the future; critical external drivers in the provision of aged care, such as government policy, politics and funding, critical uncertainties affecting the future of aged care; and market competition and potential partners. The internal environment included: the needs of the current population, now and in the future; non-negotiable factors such as organisational mission and goals; Board direction and influence; charitable status; financial status; and other business drivers, such as investments.

The third step was to explore what ethical framework would underpin the model. This would include the values underpinning the mission, how the values were put into practice for staff and residents and how they would build on development work undertaken by the group during this cycle. Following the SMT work defining how the values translated to their behaviour, they decided to expand this to identify behaviours that would guide how they related to residents and staff. Figure 12 explains how values were translated to behaviour for residents and staff.

Figure 11: Living the values: translation for residents and staff

Value	Residents (services)	Staff (work practices)
Dignity	Receive services regardless of disability or dependence	Regardless of knowledge, education or ability
Integrity	Equity for all	Equal value for all
	Availability according to need	Reward and recognition for effort
Respect	Toward contribution and involvement (or lack of)	Commitment and contribution recognised
Excellence	Best effort	Commitment to learning and development
		Commitment to continuous improvement in practice
Teamwork	Support for all	Help each other
	Recognise contribution	Common goals
Community	One community regardless of financial status, accommodation or position	Delivering services across whole site
	Part of larger (external) community	Articulation between accommodation type
	Seamless transfer between accommodation options	Connection to the wider community

Having clarified an understanding of a model of care, the discussion moved to identify goals. Feedback from residents during cycle one had revealed the importance of quality of life and the impact of change on it. A decision was made to focus on one primary goal, to facilitate the achievement of an appropriate (best possible) quality of life for all residents in their community. Quality of life was described under 11 domains (Kane, 2001) to include a sense of security, safety and order, physical comfort, enjoyment of life, meaningful activity, functional competence, maintenance of relationships, dignity, privacy, individuality, autonomy/choice and spiritual well-being

With a goal of maximising quality of life for all residents, the discussion moved to the nature and type of services that would be provided to ensure that this goal could be met. The services offered needed to: improve or maintain health, improve or slow deterioration of functional abilities, meet needs for care and assistance, enhance psychological well-being, maximise independence and autonomy, promote a meaningful life and minimise restrictions. They would be available according to need and not necessarily aligned to the type of accommodation or classification of dependence (resident classification index).

This more flexible focus of services according to need rather than accommodation type called for a review of the type of accommodation that would be available, and so informed the redevelopment (construction) plan. The community would provide accommodation and support for:

- People who lived independently in their own home, who may choose to access services or become involved in activities within the community (*independent village resident*).
- People who lived independently in their own home, who accessed services for assistance with communication, mobility, social responsibilities and/ or activities (*village resident needing some 'social' services*).

- People who lived in their own home, who accessed services for assistance with personal hygiene and care, mobility, meals or house keeping (*village resident needing low level of care*).
- People who were unable to live independently who required daily assistance with some aspect of their personal and/or social care (*low care resident*).
- People who needed daily on-going physical, emotional and/or social care in a residential care environment (*low and high care residents*).
- People who required a limited period of physical, social or emotional ‘respite’ from their current situation (*resident or family carer*).

One manager described the outcome in this way:

“This is a really good outcome for us. We can now plan our redevelopment based on the model of care and service framework. It sort of all makes sense. If we want to provide this kind of service, then our community structure and function needs to develop to enable us to do this.’

The outcome of this process of inquiry, a model of care, (see Appendix VI), became the guide for a whole-of-site community development plan, including type of accommodation, environmental design, roads and pathways, community services and options, and was used to inform the redevelopment team. It was built on feedback from residents and informed by reflection on the importance of quality of life, the impact of change and the need to rebuild the structure and function of the business.

Literature review

The CRG used journal articles and reports to explore ideas and develop new concepts. For example, during discussion of current services, articles were reviewed by members to identify and explore alternative approaches to service delivery in other countries and to reflect on their possible application for this organisation. When discussing trends in Australia’s ageing population, literature was sourced to identify demographic projections, cultural variations and service usage. At another stage, housing design and construction in retirement accommodation was reviewed. Individuals also explored particular topics of interest and brought information to the group at times to illustrate a point of interest or explain an idea. Decisions were made

by the research team about the usefulness of the literature and its relevance to the stage of the inquiry. For this study, literature became part of the ongoing process of reflection and analysis and informed participants' exploration of new ideas and concepts.

Minutes of CRG meetings

Again, formal minutes were kept for all operational meetings and circulated to members. I also kept notes at all meetings, highlighting items of discussion, perceptions and reactions and outcomes. Minutes and notes from meetings were referred back to at subsequent meetings and available to members on request.

Reflective Research Journal

My reflective research journal was continued and personal notes were made in the journal at various times throughout this cycle. Again, notes assisted in analysis and reflection.

In summary, data collected within this cycle was used to further inform the CRG. Reflection by the CRG revealed the importance of monitoring the change process and engagement with the residents as the redevelopment process progressed.

4.2.1.3 Reflection

As in cycle one, the action research process provided the structure for reflection on data collected in cycle two. Reflection on the comprehensive body of data was a time consuming process but realised an in-depth understanding of the impact of change. The process of reflection occurred during several CRG meetings, during which participants discussed the data and its significance. Reflection was an integral part of the analysis process, where participants were able to express their thoughts as well as listen to comments from others in the group. Discussion, explanation and debate within the CRG enabled members to clarify the outcomes of previous actions as well as consider future directions.

General resident anxiety was reported to be less in 2003 and less influenced by external events such as the prison redevelopment in 2002. This was supported by

data from senior managers, senior staff and residents' representatives. A resident group that had previously been most vocal and influential during cycle one, was reported as less influential within the resident population. The Resident Advisory Council and subsequent representation on the Board was well received by residents. The resident population was taking the opportunity that this initiative brought, to increase the flow of information and communication between Board and resident body.

While the empty units on site were still a worry to some residents, and a sign of change, the 'action' of building the new units was evidence that 'things were progressing'. While some residents had concerns about the new units and who would move in to them, the development was being watched with interest. Resident representatives were aware that the new population of residents who would move in to these units might be 'different', but they were keen to include and involve them in village activities and 'make them feel welcome'. In the survey, interest had clearly been expressed in access to additional services and this supported the development of a new model of care and provision of new or different services.

The CRG reported a positive change in attitude among many residents, particularly within the independent units. Residents in the low care centre appeared to be more accepting of progress and were responding well to information sessions and communication strategies. The CRG reflected on the danger of complacency but there was confidence that the relationship with the resident population through this phase had progressed.

Reflection on leadership developments focussed on several areas. The progress in the development of the Board, improvement in the relationship between the Board and SMT and progress with policies and procedures, were all outcomes in this cycle. Progress with the new whole-of-site development plan was recognised as a real achievement and there was considerable excitement about how this was going to progress. The idea of stages of redevelopment was seen to be positive and provided a better way to work, to minimise disruption among residents.

Data from senior staff interviews brought a resolution to involve staff more in the development of the new care centres and to utilise staff orientation and education initiatives more. The complexities within the workforce were discussed, in particular the rapid change of staff that often occurs in this industry. The impact that this has on training and the ability to build culture across a workforce was seen as significant.

There was a sense of achievement over how the SMT had been able to work with staff, in response to the departure of the manager and the subsequent period of unrest among some care staff. There was a feeling, however, that there was still a lot of work to do to involve staff more in the development of a new care centre and implementation of a different model of care. The articulation of a model of care that was based on values and future-focussed, was seen as an achievement in this phase.

The SMT reflected on areas of growth and areas of concern within the team during this phase. There was agreement that, as individuals, there had definitely been growth and the SMT development plan had provided structure to the program. There was also recognition that there were difficulties between some individuals and still gaps in team cohesion. Some managers chose to explore their concerns further. The identification of a desire for a values-based leadership approach was also recognised as an achievement in this phase; however, there was concern about the apparent lack of trust among some members.

The CRG spent some time reflecting on the research process in terms of a learning tool as well as the outcomes. There was also reflection on the role of the researcher as a resource for the group during the process but also as a resource to the provider in general. Commitment to the CRG and the research process continued to add additional work to the already heavy business schedule of the senior managers and the energy within the group varied. However, there was never any question that the study would continue or that the CRG would remain committed to the research process. The continuing interest in, and commitment to the study was a constant. I was always greeted enthusiastically when I came on to the site, always welcomed enthusiastically to SMT meetings and always felt that individuals were supportive of the research.

4.2.1.4 Action

Reflection by the CRG on data collected during this cycle informed further action.

The focus of action would be to:

- Continue to engage the resident population
- Confirm and strengthen the leadership team,
- Plan the development of a new care centre,
- Explore the implementation of the new model of care,
- Build a change management plan with staff.

The study moved to a third phase.

4.3 Phase three of the study: affirmation and consolidation

The events and changes that occurred within the SMT toward the end of 2003 led into the third phase of the study that continued into 2004. While not an action research cycle, this was an important phase for the SMT and the overall change process and was still in progress when the study concluded, in mid 2004. It was described by the SMT as a time to 'affirm and consolidate'.

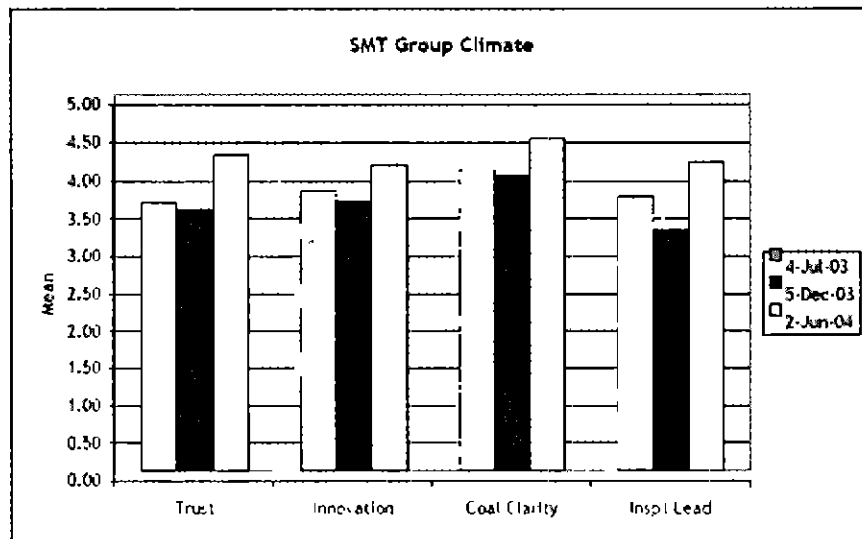
At this time, and with the completion of the formal research process, the critical reference group that had formed for the purpose of this study changed its role slightly and became less involved as a research group. The SMT continued with me as a participant in meetings. In this phase the provider confirmed its future direction, strengthened its capability and began a structured process of implementing community-wide changes.

Several key events at the end of 2003 had influenced the process of redevelopment and change. The first was a change in the structure of the senior management team following the departure of a senior executive late in 2003. This provided an opportunity to review the roles of members of the executive and senior managers and a decision was made not to continue with this position. Alternatively, a new position was created and an appointment was made early in 2004. The new position

acknowledged both a shift in organisational direction from quality processes to quality outcomes and a devolution of leadership to managers of two operational areas, the high and low care centres. This change to the membership and function of the SMT strengthened the team. It also opened up communication within the group and addressed some previous issues associated with a lack of trust and cohesion that had been identified in the second 'Team Work Group Culture' exercise.

The SMT decided to complete the 'Work Group Climate' exercise for a third time towards the end of 2004. This revealed a difference in the team's assessment of the 'Work Group Culture' within the scores since the last time. The scores for the three exercises are summarised in Figure 13. The scores for all four values were higher in this third attempt, in June 2004. This following a slight difference in the scores in the second attempt in December 2003, highlighted previously. The SMT felt that the scores in this third attempt indicated a different 'team feeling' and this was perceived to be a positive shift. A comparison of the three attempts can be seen in Figure 13.

Figure 12: Work group culture scores for senior management team



Scores for the first attempt are on the left (July 1993). When compared with the scores for the second attempt (December 2003) there is evidence of slight variation (drop) in the values of trust, innovation and goal clarity and a larger drop in the value of inspirational leadership. The third attempt reveals scores that are higher than both previous attempts and regaining lost ground from attempt two and improving on attempt one, indicating an 'agreement' that the values of trust, innovation, goal

clarity and inspirational leadership scored positively within the group. There was a significant increase in the level of trust within the group and a stronger perception of inspirational leadership.

A second significant event was a workshop convened late in 2003 involving the CRG, Board, and residents' representatives, to affirm the future redevelopment plan for the community. During the workshop, the group reflected on events over the past two years, noting achievements and challenges. The site redevelopment plan, to build a whole-of-site community, was accepted as the template for the future. A new model of care and service delivery framework was explored in greater depth, together with reflection on the workforce and resource implications. The next stages of construction and implications for residents were discussed and a strategy to progress plans for a new combined high and low care, care centre was outlined. This workshop further demonstrated the improved relationship between the Board and SMT and the value of the inclusion of residents as partners through their representatives. For the two recently appointed managers, it provided a wealth of information and an opportunity to see the leadership team 'in action'.

My participation in the workshop was at two levels. First was a presentation of an overview and discussion of this study to date, and second, observation and reflection on the change that had been occurring throughout the study. At the conclusion of the workshop, several decisions were made:

- Commitment to a new whole-of-site development plan,
- Adoption of the model of care as a guiding framework,
- Confirmation of the time frame for the next stages of construction, and
- Confirmation of business decisions regarding investment and financial expansion.

Further SMT leadership development continued into 2004, involving a structured leadership development education program for the group as well as individual development plans and education initiatives to address identified need (see Appendix VII). A major activity for senior managers was the development of a change management plan to engage staff across all classifications and areas and

implemented through an organized program of staff initiative. Staff had a major role in the planning and design of the new care centre as well as the implementation of the model of care.

The next building stage of demolition and construction involved relocation of some residents as well as having an impact on the physical environment of the community. This was progressed in 2004, along with completion of the first new units that had commenced in 2003. Strategies to manage this effectively were implemented. There was agreement that much had been learnt since the first period of relocation in 2003. A site planning and development team was engaged, including architects and advisers for the new care centre, to assist the Board and SMT. Considerable marketing and new branding also occurred early in 2004 to coincide with the new development. This was accompanied by the strengthening of corporate policies and procedures, plus improvements in systems and documentation.

4.4 Summary of chapter four: understanding the impact of change

The action research process provided the SMT with strategies to explore the impact of change. The CRG implemented two action research cycles in which they collected and analysed a comprehensive body of data and reflected on the findings arising from the analysis. With this insight, they were able to take action to effectively progress the redevelopment and monitor the change process.

It became clear to the SMT that engagement of the residents in the change process would assist them to better monitor the impact of change and to manage their reaction to situations that caused them concern. The positive response from residents to the formation of the resident advisory council and subsequent links with the Board confirmed the importance of engaging with residents in planning and development. This Council became the primary link with the resident population through regular meetings, formal and informal communication and a growing role on the Board. Strategies to increase the numbers of residents attending meetings were to be developed to enhance the effect of the Council. Ways to link new residents with current residents through social and recreational activities were also considered

important. Plans were also made to engage residents and relatives in discussions about the new combined care centre.

Analysis of the data from the two action research cycles also revealed to the SMT that change was influencing the redevelopment. By understanding how residents and staff were reacting, they recognised that the initial redevelopment site plan was inappropriate and they were able to use this knowledge and understanding to inform a new redevelopment plan.

The SMT also became aware of the importance of engaging staff in the change process and implemented an education process to identify how the staff would be affected by the model of care and proposed service framework. It was anticipated that closer engagement with staff would assist the SMT to address some of the key workforce issues being faced by aged care providers.

This also informed the SMT of the impact on the residents and how this reaction was able to influence the change process and, ultimately, the redevelopment plan. The action research process also informed the SMT of the impact of change on their development as leaders, particularly leadership style, leadership behaviour and the importance of trust and values to members of the team. As a result, they became aware of the importance of leadership for change. In addition, the action research process highlighted the need to build organisational capability for change through organisational policies, process and performance.

It became apparent that the complex dynamics of the redevelopment process occurring within this aged care community required leadership, organisational capacity and resident engagement.

CHAPTER 5 THE IMPACT OF CHANGE: THE PARTICIPANTS' EXPERIENCES

In the course of this study, the CRG acquired significant insights into the residents, management practice and operation of *Choice Village*. The clarity and understanding that emerged from continuing processes of inquiry enabled them to develop an informed understanding of the ways in which accommodation could be constructed and services delivered to residents during the process of redevelopment of the community. This chapter presents the major findings that emerged from analysis of the body of data related to this study. It reveals the key issues that needed to be taken into account by the SMT as they formulated ongoing processes of development.

As became evident during this study, particular attention needs to be paid to perspectives, issues and needs of the various stakeholders involved in the process of change. The chapter, therefore, describes the experiences and perspectives of residents who lived in the community and the leadership group responsible for planning and managing changes associated with the redevelopment. To a lesser extent, it describes issues for the Board members and general workforce. It also discusses the issues that need to be addressed to ensure that the provider, as a business, has the capacity to progress the redevelopment and manage the change through organisational processes and operations.

Investigation of the experiences and perspectives of the participants assisted to build a comprehensive picture of the complex dynamics associated with organisational change. In the course of this study, it also provided the means by which the key stakeholder group, the SMT, were able to consciously engage and manage the on-going reality of the change process. By taking account of the perspectives and issues of each stakeholder group, the SMT gained a more sophisticated and detailed understanding of the redevelopment process in which they were engaged and enabled them to develop rational and coherent development plans. In so doing, the study provides insights into the complexities and challenges of organisational change within this aged care community that adds to the body of knowledge in this area.

5.1 Introducing the residential aged care community

Residents and staff described *Choice Village* as a small country town. Housing varied and included single storeyed and double storeyed units, some like town houses and others more like apartment blocks. There were a number of other buildings, including an art gallery, medical centre, leisure centre, auditorium, grocery shop and chapel. Small streets meandered throughout the village and one larger road cut through the centre of the site. The trees were well established, as were the gardens, some of which were quite beautiful, and clearly the pride and joy of the owner. The care centres were at one end of the site comprising two, multiple storeyed and one single storeyed buildings. The administration building was within the village, with the ground floor a large, well-equipped auditorium, used for large public events and activities.

There was a bus route through the middle of the village to connect it to the outside community. Care was taken to make pathways and roads 'people safe' to accommodate the many residents who walked within the village. Movement throughout the village varied and included electric scooters, electric wheelchairs and some cars (residents and visitors). Lots of people were independent or used aids such as frames and sticks. A small electric buggy/cart provided a limited internal transport service. Some people had lived in the village for many years and had made minor modifications to units, closed verandas and created carports. Each unit was a little bit different even though the design was the same. It was a busy, active community just like any small town.

Residents lived in different types of accommodation and recreational and therapy facilities were available in both care centres as well as within the village. Access to gardens was minimal from the high-rise building but more available from single storey facilities. There was a coffee shop in the foyer of the high-rise building, well utilised by residents and families.

Residents who lived in the high care centres needed twenty-four hour nursing and personal care for physical, psychological or social needs, or a combination of all three. Accommodation was usually a bedroom, where the room was often shared

with another resident, so there was minimal space for personal belongings. There was access to common space and most facilities were shared with other residents. Individuals came to high care because they, or their family, could no longer meet their need for care at home, or, they moved from low care because their needs were now beyond the services that were available and their level of dependence greater. Sometimes with couples, one person lived in a high care centre and the partner in the low care centre or in a village unit. Level of dependence varied, as did severity of medical condition.

Residents also lived in the low care centre if assessed at a lower level of dependency and needing some assistance with personal care, mobility, meals or medical condition, but still with a degree of independence. The low care centre had several storeys and was connected to other buildings/facilities and adjacent to independent apartments. Recreational facilities included an art gallery, craft rooms, coffee shop and a bowling green, and public transport ran past the building. It was clear that residents in the low care centre could still maintain a level of independence. Accommodation was a single room or bed-sitter, large enough to house some personal belongings, and a private bathroom. Breakfast was usually in their room, although some residents went to a common dining room. Lunch and dinner was served in the dining room. Staff provided assistance with personal care, management of medications and some dressings or treatments. Residents could choose to remain in their room or participate in a variety of social and recreational activities, on and off site. Many of these residents had moved to low care from a unit or apartment in the village but some came from the wider community. Some could move on to a high care centre if the level of dependence, and their need, increased, but this depended on availability.

The majority of residents, however, lived independently in a unit or apartment throughout the rest of the village and may or may not have been engaged in activities and services available in this community. Residents lived in a combination of bed-sitter or one-bedroom units and blocks of one and two bedroom apartments connected by gardens, paths, internal streets and recreational facilities. Village life might include activity in numerous clubs and social groups, informal gatherings in the coffee shops, film nights and dinner outings.

Residents from the village also accessed the dining room in the low care centre and two coffee shops, one in the low care centre and one in the village. There was ready access to public transport and easy access to adjacent roads. Movement throughout the village was safe as traffic was restricted and roads and paths maintained for safe walking. Gardening and maintenance services were available, along with access to services brought on to the site, such as a chemist. Family and friends, and the general public, moved on and off the site at will.

While this aged care community was a business for the Board and SMT, it was home for the resident population of older people. Some residents lived independently, required no assistance, worked and participated in few village activities. On the other hand, others required full time residential care and could not live alone. Within the population of eleven hundred, there were many variations between these two situations. It was an ongoing challenge to ensure a quality of life for all residents, to meet the physical and social needs of all current residents while also anticipating their needs and the needs of future residents. It was very important to listen to the residents at all times, but particularly during a time of change, and to monitor the impact of change on what was most important to them, their quality of life.

5.2 The impact of change on the residents – the importance of quality of life

“Quality of life is the ability to enjoy life and feel it has meaning” (Ball et al, 2000).

As residents spoke of their experience within *Choice Village*, it was clear that the changes taking place within the community were having a marked impact on many facets of their life. Though individuals spoke of different issues, their overall concern was directed to maintaining their quality of life; to ensure that the place in which they had chosen to live for this part of their life, would continue to accommodate their needs. The following account provides a detailed understanding of the way they described and interpreted their experience in this context, providing an in-depth understanding of the issues and agendas that the SMT would need to take into account as changes emerged throughout the organisation. It reveals that the concept of quality of life and feeling that life has meaning, was important to the residents and

understanding the elements of quality of life is fundamental to understanding the impact of change on the resident population.

5.2.1 Introducing the residents

Tom and Betty were typical of residents in this community and their story was like many other resident stories. Now both in their late eighties, they had moved to the village 22 years ago, having lived in the family home for almost 35 years before this move. It was an easy decision, they said, because Betty had heart problems and was finding the big house just too much to handle. Tom still worked part time and felt more comfortable about leaving Betty if she was in a smaller home with people to keep an eye on her. They had no children and not a lot of savings and, as they moved into a one-bedroom unit, had to get rid of a lot of personal and household things. They had a little garden and space was limited, but they found it easy to adjust and became very happy. They walked to the little grocery store and medical centre and the bus stop was near by. Betty stayed close to home, played cards regularly and enjoyed the company of other women in the village, while Tom loved his lawn bowls and played regularly. He had brought his car with him and so was still able to do the shopping and keep in contact with the outside community. They made friends quickly and felt very much a part of the village.

However, Betty's health deteriorated fairly quickly and Tom became her carer. He had some support from formal carers (staff) but he did most of the caring and was very keen to look after Betty and keep her at home. Most of his other activities stopped as he had little time for anything else and needed to be close by. Eventually, Betty had a stroke and, although he tried for a while, he could not manage. He was able to get a place for Betty in one of the high care centres and, reluctantly, placed her in care. He stayed in the one-bedroom unit for a while, visiting Betty every day and helping with her care. He didn't have much time for anything else, but stayed in touch with activities in the village and his friends. Then, his health deteriorated too and he moved into the low care centre. He lived in a bed-sitter, went to the dining room for meals and had his medical condition monitored. He still visited Betty every day, but she had not been well and sometimes she didn't recognise him. He played cards once a week and was friends with another gentleman in his building. They

watched TV together, especially the football. He had stopped driving some time ago and had sold his car. Having Betty close and visiting each day was really important to Tom but he knew that he could not look after her on his own. He needed a bit of help now too and said he was very comfortable in his room. Tom felt that there was still quality in his life and he knew Betty was well looked after.

Tom and Betty's account revealed characteristics of resident life in this community that were shared by many residents. The account revealed the importance of friends, social involvement and interaction, adjustments that were made when leaving the family home and how personal situations can change with a change in health status of one partner. Their account highlighted the importance of appropriate accommodation and services and the need for flexibility in service delivery.

While Tom and Betty's experiences may have been common to many residents, others told different stories. What became clear, was that, regardless of the type of accommodation or degree of independence, this community was the residents' home and, in some cases, had been for 10-20 years.

5.2.2 Quality of life for residents in the high care centres - personal care and communication

While the theme of quality of life was important to all residents, elements and events that contributed to or affected quality of life and gave life meaning, varied across the sub-populations of residents. This section presents the lived experiences and elements identified as contributing to quality of life for residents in high care, and the impact of change on quality of life. The key elements of quality of life for residents in the high care centres were expressed as *personal care and communication*.

Residents, or their family members, highlighted personal care, cleanliness, meals, medications and treatments as important elements of their life experiences. They also rated friendly staff, 'good' staff (skilled) as important, along with communication and interaction with others. Being able to solve problems when they arose was important to family members and visitors were important to residents, especially family members.

For one high care resident, confined to bed unless she had assistance, the staff made the difference to her quality of life. "I like the staff to be kind and gentle to me. I am a bit slow you know." For another, a lady with a complex medical condition and considerable physical disability, "Just my room and my bed and someone to look after me, dear. That's all I want."

Another resident was a lady of 82 years with a sharp mind but dependent on staff to assist her with all daily activities of living, including showering, dressing, walking, meals and medications. This lady had been in this facility for several years. When asked what contributed to her quality of life and gave it meaning she said,

"I just need someone to look after me, dear. I don't do much anymore."

In the conversation she went on to say that she liked to get dressed after breakfast and sit in her chair by the window for a while. She explained that, although she shared a room with another lady, they didn't talk much. She liked to watch television and enjoyed visits from her family, but she did not go out of her room very much. Another lady in the same facility confined to bed unless she had assistance, felt staff were very important. She said,

"I take a while to do things these days and I don't like to be rushed. I need the girls to be kind and gentle."

She explained that she was very happy; she could not do much for herself any more and really appreciated the 'girls' who worked there. She said,

"I am a bit of bother really, you know. I can't do much for myself anymore."

A gentleman, confined to a wheelchair when out of bed, was sitting in the lounge room and reading a book. His explanation of quality of life and meaning was,

"I love my food so the meals are important and I love to read. I need to get out of my room. The chair (wheelchair) is really important so I can go downstairs and out with the kids sometimes."

One daughter, who participated because her father could not communicate, said during the conversation,

“Dad doesn’t really know what is going on anymore, but I need to know he is clean, well fed and cared for with kindness and compassion.”

This woman was a nurse and had cared for her father for several years until he became too heavy for her. This was the second facility he had been in and she said that she was much happier with him here. She described her father’s quality of life, as she perceived it, explaining,

“It is really hard. I felt badly about Dad and a bit guilty that I could not cope any more, but he is such a big man and it was just too hard. I visit every other day and other people visit too. He doesn’t talk and I don’t think he knows it is me, so it is really important that I speak for him. You know, I need to make sure his life has some quality.”

Another couple told a different story. The lady had only been in care for a few months since her dementia had become more advanced. In conversation, she answered some of the questions and initiated her own comments about her room, the staff, the things she did on a daily basis. Her husband answered independently at times, assisted her at times and, when she struggled for words, answered for her. He frequently praised her for doing so well. He said that he had been her sole carer for many years at home but, when his health started to suffer and when her dementia progressed, he felt he could not cope anymore. His children told him he was ‘killing himself’ and they had to find somewhere for ‘mum’. Quality of life for this resident meant,

“I like my meals, the food is really nice. I have a nice room and we do lots of things in the day, I mean (activities suggested by her husband) things in that room down there with other people.”

For the husband, it meant his wife was being cared for, safe, took her tablets and was happy. He explained,

“I visit every day except Tuesday and Sunday. They are my days off and the children visit those days. I ride my bike from my unit usually, unless it is too hot or wet and then I take the bus. I can’t really afford the petrol for all these visits. So I need her to be close enough (to ride). So, if she is well looked after then I will be healthy too. I like to see her smiling and happy, doing things and taking her tablets. I am really happy with everything here.”

In summary, these residents in the high care centres revealed a number of elements of quality of life that had meaning to them. Elements related to their physical health and medical condition that determined a level of functioning. Their ‘home’ was mainly their bedroom and surroundings within the centre and the people they shared this with, their family and staff. These residents described matters of personal care as very important, as was personal comfort. Communication and interaction with staff and contact with family also played an important part in their quality of their life and its meaning. Any change that altered the ability of the staff to meet their personal care needs or interfered with communication, affected their quality of life. Change may not directly affect them but if staff, the physical environment, or their family were affected, then there was greater likelihood that change would affect them. It was important not to disregard this population because they were less visible, less vocal and appeared not to be directly affected by change. They were part of this aged care community and their needs and quality of life were as important as the needs and quality of life of any other group of residents.

5.2.3 Quality of life for residents in the low care centre - independence and assistance

Quality of life was also important to residents in the low care centre but the elements and events that contributed to or affected, quality of life and gave it meaning, were expressed differently. This section presents the lived experience and elements that contributed to quality of life for residents in low care, and the effect of change. The key elements of quality of life for residents in the low care centre were also relevant to their personal situation, described as a balance between *independence and assistance*.

Personal space and belongings were important. One lady in low care said, “I feel safe here and I get assistance with my shower and dressing.” Another explained, “Enough space for my personal belongings but not too much to look after.”

During a conversation with one lady who needed assistance each day, she said,

“I need assistance every morning and night with showering and dressing and my meals. Without that I could not manage and would not be very well. I watch TV a lot, especially the sport, and I have family here all the time. But I cannot live alone anymore. I feel safe here and I don’t worry about what other people are doing.”

A man, who could no longer walk but got around with his electric scooter, was on committees and involved in some recreational activities. He explained this balance as,

“The option of activities and social interaction and my choice to be involved or not is important to me. I use the computer a lot and I like to go out with friends so I only get involved with some activities here. But I need assistance with dressing and stuff and need someone to look after my legs ”

An elderly lady with visual and mobility disabilities focussed more on consistency of the staff and said,

“Friendly staff are really important and the same carers so I don’t have to train new ones all the time. It is a real nuisance when they don’t know how I like things done. And of course, I don’t cook anymore but I can make myself a cup of tea and they bring my breakfast to my room.”

A lady, who had originally been in the village before moving to the low care centre, had a room full of furniture, pictures and family treasures. Her comment was,

“I need some space. I had so much stuff that I got rid of, but some things are special and they had to come with me. My life is filled with memories and I need them around me – that is my quality.”

A fit, well-travelled, eighty-five year old gentleman who could see very little and could no longer read, but was still independent and active, explained,

“I need to walk everyday. I am a great walker. I need to feel safe to walk all over the village each day. My room is clean and tidy and the meals are really good. I can get help when I need it but they don’t bother me either. I leave my door open all the time and people often just call out and say hello when they pass by. I listen to my talking-books and my family call me on the phone a lot.”

His comment illustrated the importance of achieving the balance between help when it was needed, but independence when it was still possible. Another woman had other thoughts. This lady walked with two sticks for support, had multiple medical conditions and was very short of breath when she talked for any length of time. When visited, she was watching the television while knitting. During the conversation she talked of her family, her deceased husband and some of her life experiences. For her, quality of life was about a balance between assistance and independence.

“I know I need help now but I don’t need to be in a nursing home yet. It is important to me to do as much as I can for as long as I can. I mean, if I give up on myself then everyone will give up on me too. It is still my life and I want to be in control. It drives my family mad sometimes (she laughed). They want to do everything for me and I won’t let them.”

Residents in the low care centre recognised that they needed care when they could no longer manage on their own but, at the same time, they wanted to maintain their independence. Their personal world was wider than the residents in the high care centres but also restricted by their level of dependence and health status. They were far more aware of the world outside their room and still interacted with that world in

various ways. Interaction with other people was important and access to social activities and participation in clubs was important for some. Having room for personal belongings and everything accessible was more important for others and contributed to quality of life. These residents were more aware of change and more likely to react to it than the residents in high care. They wanted to be kept informed and have the opportunity to express an opinion and provide feedback. But quality of life came with a balance between independence and assistance and was more likely to relate to personal situation and surroundings than the larger community. It was important to listen to these residents and to recognise the elements of quality of life that gave meaning to them, and to monitor the impact of change on their quality of life.

5.2.4 Quality of life for residents in the independent units - stability and security

The key elements of quality of life for residents living independently in the village related to *stability and security* but also included factors associated with the physical environment, personal situation and a desire to remain in their own homes. Because these residents were mobile and far more involved in activities within the community in which they lived, they were far more aware of change and some were very aware of the dislocation that came with the demolition of some of the old accommodation. Some were also more aware of the changes to the business of the organisation, the Board and CEO, and were very affected by what they saw as a change to the focus of the business. This section presents the lived experiences and factors that contributed to quality of life and gave it meaning for residents living independently, and the impact of change on their quality of life.

Some residents indicated, both during conversations and in their responses to the annual resident survey, that the physical environment of the village, the gardens and pathways contributed to quality of life. Although many of the units were old, small and rather close together, the ability to walk around the village, to stay in their own unit and tend to their own garden, was important to them. Security and safety was very important and many residents talked of the fear of strangers wandering through the village and the importance of having a security service after hours. Many

residents in the village still drove a car and used this or public transport to take them to shops, services, friends and family. The availability of public transport was also identified as a factor in their quality of life.

Many residents had lived in this community for a long time and mostly in the same accommodation and they also identified important elements. One woman who had been living in the village for twelve years said, “Security is very important to me because I live on my own.” Another couple explained, “We have lived here for years – this is our home. All our friends are here, there is lots to do and we can go out whenever we want to.”

Stability was important and living in the same unit for years achieved this. One resident explained,

“I have been in this unit for 16 years, had the same neighbours most of the time and we look after each other. I didn’t want to move really because this place is my home now. You know, it is a bit like my home is my castle.”

One woman, who had been on her own for many years and had poor eyesight, wanted stability and comfort with her environment and said,

“My eyes are failing and I know where everything is – I didn’t worry about falling or getting lost.”

For these two residents, quality was related to the security and predictability of their home, the unit they had been in for many years, and the life that they had developed around that home. Other residents expressed quality in terms of safety, security and friendship. During conversation a resident said,

“I need to know that my future is secure – will there always be a place for people like me who have very little money? “

A very independent woman in her nineties, who had been a resident for many years, felt she was being looked after and made this comment,

“I like knowing someone is keeping an eye on me. I had regular visits from the welfare staff – just keeping an eye on me. She is too busy now and only visits me when I call for help. What if I can’t get someone?”

A couple who had been residents for many years, had held positions on committees and were involved in many village activities, described the factors that gave their life quality and meaning in this way.

“This place has become our family. We have family outside too of course, but we see more of people in the village than we do our family. This place has a family atmosphere and we look after each other. You could never be lonely here – so many people, so much to do. You don’t need to go off-site at all if you don’t want to. Everything we want is here. We feel safe and security is pretty good.”

For another resident who had lived in the village for about ten years, quality of life was explained differently. This gentleman was in his seventies and had moved from a large family home in a semi-rural community after his wife passed away. He had no family in Perth and, although he had some medical conditions, as far as he was concerned, he was ‘well’. In the time he had been at the village, he had participated in clubs and, in some cases, held positions of office and coordinated activities. He enjoyed his garden and helped a couple of women living nearby who could no longer look after their gardens. He still drove his car and went out regularly. He said that he moved to the village because a friend was there.

“I had been looking for a while and had made inquiries here but there were no units available at first. Then one day, my friend rang and told me that one had become empty because the person had moved into the care centre, so I came and met with the Manager on the off chance that it might be available. It was and I moved in as soon as I could. It was only a bed-sitter but that was fine for me.”

Another couple told a different story. This couple were both in their eighties and both had serious, multiple medical problems. They had been at the village for many years

and, in times of better health, were involved in many activities and events over the years. Their original unit was very small but it was home for them. This couple were strong supporters of the old regime and friends with management and staff in the past. In their eyes, the community was going backwards and they were not happy. The woman said,

“I have worked in this kind of industry for many years, both here and in our previous place. I know what old people want – stability and security.

Her husband went on,

“I am a very sick man now and I don’t do much of anything anymore, just stay in my unit, but I used to be really involved in the village.”

He went on to explain that he felt things were changing in the village and that he wasn’t happy. He felt that someone was making wrong decisions and that they (the residents) would suffer. His comments showed how stability and security had become increasingly important to his quality of life and how change was impacting on his life. He said,

“We are not interested in new, fancy units or making money for other people to benefit in the future. We will die here eventually and we just want it to be like it used to be”

The availability of some assistance and other accommodation options on the same site was very attractive to some residents. One eighty five year old resident explained why this was important. This lady had been living in the village for many years, initially with her husband and alone since his death. She had multiple medical problems and limited mobility, but still played cards twice a week and took a taxi to the local shopping centre once a week. During conversation, she said that it was important for her to keep doing as much as she could but to also know that help was available if she needed it. She’d had several falls in the previous twelve months and needed some help for a while, but was still obviously very proud that she could cope most of the time. She commented,

“I am not as bad as some of them yet and I don’t want to go into the home. I have to keep trying to do things for myself, proving to myself that I am still all right. It would be easy some days to give up, but I seem to bounce back most of the time. My family would like me to be over there (the home) but this is my home and I aim to stay here for a while yet.”

Some staff indicated concern that this drive to keep going for as long as possible sometimes put an individual at risk and resulted in exhaustion of the partner, who might be the carer at home. In other cases it resulted in the individual not getting help until too late. In both cases, quality of life suffered. One staff member described this situation well, when she said,

“Sometimes they (residents) stay in the village too long. By the time they come to low care, they really need high care. If they accepted their need for assistance earlier, it may have been possible to support them to maintain some independence in low care longer.”

One gentleman interviewed illustrated this well. He was living independently in a unit in the village but his wife was in one of the high care facilities. When talking in his unit, he described their long life together and how devastated he was when his wife had a stroke. He said,

“I cared for my wife for 10 years after she had her stroke. It was hard work sometimes but I just had to do it. At times I was exhausted. I had to stay well and just keep going because I said I wanted to keep her at home. I felt like I had let her down when she moved into the high care centre, but I just couldn’t lift her on my own. I know she understood but I would have liked to have kept her home longer. The family told me I was crazy to wait for so long and the staff say I am wonderful (laughs). Now I visit her twice a day and help her with her meals and other things. It gives me a bit of time for myself. I didn’t realise how exhausted I was until she went. It took me ages to feel well again.”

For him, quality of life and meaning was having his wife looked after, being able to visit her and participate in her care, but also to look after his health and maintain some independence.

Concern sometimes came from the family, who may be worried that a loved one was not coping. Or, on the other hand, they may have had a perception of 'normal behaviour' for an older person that sees age as synonymous with illness rather than the concept that ageing is a healthy, normal process. A resident explained this when she discussed the reaction of her family to her wish to stay in her unit after her husband died, rather than move in with them.

“We had been married for 45 years, lived here for ever, since he retired. We always looked after each other. When he died I was very lonely for a while and a bit depressed and I guess the kids thought I wouldn't cope on my own. But this is my home and everything in it reminds me of him and our life together. I was not keen to go anywhere else. They couldn't see that even though I was alone, I still was healthier being here. And all our friends are here and I knew I could get help if I needed it.”

Understanding the elements that contributed to quality of life for residents in the village brought greater understanding of the concept of quality of life for older people. The key elements were identified as stability within their personal situation (financial and health) and security within the community environment. Many residents were keen to remain in their own home but to have ready access to recreational and other services, if they chose to access them or need them. The knowledge that assistance was accessible within the community, either in their home but at a later stage within the care centres, was also important. These residents revealed that they were most directly affected by the redevelopment and associated change and were very keen to be kept aware and, in some cases, involved in decisions. Many were confident that their future was secure and had confidence in the management. Others did not and were very critical of 'how things had changed' in recent years.

Through careful analysis of resident interviews it became evident that quality of life was a complex, multifaceted concept. Although there were common elements, quality of life varied according to personal situation and health status. This study highlighted the need for the SMT to recognise how these elements differed for the residents in the three sub populations in this community, to recognise how the redevelopment process was affecting them and to develop a range of strategies with which to respond. This knowledge and understanding became a significant tool for the SMT as they developed future accommodation plans and a new model of care and further informed the development of a change management process. They were able to use the information to develop guidelines for potential developers and builders and to evaluate future decisions.

5.2.5 The impact of change on quality of life

The collection of conversations with residents in this community became their stories and through these narratives, key factors perceived to be important for quality of life were highlighted. These stories also revealed that change had impacted on some of those factors that they had identified as important to their quality of life. Stability, security and routine were all important and change to any of these was unwelcome. Even with the death of a partner, staying in the same unit enabled them to maintain their quality of life, as the unit was familiar and full of memories. Having friends close by and being in familiar surroundings were also important, along with access to facilities and services. Any change to these factors was seen as a disruption and had an impact on quality of life.

Independence was critical to quality of life, being part of a village but still living independently. Residents were concerned that the redevelopment and associated change would alter the balance that they had established. On an organisational level, some residents indicated that they felt that the organisation (community) was changing and feared that they would not be 'treated' in the same way under the 'new' management.

The impact of change was revealed in a number of ways. One resident explained,

“Old people don’t like change. When they get to 80, they want the day to happen exactly as it did the last time.”

The impact of change within this community took on special meaning because the community was a twenty-four hour, seven-day a week business. One manager explained by describing the community as a ‘living organisation’ and went on to say,

“It is different here. In other businesses you can shut the doors and go home at night and start again tomorrow. You don’t have any clients over night. But we do. The residents live here all the time and their life is affected all the time, whether we are here or not. ”

Reactions to change varied among residents. For some, change was viewed as negative and disruptive while for others, it signified growth and development. Some saw a loss of what was so unique and good in the past but others welcomed the introduction of progressive new ideas.

Change appeared to be of less concern to the residents in the two high care centres as their quality of life related more to personal care they received (cleanliness, meals, activity, mobility, safety), communication with family and staff, staff attitudes and skills, family/partner involvement and the ability to resolve problems and issues if they arose. When asked if they had noticed any change in the past 12 months, the residents were not aware of any organisational changes, although one resident said she felt that there had been some new staff. She said,

“I see some new faces among the staff sometimes, but mainly it is the same ones.”

One family member knew that there had been a new CEO appointed, she also knew about the change of high care manager, but was not aware of the building program on site. She explained that she really just visited her Dad and didn’t get involved in

anything else, although she did come to the resident/relative meetings when she could.

‘This is a really big place but it is really only this building that interests me. I know there are units in the village but he (Dad) is past them so I don’t really pay attention.’

Residents living in the low care accommodation shared different views. They were aware of the building program that had commenced on the vacant block within the village and that some of the residents living in independent accommodation had been moved to other units as part of site redevelopment. One resident said,

“I have looked at the plans for the new units but they don’t mean much to me. This unit suits me fine now.”

In 2002, many residents knew about the prison development adjacent to their main accommodation site and expressed views in petitions about moving the prison to another site. They watched the demolition of the old buildings, felt the vibrations of the construction equipment and were angered by the removal of old trees along the boundary line.

“This is no place for a prison, next to all us old people. We told the government but they didn’t want to listen.”

The dust, noise and disruption during this construction had been considerable and watched with interest by many residents. Interestingly, the improvements to the site was also noticed in 2003. The development had resulted in new fencing, landscaping, improvement to adjacent roads and a significantly more attractive outlook from the low care centre. One resident explained,

“I have to admit, it does look better. That old place was awful and this is much nicer. I like the new buildings and the garden will be lovely when it all grows. It is a much nicer environment now.”

Other changes that had been noticed were changes to Board membership, a new CEO, some new staff and some changes to meal services. Residents received a monthly newsletter and said it was helpful in keeping them informed. The response was positive, but one resident also said,

“Yes, I read it. But I get all my information from the ladies in the dining room. You get all the information and gossip at meal times.”

A good example of the effect of change on quality of life was seen in the reaction to changes to meal service, explained by residents in the following ways. Meals became an important part of an older person’s life. They defined stages in the day, “I need to be up for breakfast”, provided an association to time, “it must be 12 o’clock because it is lunch time”, offered opportunities for socialisation, “I sit at the same table with the same people”, and they incorporated exercise, “it is good for me to walk from my room to the dining room”, as well as providing nutritional value.

While residents in the village could choose to attend meals in the dining room, or coffee at the kiosk, they also had the choice to eat at home. Residents in the low care facility could have some meals in their room (particularly breakfast), but they were likely to come to the dining room for other meals and go to the kiosk/coffee shop at other times of the day. Residents in the high care facilities had meals either in their room or at central meeting areas. Meals were a large business item for this provider and the service needed to be cost effective and efficient, as well as attractive and meeting the nutritional and social needs of residents. One resident in the low care centre explained,

“I go down to the dining room twice a day to talk to people and hear what is happening around the place. We sit at the same tables with the same people and have become quite good friends. We often have the same staff too and that is nice.”

During a conversation with a resident in the low care centre, he said that he was going to have his breakfast in his room in the future rather than the dining room.

“There have been some changes to the meals. I don’t know why, but they (staff) tell me they are trying to improve things – make savings. Just as long as they don’t mess up my routine or do anything to spoil my meal.”

In another conversation, another resident said,

“I will be having my breakfast in my room now. That’s okay because I can get dressed after breakfast now rather than rush around to be dressed to go to the dining room.”

She went on to explain how meal times had become a way of keeping up with what was going on.

“I have been sitting with the same people for ages and we always tell each other what we have been doing. I don’t like sitting with other people now. You know, you get used to the same people.”

When asked if she had noticed any changes in the meal service, she sighed, rolled her eyes and answered,

“Yes, I think they have been trying to save money and some things have changed. Some things come in packages now, not dishes (individual serves) that are okay I suppose, but some of them are a bit hard to get open. I don’t mind a bit of change, just as long as the meals are good and I get what I like. But some people aren’t happy. We didn’t know things were changing and so some people got a bit upset and complained.”

In this case, while the intention was to improve quality in service as well as cost effectiveness, changes to meal service had a real effect on residents. A change that may have appeared to be a good business decision was perhaps not planned and implemented well, and angered and disturbed some residents.

The residents most affected by change were those living in the independent village accommodation. There appeared to be several reasons for this. The Administration

Centre, where the CEO and some senior staff had offices, was in the middle of the village units and this was where residents went to attend to business matters. There was evidence of change within the Administration Centre with signs and posters. Some of the changes to administrative systems and processes disrupted routines and past practices - for example, changes to office hours, new staff and different forms of communication. Some residents revealed that they were opposed to changing the physical environment and accommodation.

Another example of how quality of life can be affected by organisational change was revealed in the reaction of some village residents to the change of name and associated signage that occurred in 2002. This was not well received by some residents and was viewed by some as the most visible example of the 'new' organisation and a rejection and disregard for the past. One disappointed village resident explained:

“What was wrong with our name? We have become a village of no care.”

Reaction to the name also centred on the word 'care' where, for some residents, the word implied disability. During a conversation one resident explained,

“I don't need care, I am independent. It sounds like I can't manage.”

One resident was living in the low care centre and had moved from a unit in the village about 6 years previously, when he was no longer able to cook and clean for himself. He explained the reason for some of the reaction to plans for new accommodation in the village.

“I was happy with my little unit but when I look at it now I realise that people coming in to the village in the future would never settle in it. It is just too small. But those new units look so big – who wants all that space? It just doesn't make sense to me”

When asked how he felt about the change that was occurring, he responded,

“I can see what they are doing. The problem is they (other residents) have lived here for years and paid a pittance for the privilege. They can’t understand that without a good business base, they won’t be able to live here at all because the place will be run down and go broke.”

As in any organisation, information about change was important. Many residents seemed happy with the level of communication and said that they got information through a range of sources. This included a monthly residents’ newsletter, called “Tidings”, news bulletins and notices posted throughout the village, regular resident and family meetings in the care centres and regular resident meetings in the Village convened by the Residents’ Council. Other strategies were public information forums, ongoing feedback mechanisms, individual meetings and telephone conversations, and information technology (IT) initiatives. But, as in all organisations, not everyone read what was made available, or ‘heard’ the information in the same way. Maintaining communication remained a challenge as was finding different ways to circulate information through the community.

5.2.6 Engaging the residents in the change process

Choice Village was home for some eleven hundred residents and remaining in touch with them all was a constant challenge for the SMT. Effective communication requires strategies to ensure that residents were both listened to and kept informed. As the research process progressed, through a process of discussion and reflection and feedback on data, managers became more aware of the importance of listening to the residents to understand the impact of change. While recognising the importance of this, a manager shared the frustration of trying to meet the needs of everyone when she said,

“We try to listen to everyone and we try to be here for everyone. We can’t of course, but we really try to have everyone happy. There are a lot of people in this village and lots of different personalities and needs. Some might never be really happy but it is important that most are, you know, as happy as they can be.”

She went on to say,

“Some of them have no family you know; we are all they have. They rely on us, this organisation, the contact with staff and other residents – that is all they have. Whatever we build or change, we have to monitor how they will be affected.”

One manager told how the residents had coped with some changes to services during the year. What was important was not just how the changes had affected them but that they were comfortable enough to express their opinion and not frightened to speak up if worried. The manager explained,

“The residents are my priority. My relationship with the residents is my core business. We need to review our services and make changes but we need to involve them”.

The manager went on to say,

“They have really been very accepting of the disruption (referring to the construction on site), as long as they feel they can come and tell me when something is worrying them, when it is affecting their day to day life. It is really important to me that they remain happy.”

From the outset it was clear that the organisation needed to have clear lines of communication in order to involve residents in the change process. The resident newsletter was produced monthly and informed residents of many things, including club activities, films, church services, a dinner club and access to external events. One village resident explained,

“There is so much available – you can’t be bored. The newsletter and the social club keep us informed of everything that is happening.”

The newsletter clearly provided a means to inform residents of pending changes. Listening to the residents revealed that their attitudes towards the changing environment did change over time. In 2002, it was evident that there was a vocal,

dissatisfied group within the village resident population. Residents reported that this group became less vocal and lost influence with many residents as change progressed. Minutes of meetings indicated that resident forums were better attended and information that was presented about the new directions was well received. One resident described this change in this way,

“At the 2003 Annual General Meeting we were expecting problems, like last year, but it didn’t happen. Residents got the information, the facts, and it was clear that decisions were being made based on knowledge and good information. People were very pleased. It was a good meeting.”

Another resident provided this insight during a conversation,

“You know this is a big place and there are a lot of people living here. You will never please them all. Some of them have been grumblers all their life and they will never change. They don’t get out in the evening and don’t participate in anything. They just criticise. But most of us are happy; we can see that good decisions are being made and we know that we are in good hands and will be well looked after in the future.”

It became apparent during this study that, while the SMT had been listening to residents in the past, change and the reaction to change re-emphasised how important this was. With this realisation, the SMT developed better ways to communicate with residents, learnt to listen more closely and to reflect and act more effectively on what they heard. The SMT also learnt that residents listened to each other and provided useful insight into resident reaction to situations. This again emphasised the concept of community and the value of creating ways for physical interaction and connection.

5.2.7 Summary - the impact and influence of change on residents

As can be expected in any community of eleven hundred, the lived experiences and perceptions of quality of life described by residents in this aged care community varied markedly. Many had been part of the community for a long time and considered this community their house, home and family. Others saw it as a place to

live and/or the provider of a level of accommodation and support needed for them to live to the best of their ability. Some were actively involved in the community while others connected very little with other people or events. Remaining aware of, and understanding, their needs and concerns was a continuing challenge.

This account presented the narrative of many residents and collectively illustrated that, regardless of personal circumstance or accommodation, residents consistently identified that maintaining quality of life was important to them. While many residents had unique perspectives about the quality of their life and the elements that contributed to this, there were a number of common elements within the three sub-populations of residents. Residents in high care emphasised elements associated with personal care and communication, while those residents in low care emphasised the importance to them of obtaining assistance when it was needed but still maintaining their independence. Residents living independently in the village indicated stability and security as important elements and all revealed the importance of routine and predictability.

Quality of life is a multi-faceted concept that encompasses personal, social, environmental and functional elements. Recognising the elements of quality of life for residents and the impact of change on elements of quality of life, was critical for the Board and SMT as this enabled them to manage the impact of the redevelopment on the residents' perceived quality of life.

This study revealed that, while there was some awareness of the need for change, many residents appeared challenged by this and continued to yearn for the past. Resistance by some residents might also be viewed as a symptom of fear of the unknown, insecurity or just being comfortable with old ways; however, resistance must be recognised and dealt with. Information about the redevelopment and possible changes and involvement in planning did address some of the concern and resistance and did assist residents to understand the reason behind the redevelopment and appreciate its purpose and value.

Communication and effectively responding to issues and concerns is particularly challenging in an organisation that is a home to eleven hundred residents as well as a

business entity for the Board and SMT. Finding ways to listen to, and involve residents, was critical to the progress of the redevelopment.

5.3 The impact of change on the senior management team – being leaders

“Leadership is not an individual, but a collective, relation-based activity”
(Fairholm and Fairholm, 2000).

Organisations need leaders and this study revealed the importance of the SMT as leaders in *Choice Village* as well as key leadership behaviours. Leadership during a process of change is important and this study highlights how the change process both influenced individual leadership behaviour and as well as the leadership behaviour of the team as a whole. As the SMT grappled with the complex array of issues requiring their attention, they discovered the need to make changes in the membership of the team as well as the need to develop their capacity to deal with the redevelopment of the organisation.

The redevelopment would result in changes in all aspects of community life and ultimately require a new vision for the community, a new model of care and a framework for the delivery of services. Thus the process of forming, building and creating a ‘new’ vision for the community not only required the SMT, as leaders, to engage in careful management practices, but also to engage in a complementary process of professional development. As the following narrative reveals, providing leadership for change in an aged care community is a deeply human endeavour involving careful consideration of the needs of all those involved.

Change is a force in itself and the change process influenced the growth and development of the SMT and changed membership. The response to the impact of change influenced the development of principles underpinning the model of care and a subsequent framework for services. The continuous process of reflection by the SMT within the research process brought greater understanding of leadership behaviour and facilitated the development of values-based leadership and a team approach to management. The SMT learnt that these approaches would enhance their leadership ability and better prepare them to lead the organisation and manage the

change process. This process of growth and development was viewed by members of the SMT as a series of stages, each with a particular focus. They described their journey as a process of forming a vision, building a vision and creating a vision for this community.

5.3.1 Introducing the senior management team

Management responsibilities were shared within the SMT with each manager having responsibility for a functional area of the organisation. This gave them responsibility for the management of staff in their area, physical resources, workloads and budgets. In 2002, at the beginning of this study, this group was a relatively new team. While some members had worked for the provider for some years, others had joined more recently. Collectively, they brought different experiences across a range of disciplines and work areas. Historically, this senior management team had not had a strong voice within the organisation that, in the past, had been directed by the Board of Management. Regardless of individual experience or length of employment, individual managers were committed to aged care and keen to do a good job of providing accommodation and services for the residents in this aged care community.

With changes to Board structure and function and a new CEO, the team was encouraged to take a stronger leadership role and had been asked, by the Board, to embrace a long-term redevelopment program. Without a great deal of consultation, they had been asked to adopt a proposed site building/construction plan. At the beginning of this study, the members of the SMT presented as keen, committed, enthusiastic individuals who recognised that they had a significant task ahead of them.

The SMT was comprised of individuals with a diverse range of experiences. Kerry, for example, had worked in aged care as a clinician and then a manager, while Simon had worked for many years in a corporate business role in the health sector. Julie, on the other hand, came to the organisation from outside the health sector (not real names). Each person brought knowledge and expertise relevant to the industry and to their particular area of responsibility, but they also brought a common commitment

to the residents, a unique population of individuals who lived in this community twenty-four hours a day, seven days a week.

Interaction and conversation with Kerry, Simon and Julie revealed that they all had a vision for this aged care community. They wanted it to be recognised as one of the best in the industry but, more importantly, they wanted it to be ‘the best’ for ‘their’ residents. While they knew that it had a fine reputation, it was physically and functionally old. They had a vision for the future and they had to create a pathway to bring that vision to reality. The senior management team’s story is about this journey and associated learning. The account is told in four sections that represent stages of the journey as they described them: the first section involved shaping the team, the second forming a vision, the third building that vision, and the fourth involved creating the vision (bringing to reality).

5.3.2 Shaping the team – developing leaders

One of the primary challenges confronting the SMT was to build a leadership team based on agreed organisational values and accepted leadership behaviours. The importance of leadership was highlighted as they faced new challenges associated with the redevelopment and associated change.

In the past, the Board ‘managed’ the organisation even though there was an executive management team. Records revealed that in 2001 the executive was the CEO, Care Support Director and Care Director. The Care Support Directorate encompassed a number of functional units – finances, hotel services, admissions and lifestyle and information systems. The Care Directorate encompassed high and low care centres, village care and education. A support team provided services to both directorates in human resources management and safe practice and environment. Further support was provided through the office of the executive assistant. The executive, plus managers of functional units, formed the SMT, responsible for all aspects of day-to-day operations. The CEO and two managers joined the organisation in 2001 but most had been employed for some time.

Communication with the Board mainly occurred through the CEO and the relationship with the Board was described as “strained” by one of the managers. One manager who had been employed for many years explained,

“I don’t think the old Board had respect for the managers. They didn’t include us and didn’t seem to think we could add value. They just made all the decisions and expected us to do the job. I don’t think they trusted us. I didn’t really respect them either, but I never got the chance to (respect them). I didn’t see much evidence of the values of the organisation in behaviour. For me, things had to change.”

Another manager revealed,

“This organisation has a long history and a complex culture. The Board managed it for a long time but there was very little leadership from within. I am sure the people who worked here during those years were good people and really wanted to do a good job. But the documentation suggests that it had not thought much about the challenges that it would face it in the future.”

This manager went on to tell the history of the provider, the people who established it and what it was like to work there then.

“The work was done on a daily basis but it was pretty task oriented; you just did your job. I certainly don’t remember planning sessions or being involved in developing a strategic plan. I guess we just presumed that someone else had done that. Yes, we had a mission statement and the ‘values’ were in documents, but I don’t think people felt they guided their work. I certainly didn’t feel connected to them.”

Another explained,

“I have enormous respect for the founders of this place. What vision they must have had and what energy to build it over all those years. But that commitment and loyalty was rather restricting and got in the way of progress.

It would have led the place down a very different pathway in future years had things not changed. The Board may have thought they were committed to the vision and values but I don't think anyone else related much to them. It was not a good business model and didn't give rise to a sense of team."

With this history and past relationships, it was difficult for some managers to let go of past practices and move on. One manager explained,

"I have worked with both the old organisation and the new and it has been hard to let some of the old things go, forget the relationships. Sometimes I don't think we realised how much we needed to change until we started to see an alternative, you know, realise that our systems were old and we were not set up for the future. There came a time when we had to just let go."

However, this manager also reported recognition of a readiness for growth and change within the SMT in 2001, especially with the appointment of a new CEO.

"We (the managers) were really ready to grow but we needed a leader and we needed to feel we were working with the Board and valued."

It was also revealed that the executive leadership team had not been cohesive in the past. The roles within the SMT in 2001 continued into 2002; however, there were changes of membership within the team as managers of two functional areas left for different reasons and new appointments were made. Progress in the relationship between Board and SMT was also reported during 2001, and this was supported by some change in practices by Board members. The growth and development was facilitated by the CEO and described by one manager in this way,

"It is a pleasure to work with this Board (compared to the past). There is no subtext, no self-interest and I don't feel bullied like before."

But it seemed that the change was not easy, as explained by one member of the team,

“It’s been hard work to get the Board to see the value of a change in role – to see their role to advise, influence and support, not manage and get involved in day to day operations. It has been rewarding to see how they have taken on the information and how much more effective they are in their role. I can see the results within the business.”

During a lengthy conversation with one manager at this time, it was possible to sense the struggle that had been going on. This manager had worked with the past regime and had experienced the time of transition until the appointment of the new CEO. While ready for new leadership and excited about the new direction, there were mixed feelings at times. They explained,

“I can see that some of our systems are not in good shape and there is a need to get the business foundation firm. I guess I suspected we were not really looking forward, but I was used to the way things were. I have had to get to know the new managers and they have to get to know me too. It is about respect and trust as well as confidence and ability.”

With an obvious commitment to improving relationships and under the facilitation of the CEO, in 2002 the SMT talked about a process of team development, built around organisational values and leadership behaviour. One manager highlighted the importance of values in this way,

“We are a values-based organisation; our business and our behaviour needs to reflect our values. There isn’t much point having a mission statement and a list of values posted everywhere if we can’t see them in the way we work and do our job.”

Another commented,

“I think trust is so important. We have to trust each other and trust in our ability to do the job. The residents depend on us to get it right; it is their well-being that matters. If we can’t show them we are one and that we adhere to

our organisation values, like trust, respect, then we shouldn't be in this business.”

However, this beginning growth was interrupted when the membership of the SMT changed again in 2003. One of the managers appointed in 2002 left for career reasons. Again, the team reformed and membership then remained constant until the beginning of 2004, when one member of the executive and one area manager left. The manager of the functional unit was replaced and the new member joined the SMT in March. However, following a review of processes and responsibilities, the executive position was not filled. Some managers revealed that this changing of the team was unhelpful and disruptive to the process of developing the leaders, as individuals and as a team, and they felt that the SMT did not really consolidate until early in 2004.

In the course of this study, therefore, the SMT became increasingly aware of the importance of a strong leadership team. With reflection on the data from individual interviews, there was also an opportunity for senior managers to reflect on how their team had changed since the organisation had begun the redevelopment process. Many tough decisions had been made by the Board and their commitment to empower the SMT to be the leaders of the implementation of the redevelopment process brought feelings of both satisfaction and apprehension to members of the SMT.

For some individuals there was a need to let go of the past so they could embrace the future and grow with the 'new team'. This was a different process and some individuals struggled, but they accepted it as necessary for progress. Board members were also committed to new ideas and relationships and were required to recognise changes in their roles. The evolution of the combined Board and SMT, as a committed leadership group, was a critical step for the organisation and significant in the change process. Such unity is not always seen in organisations and the way this relationship developed is an important finding.

While communication, interaction and the growing relationship between the Board and SMT continued to grow and develop, and remained an important aspect of the

redevelopment process, the importance of the role of the SMT became clearer. Their journey of development as leaders occurred in stages that they described as forming a vision, building a vision and creating a vision.

5.3.3 Forming a vision - what will it look like

The development of a vision as part of a strategic plan is common practice in most organisations. As became clear in this study, however, the clarification of a vision was part of a process of defining the direction of the organisation and knowing 'what it will look like' in the future. This first stage of the SMT's journey occurred mainly during 2002 and focussed on developing an appropriate culture to support the new vision. For some members of the team, this required a letting go of past practices before they could see the future.

The SMT also realised the need to *form a vision* that would help them to drive the change process in which they were engaged. During meetings, managers identified three particular outcomes to strive for: the establishment of a five-year strategic plan; the development and ongoing review of the operational plan as part of management practice; and clarification of roles and structure within the team. During one conversation, a manager explained the significance of the operational plan, describing it as a 'road map'.

The operational plan, including tasks, time lines and responsibility, became a structure for team meetings and was reviewed regularly. Within the process, it was evident that achievements were recognised and acknowledged and modifications made as circumstances changed. The plan seemed to help keep people on task and identified key performance indicators for the team.

During this period, it also took time for new members of the SMT to settle in to their new roles and to develop a relationship with their staff. New team members brought experience and knowledge from other areas and also questioned practice. As with any new position, systems and processes were viewed differently through different eyes and sometimes challenged. One staff member explained her reaction in this way,

“It is good to have someone challenging what we have been doing and putting new systems in place. We need to be more efficient and to find better ways of doing things. Sometimes you just get stuck in your ways and think that is the only way to do something.”

Another commented,

“It has taken some time but we have got to know each other – how we operate, what we are used to. There has been a lot of change for some staff and not everyone has liked it, but I think it has been for the good in general. I mean, we have to trust that we all know what we are doing. But we have to respect each other’s experience too. I think it is going well”

It was apparent that, within the SMT, it also took time for the team to form. One manager explained,

“It takes a while to become cohesive but at least we have a process and leadership to help us. The meetings have a purpose and we have the (operational) plan to work towards. We are all learning to share information and to feel comfortable with each other. We all have a lot of experience and some of us have a lot of corporate knowledge. It is important to respect all of that. We still have a long way to go but I think we are making progress.”

The CEO initiated a number of activities with the SMT in 2002 to develop the culture and establish the values base for the team. He was particularly focussing on trust as a critical value. He explained,

“I think culture is very important in an organisation – it sets the scene for how people behave and places an emphasis on expectations in performance. I think trust, authentic trust, is really important. People often say they trust someone else, but they just mean the behaviour, their work. Authentic trust is being able to trust someone and also to be trusted. It is a two-way process. It means I don’t have reason to doubt or question your behaviour, your reason

for a decision, because I trust you as a person – it is more a comment on your personal values.”

Further exploration of the importance of trust occurred within SMT meetings and during ‘toolbox’ sessions, when the focus was more on learning and development rather than operational issues. The practice was to have toolbox sessions regularly as part of a management development program. This was rather ad hoc at first but eventually developed into a structured program of development with learning across several areas, with a focus on quality outcomes for residents as well as individual learning. The areas of development were agreed to be leadership, values, culture, education, personal growth and development, change management, business outcomes, strategic planning and organisational behaviour. The CEO explained,

“This program outlines the areas that I think are important within the role of manager and so we can direct our learning to these areas. Individuals can identify particular areas or topics and some will be team learning.”

As understanding of the values grew, the SMT engaged in an activity that involved the translation of organisational values into actual behaviours. For example, an organisational value was *dignity*. The SMT determined that ‘we treat others with dignity’ translated to, ‘we will recognise and respect the value of the individual; approach people with warmth and genuineness; respect and value cultural diversity and cultural difference.’ Through this exercise, behaviours were associated with each of the values. The outcome of the process was a series of performance expectations for everyone who worked in this team. For one manager it meant,

“I can apply these statements to job descriptions and include them in work documents. It gives me a really good foundation on which to build performance.”

Another manager said,

“I know some people might think this is just words, but it means more than that. It means we are really trying to live the values, show how we have

applied the values to our behaviour. I think it is a really good base line for organisational culture.”

Managers identified that the importance of values needed to be passed through the organisation. Following a conversation about the importance of orientation in an organisation, one staff member commented,

“We present the values to all new employees and say this is the basis of our culture. But they are just words. We need to be able to show people how we expect them to behave as employees, with each other and with residents. It is important to make the values real.”

This first stage in the SMT’s journey revealed both the importance of developing the team as individuals and leaders and how this development process brought progress and a great deal of learning for individual members as well as the whole team. During this process, the SMT acknowledged the difficulties that arose for them with several changes of membership and how such changes disrupted progress but eventually led to greater strength within the team. As leaders, they came to understand the future direction through the strategic plan and work progressed to activate this through the operational plan. Members indicated that they felt they were developing as a team and developing respect for each other, while learning to work with the Board. Forming a vision was described as realising who they were and where they wanted to go. One manager said,

“We have a picture: we know what we want to build; now we have to do the work to make it happen”.

5.3.4 Building a vision – getting it right

Visions provide organisations with something to strive to attain but having the capacity to succeed needs additional work. Knowing what the new organisation would look like was a critical first step for the SMT but building the capacity of the organisation and the leadership team to achieve this, was the next challenge. The second stage of the SMT journey, primarily during 2003, was focussed more on

building leadership capacity and strengthening trust and respect within the team, and was described by them as *building the vision*. This phase included a number of key organisational activities: understanding how to balance means and mission, a site development plan, commencement of construction and a new model of care.

As outlined previously, there was also further change within the SMT. Team progress was interrupted early in 2003 when one manager, an appointment of 2002, left. This area had functioned without a designated manager for some time and the appointment of a new manager in 2002 had been welcome. Some changes in practice had occurred and not everyone was accepting of them, but the perception was that progress had been made with those staff who had been less accepting or resistant. Residents and their families remained happy with care. The sudden departure of this manager was unanticipated and split staff into two opposing camps. It was clear that there was a great deal of emotion associated with the departure that also exposed other unresolved problems and issues for some staff. A second senior staff member in the area also left at this time, adding to the disruption.

This came at a critical time and had a significant impact on the SMT. It was discussed at team meetings, along with the staff unrest. A process of resolution was implemented. Staff participated in forums to identify concerns and issues and discuss events. The findings were summarised, fed back to staff and used to guide interventions. Individual staff had the opportunity to identify and address issues. In the meantime, an interim manager had assumed responsibility and was working hard to rebuild staff morale and maintain quality of care.

It was clear that the resolution process had been time consuming and involved a number of the senior managers as well as staff within the area. It had also revealed other unresolved senior staff issues and a failure of some existing systems - in particular, the resolution of staff grievances and communication processes. A series of staff development activities were implemented with effect, but also directed resources away from other planned activities.

The high care centres again were without a designated manager and the process of recruitment had been commenced. The impact of this event was described by a member of the SMT in this way,

“It has been a very unsettling process and, unfortunately, some people have been hurt and some have left. But there has been a great deal of learning for a lot of people and in time, after things settle down and people stop hurting, I think there will be some good come out of it all.”

Another said,

“A lot of people are angry at the moment and that is a great pity. This sort of sudden event can be really unsettling for everyone, but we have to move on from it and look at how we can make sure it doesn’t happen like this again.”

One of the managers who became involved in the resolution process for this event had this to say:

“The problems that led to this manager leaving were there before. She didn’t create them. The overall change, the new direction, new practices, has had an impact, challenged some people and the fall out has been a really big shake up for lots of us. But it has forced us to recognise and address some other related issues and other people have had to be accountable. What disappoints me most is that I thought we had processes in place so that staff could bring their concerns and grievances forward. Maybe we did, but it seems no one was using them. Maybe they didn’t trust us – believe that we would handle them well. That worries me most, the lack of trust.”

Another commented,

“Such a pity: we were just forming the new (SMT) team and starting to really make progress. We are all feeling badly for the individuals involved but I also feel disappointed that we have sort of lost momentum. It just goes to show

that change is not easy and how important leadership is – to get you through the tough times as well as growth.”

The sudden departure of senior high care staff destabilised the workforce within the two high care centres and disrupted the process of development within the SMT. It was an unsettling time and involved quite a lot of anxiety and emotion within the team. The SMT had reformed with the appointment of another manager for the high care centres some weeks later. This manager’s appointment was welcomed but again they needed time to fit in to the SMT. Management styles of the two high care managers had been compared and judged by staff. One staff member said,

“This manager is very different, her work style is different. You can’t help comparing them, it’s natural.”

The high care centres took time to settle again with the new manager, who later explained the emphasis of her work in the first months in this way,

“ I have been just getting on with the job; putting systems into place, getting to know staff and slowly achieving small changes. I have been introducing some tools to achieve changes in practice and to engage staff, to develop some consistency and predictability. I have been getting to know staff and they have been getting to know me. Some repair work was needed and I need to establish myself as not influenced by other managers, not manipulated by others and clear in my own vision for high care.”

A change in Board members during this phase contributed to an improvement in the relationship between the Board and managers. Communication had improved and meetings were ‘more productive’ and ‘less uncomfortable’. This development was explained,

“We now have good processes in place and everyone is getting on with doing what they should be doing as a Board, advising and supporting us. It frees us up to get on with all the operational issues as well as all the new

development. The organisation continues to be in a very strong position and we can all now focus on the next phase.”

Another manager reported towards the end of the year,

“I feel like we have really let the past go and are now focusing on the future, for this site and for the community as a whole. It has been a really tough year, but I can really see results.”

The degree of resistance among the village residents had been discussed as part of the process of building the vision. This was explained,

“There is still a group of village residents who don’t like the changes and want the place to be like it was. They seemed to call the shots last year but their influence is decreasing. The majority have come on board, learnt to trust us, that we have their interests at heart. But we can never be complacent. Every new thing is huge for them and potentially unsettling. There are some great leaders among the residents and they are trying really hard to help us bring about change.”

Another comment was,

“I feel we have reclaimed the residents. I think we lost them for a while with all that was going on. I think they trust us more and are back on board. I feel really good about that”

Managers had also built their area teams. One manager explained,

“Now I am clearer about what we are aiming for, I can work with my team to build their commitment and understanding. Everyone needs time to see what we are planning for the future and to see how it affects them.”

Another talked about the need for new roles saying,

“We all have to look at how we do things, examine our processes and practices. It doesn’t stop at the manager level. I think there is still room for improvement and perhaps different roles. Some people have been working in the same area for years and yet know nothing about any other area. I think we need to look at moving people around a bit and creating less mystery about certain jobs or certain areas. We need to break down divides and feel as if we are all part of one big team.”

The SMT described this second stage as a bit of a roller coaster ride in some ways, even though the team’s direction remained positive and many achievements were reported by members of the team. Particular achievements related to stabilisation of Board membership, including resident representation and a better relationship between Board members and managers. Other achievements reported were the implementation of improved organisational systems and processes and agreement of a new, comprehensive, community-oriented site development plan to replace the previous ‘housing development’ plan. For the SMT, one of the most significant achievements was the realisation of the need for a new model of care and associated framework for services to guide the site development plan. Finally, the progress in the construction of new units on the site to support the development financially, was reported as a major achievement.

Some members of the SMT did report some difficulty associated with the change in managers but also good growth within the SMT. Individuals indicated that they had learnt a lot about themselves through the development exercises and the team had gained confidence in each other’s ability, as well as the ability of the team. While some individuals perceived that team cohesion was still fragile and some managers were not always confident to speak up, others felt trust was growing for some, but not for all members of the team.

One manager explained,

“We have come a long way but I am not sure if we have all come together.”

5.3.5 Creating a vision – making it happen

It became increasingly evident in this study that the process of building an organisation for the future was a challenging and complex task. Many organisations can articulate what they want to achieve and believe they have the capacity within to achieve this. However, turning all the planning into a result is another critical step in the change process. The third stage of the SMT journey, primarily towards the end of 2003 and continuing into 2004, brought further focus on consolidation of leadership behaviour within the SMT. Implementing the next stages of the redevelopment plan was occurring and this brought relocation of some residents in preparation for construction. A major focus for the SMT became the development of the model of care and service framework and decisions about future services to meet residents' needs. This stage was described by the SMT as creating a vision – making it happen.

The SMT had described 2003 as a very busy year. There had been change to Board structure and function, membership of the SMT, site planning and construction and improved engagement of residents. Towards the end of 2003, the study reveals that this aged care community was rather 'tired' and reacting to a great deal of work and change. One manager interviewed towards the end of 2003 explained,

“Part of me is exhausted, it has been full on all year. The other part is really excited about our progress and our future.”

Another explained,

“I am looking forward to next year but I am so tired at the moment that I don't know if I will have the energy I will need.”

One manager looked at it differently, saying,

“Yes, I am tired, but so is everyone else. That is not an excuse for poor performance. We have raised the bar and now we have to see who can reach it. It won't get any easier.”

Construction of the new units and their integration into existing physical and operational environments appeared to add extra work to already busy operational schedules for some managers. The reaction of residents also had to be monitored and managed, as the construction became a reality and the ‘talk’ of the residents’ dining room.

“It is good to see how the new units are taking shape. It helps to see what it will be really like in the future”, one resident said,

Another commented,

“The new units are changing that end of the village but they seem to fit in quite well.”

This was supported by feedback from a resident, who was very active on the social committee, when he said,

“It will be really important to welcome the new residents when they move in. We need to tell them about all the clubs and activities so they can join in if they like. I am determined to make them feel welcome.”

Feedback from other residents was that they had compared the completed units to the old units.

“You can really see the difference now; I mean, who would move into the old ones if they could afford the new. They are too big for us but they do look nice.”

The completion of the first units occurred early in 2004 and was celebrated as a milestone by the whole community. The new name was prominent at the entrance. It was clear that the planned articulation of land and gardens between old and new would further connect the new site with the old and, when the traffic was able to move freely between, the division would be less obvious.

Managers reported that some of the residents in the low care accommodation were more affected by the continuing development of the adjacent prison site throughout 2003 and this brought some anxiety. Initially, many residents had reacted to the loss of old trees, disruption and noise from the construction, and the inconvenience of trucks, workmen and changes to roads. Now, it seemed, there was some appreciation of the improvement to roads and site access, new fences, attractive buildings and planned landscaping. But progress also brought new problems. The improved roads were ideal for the many walkers among the residents. However, the widened road became an enhanced access for trucks and cars. New guidelines had to be put in place to secure the safety of the residents and to manage the traffic.

Planning for the next stages of redevelopment consumed many SMT meetings. There were also discussions about relocation of residents within the village to accommodate building plans and future positioning of the high care centres. Discussions about design for the new care centre, as well as types of services and staff, began to become more prominent. Toolbox sessions also continued, along with implementation and evaluation of the operational plan. Some expressed some concerns, one saying,

“I think we have realised what a big target we have set ourselves and it’s a bit overwhelming. Sometimes I think some of us aren’t up to it, the magnitude of the project.”

Another raised concern in this way,

“We all need some extra fuel in the tank that we can draw on, for the tough times. I am not sure if everyone can do that.”

One development exercise towards the end of 2003 was a repeat of a ‘Work Group Climate’ assessment exercise. This involved individual ratings by the SMT on dimensions of trust, innovation, goal clarity and inspirational leadership. Results were compared to the first assessment some 5 months previously. Based on a range from 1 (strongly disagree) to 5 (strongly agree), results indicated no progress on the dimension of ‘trust’, in fact, a very slight drop in score, and a slight drop in the

values of 'innovation' and 'goal clarity' and greater drop in the dimension of 'inspirational leadership'.

During individual conversations following this exercise, members indicated that they were disappointed with the results, particularly the lack of growth in the dimension of 'trust'. Concern was also expressed that some managers were not honest in their response, choosing a neutral score to avoid commitment.

"I don't think everyone was honest. Either they are not prepared to walk the talk or are concerned about answering honestly. Both situations are not good."

Other comments indicated concerns,

"Some people are not pulling their weight. They are more interested in their own agenda and goals, not the team. They won't commit and show their hand."

"The SMT has been pulling in opposite directions the last few months. It is fragmented and issues are not getting resolved. We need some strong action to pull us all back together."

"This shows some people are not happy, not comfortable with others in the team but not trusting enough to talk about it among the group. That worries me."

Others felt the pace of events might be at fault, saying,

"We have been working very hard and moving very fast. I think we might have missed a few steps along the way."

Not everyone was negative. Some reflected more on what was needed in the future rather than what was demonstrated in the present, saying,

“Trust is a work in progress. We need to do some honest talking and get a few issues on the table. Put personal egos and power games aside and really talk through our strategies. This is just a picture of a team under stress. It is not the end of the world”

Several managers articulated the pivotal role of the CEO in the development of the team and their ultimate performance. One comment was,

“Now it is time to get tough. Shape up or ship out. We need to put our commitment on the line; the organisation and the CEO have a right to ask for that.”

The results of this exercise proved to be particularly important for some managers, who reported following up with individual discussions about the results and implications, with the CEO. The results seemed to provide a catalyst to talk more openly about trust within the SMT and, in some cases, issues with individuals.

As was outlined previously, 2004 brought further personnel changes to the SMT. A manager of one of the functional units left to pursue other career opportunities at the end of 2003. The position was subsequently filled and the new manager joined the SMT. Early in 2004, the Director of Care left after many years of service, however, a decision was made not to appoint to that position. The restructuring provided opportunity for growth and increased autonomy in the two reporting positions. Further, a new position was created, Coordinator of Organisational Productivity and Development, providing resources in development and continuous quality improvement. It was clear that this new position demonstrated a shift in thinking.

“We need to focus more on organisational development. Accreditation is still important but it needs to be seen as part of a bigger picture, more strategic”

Unfortunately, another crucial development position, that of staff educator, was vacated in 2003 due to illness. The responsibilities were reallocated in 2004 to other areas, with overall coordination responsibility going to the safe practice and environment portfolio. While still developing, this was reported as a good move.

The SMT realised that this stage of the journey brought further change and more growth and development at Board level, between Board members and SMT, and within the SMT. It also saw a reshaping of leadership behaviour and changes to leadership style to address the changing future directions. This stage revealed considerable growth but also highlighted new challenges, particularly managing the change process within the aged care community.

5.3.6 Managing the change process

As became evident in this study, the processes of change are both complex and dynamic. Changing circumstances and a turnover of people who are involved provides a difficult context in which to engage in a major redevelopment that impacts on the whole community. While continually progressing the changes arising within the redevelopment, there is a need to deal with day-to-day issues associated with managing an aged care community. This calls for careful planning and considerable energy and resilience within the leadership team.

Phase three of this study progressed into 2004 and incorporated action from action research cycle two, as the SMT implemented the action informed by the second action research cycle. The SMT reformed with renewed vigour in 2004, having resolved a number of the factional and interpersonal team issues at the end of 2003. The impact of the change process became more evident throughout *Choice Village* and there was a clear need for an effective change management plan and process.

A decision to hold a combined planning day early in the year for Board members (including resident representatives) and members of the SMT, was seen as a significant change management strategy. One manager commented,

“This is one of the only times we have sat together with the Board and really engaged in discussion about the impact of the redevelopment and change. It is so good to see we are all in this together.”

Another commented,

“This is such a good example of how much we are working together and how much our relationship has grown.”

A Board member described his feelings with this comment,

“Our SMT has been working so hard with this redevelopment and we are so lucky to have such a team of people doing such a good job.”

A resident representative made this comment,

“I have really become involved in all this with two meetings yesterday and now today. But it is so good to be involved and to see where we are heading and to hear about all the exciting plans for the future. Sure, some residents won’t like it all, but we can deal with that. Most can see that it is all for our future and benefit.”

The half-day workshop was reported by the participants as going a long way to establishing a change management plan, but it was also seen as an opportunity for reflection on past achievements and progress over the past two years. There was reflection on external pressures such as industry issues and challenges, as well as reflection on internal matters, such as strategic initiatives and the new site redevelopment plan. There was also discussion and agreement on the priorities for 2004.

There was also reflection on the research process that had been occurring over the past two years as part of this study and there was agreement that the research process had become a key factor in the growth and development of the organisation, particularly for the SMT.

At the conclusion of the workshop, the whole team identified the goals for 2004. For the residents, this was to be the relocation of the next group of residents prior to further reconstruction design and new strategies to increase engagement and involvement and improve communication. For the redevelopment, there was to be a focus on planning for the new combined care centre. For the SMT, the priority was

planning for the implementation of the new model of care and service framework, and increased engagement of staff in the change process. Many staff development and education initiatives were put in place to engage staff and keep them informed of progress and change. Staff were aware of many of the changes and involved in their particular areas, but it was felt by the SMT that more engagement was needed. One manager explained,

“We need to get some fire in the belly – get staff excited about the future and get them involved.”

Another made this comment:

“Some people will struggle with all the changes; it will be a joint responsibility to help them to adjust.”

Growth within the staff population was noted with one manager commenting,

“Things are changing. This year (2003) I have seen glimpses of contemporary management practices in the care centres. Staff seem more empowered, are making decisions and are growing. They seem more satisfied.”

In summary, developing a change management plan and process was identified as a key activity for everyone in 2004, particularly the SMT. This was to include increased engagement of staff by the SMT along with more involvement in all aspects of the redevelopment, but particularly with the new care centre, model of care and service delivery framework. Engagement with residents was also to increase along with good communication. For the SMT, there was a commitment to further strengthen the leadership capability and cohesion within the team.

5.3.7 Summary - impact of change on the senior management team

An analysis of the complex landscape of individual development provides clear evidence of some of the key features associated with the process of developing leaders and leadership within an organisation, particularly when those leaders are

charged with leading a major redevelopment. In the course of this study it became increasingly apparent that change did impact on the SMT and influenced the growth and development of the team as it adapted to, and dealt with, the complexities and challenges of the redevelopment process and associated change. The struggle to unify and shape themselves as a team and to develop individual and team capacity is revealed through the data. This struggle required the development of leadership values, behaviours and strategies and built confidence and connection through trust. The outcome was a values-based leadership approach, built upon the mission and values of the organisation.

Change also impacted on the SMT as this team struggled with new roles and relationships. But it is apparent that this process also brought cohesion and strength to the SMT as they progressed the redevelopment. The three stages of this demanding process is encapsulated in their words and the picture they paint - forming a vision (what will it be like), building a vision (getting it right), and creating a vision (making it happen).

Major outcomes were achieved during this evolution and informed the redevelopment and direction of the organisation. The key outcomes were identified by the SMT as:

- a clear strategic direction, strong business infrastructure and a comprehensive site development plan,
- a better understanding of the impact of change on their current resident population,
- a cohesive, committed leadership team comprising the Board and SMT, ready to take the community into the future,
- the development of a values-based leadership approach with a strong focus on trust, integrity and respect, and
- a model of care and service framework that was informed by residents' needs rather than accommodation classification.

The process of development and the outcomes enhanced the body of knowledge on the importance of change.

5.4 The impact of change on the organisation – building capacity for change

“Managing change requires consistency of approach and constancy of purpose” (Victor and Franckeiss, 2002).

Organisational performance is not a set of didactic tasks and behaviours but rather a complex collection of structures, processes and people. As was revealed by this study, *Choice Village* was clearly a combination of people, structures, policies, processes, products and services. While its effectiveness may be measured by the satisfaction of the residents and the staff and by the performance of the Board and senior staff, its success as a business is also measured by the efficiency of the structures, the effectiveness of the policies and processes, and the appropriateness of products and services. It became clear that change would also reveal deficiencies in systems and structures and out of date policies and processes. Building the strength and capacity of the organisation to support and manage the change process was revealed as critical to the progress of the redevelopment.

As this study progressed, the need to understand the dynamics of how the business was performing became apparent. Growth in the financial management had resulted in the decision to reshape the redevelopment in 2002 and, as this progressed, this necessitated close examination of other business processes and activities. The capacity of an organisation to change is also dependent upon its business capability.

5.4.1 Choice Village: a changing organisation

The history of the organisation is well documented, along with the journey of its development, major milestones, hardships and successes (Clever, 2002). Over time, the organisation grew to provide 266 high and low dependency residential care places for older people and 667 units for older people still able to live independently. In 2002 it employed 350 people, mainly in the care centres but also in the administration of the organisation. Community representatives were on the Board for many years, including the founding chairman, who held that position for some 38 years, and commitment and loyalty came with longevity. Data from the staff survey revealed that longevity and commitment were also features of the staff, as was

commitment to meeting the needs of residents, many of whom were considered 'like family'. On review, historical documents made much of the benevolent nature of the organisation, meaning people with few assets could obtain simple but adequate accommodation, within a culture of looking after its residents as members of one big family. Over many years this organisation developed its own culture, work environment and business practices, appropriate to the era as well as the knowledge and expertise of those involved.

The organisation had a colourful, unique and commendable past but, like many other aged care providers, it had struggled to adjust to a changing environment and to secure its future. It faced a need for more contemporary governance and management practice, rebuilding of old and out of date accommodation and increasing financial pressure from external political, legislative requirements and policies.

Examination of several reports from a number of external reviews during the period 1998-2000 revealed a common view of the need to change. One report resulted in recommendations addressing a number of areas of organisational activity.

Recommendations identified the need to:

- review Board membership, tenure and function,
- improve lines of communication and reporting between Board, CEO and senior managers,
- alter the role of the senior management group in the organisation to include planning and setting future directions,
- enhance human resource, financial and various business systems, and
- establish a site maintenance program.

It was also noted that the three care centres had, in varying degrees, deficiencies in space and service provision and a lack of private living areas.

While also recognising the need for change, another review identified a number of unique internal strengths of the organisation. Strengths were identified as:

- a unique community of contented residents engaged in a wide variety of social and educative activities,

- a long successful history that had seen many developments,
- dedication and commitment by volunteer staff, management and Board,
- customer focussed waiting lists,
- a strong value base built on honesty and integrity,
- commitment to human dignity and empathy with residents, and
- levels of care that provided the foundation for future service development and growth.

This latter report indicated that the organisation had limited understanding of the external (industry) world and went on to say that it needed to let go of past glory and move forward with an agreed strategy. It went on to draw attention to some external threats which, if not attended to, would restrict the organisation's future performance. These included Local, State and Commonwealth government legislation and regulation, tax reform, impact and requirements of future building codes for 2008, changing funding models and increasing accountability and the impact of a range of competitive forces.

5.4.2 Reshaping the culture - letting go of the past

Culture within an organisation provides the fibre and fabric that connects the people and processes. While often difficult to describe, it is critical to organisational performance. Culture is not static and can change as a result of changes to leadership, business direction, products, services and people. Progress within an organisation can be inhibited or enhanced by the predominant culture.

In 2000, with the information from these reports and a background of 4-5 years of transition in the leadership of the organisation at both Board and CEO level, the Board accepted the need for change. Failure to change would have compromised the organisation's ability to remain effective in the future. One manager explained the realisation in this way,

“Look, we know we have provided good accommodation and services for our residents for years, but the organisation is structurally and functionally old

and we will not be around in the future if we don't change. No one will come into these old, tired units in the future. Our business practices need to be more efficient and then we will be able to improve what we have now and be able to offer what future residents will be looking for."

Others described the organisation as a cottage industry, a rudderless ship where decisions were made without wisdom and without a business plan. Commenting on past practice, one manager said,

"The organisation is operationally run down and out of date. Systems are absent; there is no overall plan for activity, such as a maintenance plan for the accommodation. Some of the buildings have become quite old and there is no program for repairs. Things just get done, or not, and no one seems to have records".

One manager who had been with the organisation for some time commented,

"You have to admire what was achieved here and to recognise what an amazing organisation we had become. But it was out of date and so inefficient and in real danger of not maintaining its relevance and position for future populations"

Several members of the current SMT held positions under the previous regime and, while they expressed feelings of loyalty toward individuals, they also expressed enthusiasm for change. Managers equated the need to build firm foundations as getting the structures, systems and processes right. Individuals expressed their thoughts and feelings differently but there were common themes and concerns. One manager explained the past,

"There was no sense behind what we did, no plan and no apparent reason. It was hard to see the knowledge behind decisions and practices and often things did not make sense. We just came to work, did our job and went home and were none the wiser about anything"

Another explanation was,

“We felt we were floundering- no leadership, the systems were out of date, staff did their work and did not share with each other.”

The CEO in the past had not had responsibility for running the organisation but was described as a ‘really nice and very committed person’. Managers said they felt undervalued and excluded from decisions. One manager described the management team of the past as ‘a dysfunctional group’. Managers said they loved their work but they struggled with the lack of leadership cohesion and strategic direction. This manager went on to say,

“There was no wisdom behind what we were doing and I was frustrated by the spending and the lack of direction. We had been going along as it had been for years, for so long that every thing had become routine and just the way things were done. There was no strategic plan, policies were often unwritten and practice was rarely questioned.”

They went on to explain that communication between Board members and managers was not open so staff did not feel up to date with what was happening at a senior level. Actions and decisions often came as a surprise, making the role of a manager very difficult. It was hard to be responsible for a decision they had no input into. Managers identified a need for a clear direction for the future that could be translated into an operational plan, as well as a need to review financial, human and physical policies and practices. They felt that, in the future, there must also be a strong working relationship with the Board and a clear decision-making process within the SMT.

In the past, the culture of the organisation may have been appropriate but the SMT realised what was needed now was strong leadership and a team of managers who were empowered to lead the organisation, with the support of a proficient Board. *Choice Village* needed to strengthen its business practices.

5.4.3 Restumping the business foundations – strengthening operations

Change in an organisation requires sound business systems and processes. An important challenge for the Board and SMT was to improve business practices and this was referred to by the SMT as ‘restumping the foundations’. In 2002 the Board agreed that the future depended on a process of strategic redevelopment, including redevelopment of the independent living unit accommodation, a new care centre that would meet 2008 building standards for the industry, change to organisational policy and procedures, improvement in reporting outcomes and financial capacity for current operations and for the redevelopment. One manager described this in this way,

“There is such a lot of potential here but we sit on rocky ground at the moment. If we can get better equipped as a business, reform the foundations, we will position the organisation really well for the future and everyone will benefit.”

Another commented,

“We have to be more transparent and more accountable as an organisation and be able to explain and justify what we do. There is no room for unsound decisions and bad investments.”

In light of an acceptance of the need for change, the development of a strategic plan was one of the first activities for the Board and SMT during 2002. The CEO and Board developed it over time, with involvement of the SMT. The process became evidence of a new collaborative process and continued to be reviewed regularly. It was a guide for the development of an operational plan, described by one manager as a ‘work in progress’. This plan was also a guide for responsibility and performance and was referred to frequently within regular senior management meetings. New policies and procedures were developed to achieve the outcomes of the operational plan across the organisation. A manager explained the value of having a strategic plan in this way,

“We know where we are going and we have something to measure our performance against.”

Another explained:

“It is a process of organisational development that has moved the organisation from a cottage industry status to one that is progressive and contemporary.”

Other staff expressed interest in these developments and some excitement about the changes that were occurring. A senior staff member who had been with the provider for some time explained it in this way,

“It feels like we are a living organisation now, not a dead one.”

She went on to comment on the effect of the new direction that the Board and management team had taken and how this resulted in better systems and processes. It was her view that the change had to happen and probably should have happened years sooner.

“You know, this organisation was up there with the best in the past. But if we don’t get with the times and compete in the market place, we will be left behind. We can’t stand still in the industry anymore.”

In other conversations, staff commented on the way the Board and management team were working better together, presenting a common front and heading in the same direction.

“The organisation is healthier than in the past, when business was very much kept within Board meetings and little was communicated to the staff body. Now we talk about what is happening and we are invited to make comments. We see more of Board members and they are getting to know what we do too.”

In summary, the process of restumping the foundations required the Board and SMT to work together as an effective team. This resulted in the development of a clear organisational plan for the future and a strong organisational management team to provide the expertise and energy that was needed. The process also required the Board and SMT to commit to a comprehensive, coordinated redevelopment of the accommodation and environment.

5.4.4 Rebuilding the site – creating a community environment

Early in 2002, the Board agreed to a building program where the focus was on a staged process of building new housing accommodation for village (independent) residents, more in line with contemporary architecture. However, an appropriate financial plan for the development was not included at this time. Records indicate that there was little consultation with either residents or management and, as one manager explained,

“It was a housing estate decision, nothing about a community of people.”

Managers reported that the proposed plan did not take into account the needs of current or future residents or trends in community accommodation for older people. However, this plan required that some village residents be moved to other accommodation on site so that the building program could be completed in stages. Staff involved in this process reported that they felt they had to cope with a very hard process and some found it very stressful, describing it in this way,

“It was a logistic nightmare as well as an exercise in crisis management. We knew some of the residents were not happy and we were doing all sorts of things to assist them.”

One strategy implemented by the Board was the appointment of an external consultant to talk to residents and find out what they were thinking about the moves and how concerns could be addressed effectively. The community consultant was engaged over some months and gathered quantitative and qualitative information

from residents to feed back to the organisation in regular reports. One of the consultants explained,

“We are making appointments with lots of residents who are affected by the moves as well as others in the village to get a picture of the issues and concerns they have. The Board felt the residents might feel more comfortable talking to an outsider. We give our reports, a summary of what we have been told, aggregated into themes, to the CEO so they can act appropriately.”

Even though staff also implemented many of their own strategies to minimise the stress and facilitate the move, some residents who had to move remained unhappy. During conversations, some residents even indicated that they felt bullied into moving. A manager felt that it turned some of the residents against the new CEO and went on to say,

“It was a difficult time. Many residents were very upset and considered leaving rather than moving.”

During 2002, improved financial management practices demonstrated that this was not what the village community needed for the future and progressing the project would compromise the organisation financially. Some residents were settled in different accommodation but what was left was physical evidence of a failed process - many empty village units and some disillusioned residents who now could not see any progress from the move they had endured. These empty units were described by residents and managers as ‘visible scars’ within the village. This decision fuelled a degree of unrest among some residents who had been living there for many years. It provoked this reaction from one resident,

“Look at all the empty units. Even if I am not in it, why isn’t it rented and earning income? It is just another example of their (Board and management) lack of planning.”

Another resident said,

“They (Board) are changing the village – it will lose the family atmosphere it has always had. What is the matter with the current accommodation?”

One resident, who had been moved after a fairly short period of time in his first unit, expressed frustration when he said,

“I guess I didn’t really mind except I had only really just settled in. It was just inconvenient and the garden was just getting nice too. But I thought, well I guess if this is what has to be done in this redevelopment, then I didn’t really have any choice.”

As it turned out, the unit he moved to was bigger and in a more attractive area of the village. He went on to say,

“They were very helpful with the move and I have much more space and a bigger garden. It went pretty smoothly and I settled in pretty well.”

What irritated him, however, was the fact that the old unit had been empty ever since and the area around the unit had been neglected. He explained,

“It is a mess, weeds and everything where I had it looking really nice. What was the point? No building has started and now it has all been changed. What sort of planning is that? I mean, who made that decision in the first place? All those people have been inconvenienced and there is nothing to show for it. It is a joke. I looked at the plans they put up and I thought they (new units) looked pretty ordinary and they were jammed in together. I think they were right to reconsider, but it doesn’t show much planning.”

The first construction plan was eventually aborted. It was a decision based on both the design of the plan and the lack of appropriate financial planning to realise the redevelopment. The CEO explained,

“Apart from my concern that the site plan did not include the most appropriate housing designs, nor presented a view of the whole community, I

was very concerned as to how it could be financed. I could see a lot of financial difficulty ahead.”

The Board agreed with the CEO’s concerns. Following further consultation and review, a different strategy was proposed - develop new units on existing vacant land on the site and use the sale of these units to finance further site developments. After due process, construction of the units commenced early in 2003. The design of accommodation was in line with retirement village housing elsewhere (two and three bedroom units and apartments) but incorporated design characteristics that would support delivery of services and an ageing-in-place approach to care. They were also significantly different from all current accommodation on site. This section of the site was given a different name, to signify the first stage of a new community. The name had historical significance to the area and the plan was to have the whole site renamed, while retaining the original company (trading) name.

This construction did not involve current residents and so was less disruptive and managed independently of other day-to-day matters. Although the construction process brought some noise and impact on vehicle access, feedback indicated that neither the residents in the care centres nor village were directly affected. Plans and information were circulated widely throughout the community; however, some residents expressed little interest in the design of units and many indicated in the 2003 quality of service survey that they were not really affected or interested. Other comments were about the size of the new units (why anyone would want such a big place), the change to the face of the community (the units look so different), or about a different type of person moving into the village (not like us).

For other residents it was another chance to challenge the management and the decisions of the Board. One resident wrote in the 2003 survey,

“How can they afford to do this building when all those units have been vacant for over a year and not earning income? I suppose we will have to pay through an increase in fees.”

Another comment was,

“All the organisation’s money is going into building fancy new units for young people – who will look after the poor old people?”

On the other hand, some residents watched the development with interest and even expressed enthusiasm that the units and their owners would bring a new dimension to *Choice Village*.

The experience from the first building plan resulted in the Board making a decision to revisit the whole site redevelopment before continuing with further building plans. They acknowledged that there were empty units not earning rent, but construction would only commence when a critical mass of empty units had been reached. The ‘new units’ progressed well and proved to be very attractive in the market place, with no shortage of sales, so the financial plan progressed well.

To avoid making the same design mistakes, the Board put the project out to tender, inviting firms to submit a proposal outlining how they would go about such a site project. Interested parties had access to documentation that presented the organisation as a community, not a housing estate. Submissions included recommendations for all aspects of the site, including the care centres and community facilities, not just independent accommodation.

One manager commented on the process,

“I really enjoyed the consultation. It changed my mind about a lot of things and helped me to see what was really possible.”

Another said,

“I have had ideas for ages and it is really exciting to see them incorporated into a new site design.”

Eventually, a team was engaged to produce a whole-of-site community plan with short, medium and long-term strategies for development. The team consulted with

staff and residents through forums, interviews and observation over several weeks. Members of the team indicated that it was also a learning process for them as to what people wanted and an opportunity to clarify what was really important for the future of the organisation. In meetings, they were learning to fit the old with the new and listen to the views of staff and residents.

In 2004, a plan that incorporated new accommodation, redevelopment of some old buildings, plans for new care centres, increased community open space and recreational facilities as well as some external retail opportunities, was presented to the Board and the SMT. The site plan connected the community with two intersecting traffic pathways (north-south, east-west) plus many additional walking pathways and recreational areas. This was well received by both the Board and SMT as a better representation of the community that they were trying to create. The plan was described by the organisation as a work-in-progress rather than a definitive template, subject to change as the details of the redevelopment progressed. The plan was posted throughout the organisation and explained at resident forums and in newsletters.

The process of redeveloping a large site may appear to relate more to 'bricks and mortar', size of plots and housing design. This has been the focus of many aged care communities, described at times as housing estates. This study revealed that this approach was not what *Choice Village* was after and failure to address many other aspects of a redevelopment would impact on the residents, the staff and the performance of the organisation.

It became clear that what made *Choice Village* different from many other similar aged care organisations, was its commitment to create a community that would respect and accommodate the old while embracing the new. How this was achieved is revealed within the body of data and was facilitated by an action research process involving continuous cycles of planning, action and reflection.

5.4.5 A model of care and service framework – aligning services with resident need

The complexities of redevelopment became increasingly evident as the SMT tried to come to grips with the multitude of competing issues that continued to emerge. While financial plans, policies and procedures, accommodation and the physical environment were important, the provision of a range of services for residents formed another critical component of the business. The SMT were aware that residents were attracted to this community because it had a range of accommodation options, including care centres, and that services were available as their independence decreased. Residents could access some personal care services, housekeeping and cleaning services, help with gardening and maintenance, ready access to medical and allied health services and security and emergency assistance after hours. Although natural progression through to care centres could not be guaranteed, accommodation for village residents was a priority. This approach was explained as,

“Our service delivery is based on the principles that residents have access to a continuum of services from independent living to high care if required. Every effort is made to ensure that village residents are able to gain admission to our care centres, when they choose.”

This option was very attractive to individuals and especially to couples where only one member needed care, while another could still live independently close by. One resident told me,

“It is so good to have Mary so close to me. I visit her every day and if she is not too good, I can leave and come back later. And when the kids come to visit me, they can go over and visit Mary as well.”

This gentleman lived in a village unit and was quite independent. He was involved in a number of village community activities and swam at the local community pool three times a week. He did not drive a car any more but rode his bicycle to the local shops. Prior to the interview, he was in the kitchen making a cake in preparation for a

visit from his grand daughter that afternoon. He had been his wife's carer for 10 years and still assisted her with lunch and dinner every day.

Another resident, who had a suite in the low care facility, told a different story.

"I really stayed in my unit for as long as I could. I resisted moving out. It was hard to manage in the end and I kept falling over and then having to wait until someone found me -- my daughter, the neighbour or security officer most times. I should have moved sooner. Now my friends still visit me and I go to bridge club every Wednesday. I'm glad I didn't have to move too far away."

As part of planning for a community of residents in the future, the management team felt that it was important to review current services, explore different services for the future and review how services were being delivered. More residents in the care centres accessed services than residents in the village but staff felt that this did not necessarily indicate need, explaining,

"There are a number of residents living in the village who need services on a daily basis, such as help showering and dressing and some meals. They are just as needy as the residents in low care. But they won't leave their units and we have no places for them in low care. I'd like to be able to provide services regardless of where they live."

A number of people talked about how the location of residents and degree of need divided the village -- one half was the care centres and the other the village. It was referred to as a 'natural divide'. A street ran through the site and formed a natural physical divide between the care centres and the rest of the village. The majority of staff worked in the care centres and most services for residents were offered in the care centres. Some staff worked mainly in the village or central administration building but far fewer than in the care centres. A staff member working in a care centre explained,

"All the action is in the care centres, that's where most of us work. We don't see much of admin staff and neither of us really knows what the other group does, what their work involves. It is a pity really -- it sort of splits us all up,

the residents and the staff. But really, there isn't much difference between residents in low care and some of the people in the village.”

This division was also noted by staff in administration and explained in this way,

“The SMT doesn't pay as much attention to the village side of the business – they are light weight compared to low and high care because of the demand for services. Some staff who don't work in the care centres sometimes feel they are less important.”

She went on to say,

“And the care centres don't always appreciate that there are some very complex residents in the village and they are really demanding. They don't understand the work – what we do.”

In another conversation, a staff member commented,

“I think having the three areas of accommodation, high care, low care and the village, is misleading because there are many residents in the village who are in just as much need of services as the ones in low care. But because they are in the village, we don't think of them in the same way.”

On another occasion,

“Most of the staff work in the care centres and we get to know the residents in the centres really well. But we don't get to know the residents in the village nearly as well. It worries me because I think there are many who should be getting the same care as the residents in low care.”

It became evident that the physical division created by the structure of the site and public road access, had created an internal divide in *Choice Village* among residents and staff. Each 'side' of the divide felt that they were not considered as important as the other even though there was little evidence to support the perceptions. This highlighted to the SMT how important it was to view the community as much more

than buildings. It informed planning for the redevelopment to make sure that pathways and roads would create connections, not divisions, throughout the village. It also revealed the importance of creating a united workforce where everyone was working towards the same goals and supporting the same organisational values and where different roles were recognised as equally important. The SMT were able to see how important it was to 'treat' all residents equally and to avoid viewing those who were more independent as 'not needing' as much attention as those in the care centres. This understanding provided valuable information for the development of the model of care by the SMT and the development of the service framework. It also informed human resource and staff development programs.

The SMT completed a process of inquiry over several months and determined how to guide the delivery of services within the community. The process was described by one manager as a learning journey, by another as a challenge.

"I have wanted to introduce the services we offer in the care centres into the village for some time but haven't known how to do it. This process has given me some good ideas. It has also made me see that the needs of the residents in the village aren't much different from the needs of people in our low care centre and yet we don't see the village residents in the same way."

As part of the process of realigning services, the management team engaged in a number of activities that significantly enriched their planning. They reviewed the literature, examined future demographic projections, reviewed current resident statistics and demographics, discussed financial implications associated with different services and looked at other providers. The decision linked services to resident need and aligned service delivery to the vision (excellence in the provision of services to seniors), the mission (to create a community environment for seniors which fosters confidence, self worth and well-being) and the values (dignity, integrity, respect, excellence, teamwork and community) of the organisation. Through review of the literature and further discussion, lifestyle and health, flexible and adaptable accommodation, and decreased emphasis on institutional service delivery were agreed as important principles behind service delivery. One manager explained,

“Residents must be at the centre of what we do and the services must make a difference to the resident’s quality of life. Therefore, we need to be more flexible.”

Another described their thoughts in this way.

“We need to focus more on the residents’ needs and less on the service convenience, what is easier for us to do; we have to break down the barriers between areas.”

In another discussion, a manager said,

“We have to aim high to be competitive, to respond to market trends. This means doing something different and a bit unconventional. Everyone knows what services you get if you live in a low or high care facility but what about offering similar services to someone in their own home? We can’t keep services inside buildings in the future, we need to offer them beyond those walls.”

Financial implications of services were also discussed. In some meetings, discussions focussed on cost of specific service options and whether residents would be prepared to pay for additional services if they were offered. At times they focussed on accommodation type – would residents be attracted to serviced apartments, should units be clustered together or separate, should care centres be separated or combined for low and high care needs? Other discussions were around types of services – restaurants or cafes, meals on wheels, laundry and dry cleaning. Managers also had ideas about site design with access to retail services as a way of attracting people who did not live on site, to increase interaction with the wider community.

“There are so many clubs and leisure activities going on all the time. Maybe people living outside the village might be attracted to join in if it were possible. Then we would really create a sense of community.”

The idea of increased interaction with outside service providers all featured in discussions.

“There are some areas that don’t get utilised as much as others. Maybe we could attract others to use them, to add to the atmosphere and promote the place in the wider community. After all, we are as big as a small country town, as many people live here.”

The process of reviewing existing services and structures, as well as considering new ideas, became a tool in the development of the SMT as well as the foundations for a new site development plan. This was explained in this way,

“As we have discussed all these options, listened to each other’s ideas, we have got to know more about each other – what we all do and what we are all interested in and committed to. It has been a really good way to build the team because what we decide on will come out of the whole group. The process has been really interesting and very valuable to me.”

As the SMT reflected on the importance of quality of life to residents, revealed within this study, the inappropriateness of the current categories of dependency and associated services became increasingly apparent to them. However, it was a challenge for the SMT to develop an alternative approach within the restrictions of current government policy and funding. The decision to link this to the redevelopment of *Choice Village* accommodation and infrastructure added an additional challenge to their task.

The process of exploring alternative models was a period of significant learning for the SMT. The process of explaining, referring and justifying their ideas to themselves as well as the Board, brought added value as it became an integral part of the evolution of the team and the application of the organisational values into practice.

This study reveals how it was possible for the SMT to think creatively within the constraints of the current system, to meet organisational requirements and, at the same time, develop a model that would enhance quality of life for the residents.

5.5 Factors influencing change in aged care communities

“Good research is research conducted with people rather than on people” (Heron and Reason, 2001).

The process of organisational change may sometimes appear straightforward. A leadership team, usually comprised of a management committee, is charged with the responsibility to plan and implement changes throughout the organisation. As the literature on organisational change indicates, however, processes of change are much more complex than this simple explanation. Not only are management plans and directives to progress change formulated according to leadership perspectives and operations, the way things are done, they are also deeply affected by values held by those responsible for implementing them. The best plans can be affected by different perceptions, understandings, experiences and values of diverse groups of staff and clients who may be affected by what is proposed. Change processes therefore need to take into account not only the complex web of perspectives and demands of all those involved, but to also accommodate the continuing flow of contextual and organisational issues that affect the smooth and effective functioning of the organisation.

The difficulty of accomplishing change is enhanced by the fact that there is no simple recipe appropriate for all contexts. Changes are affected by the specific types of business in which the organisation is engaged and the culture and needs of the client group. As became evident in this study, aged care provides a unique context in which formal business procedures combine with the delivery of services for groups of people with individual needs and, sometimes, a degree of vulnerability. As this chapter reveals, there were key elements that needed to be taken into consideration so that business activities could go on and the well-being of residents maintained, while change was being implemented and the redevelopment was progressing.

This study sought to explore the impact and influence of change on a residential aged care community and to highlight the impact of those aspects of the process that needed to be considered. Understanding elements of quality of life and the impact of change on quality of life was a key factor in achieving change. The findings revealed that regardless of personal circumstance, type of accommodation or location, residents consistently identified quality of life as critical to their well-being. For many of the residents in this community, elements contributing to their quality of life were individual; however, there were a number of common elements across the three areas. While each area was viewed as a sub-population relevant to level of dependence/independence and type of accommodation, there was increasing blurring of the boundaries between the three categories. The findings also revealed that the type of accommodation did not necessarily correlate with degree of independence/dependence and, therefore, did not always indicate need for services.

The 'boundaries' between resident sub-populations were not clearly defined. Understanding elements of quality of life and the importance of quality of life as an indicator of well-being was important and critical to managing the impact of change on the resident population.

The residents' account also revealed how change impacted on their quality of life. Some residents were challenged by change. While there was some awareness of the need for change, many residents continued to yearn for what they had always had. Resistance to change by residents might be a symptom of fear of the unknown, insecurity or just traditional thinking, but preparation of residents for change, information about change and careful management of the impact of change are all important. They are particularly important in a community that is both a business and a home to many residents. The account also revealed the importance of monitoring the effect of change and not underestimating its impact, even if the change is perceived to be small or 'in their interests'.

The residents' account highlighted the unique relationship between resident and provider in a residential aged care community. While the provider may view the aged care community as a business and need to ensure business and financial viability, the resident population view the aged care community as their home and, for some, the

people who live and work within it, as family. The findings reveal that change to Board membership and function, management membership, capability and function, organisational policies and processes, and staff attitude and satisfaction, also impact on residents.

Change to physical environment and buildings also impacts on quality of life of residents. In fact, in this study, understanding the impact of change on residents influenced the redevelopment process and informed the design of the 'new' community site plan. Planning for future populations as well as current residents is an additional complexity and understanding the needs of both populations and the elements of quality of life relevant to their need and choice of lifestyle, is an important component of understanding the impact of change.

The findings also confirm that change impacted on and influenced the SMT as the leaders of the organisation. While the Board's role in providing leadership for the organisation is clearly important, particularly through the relationship with the CEO and SMT, organisational day-to-day leadership lies more at the level of the senior managers and this is where the organisation comes to life. It was this team that translated the mission and values of the organisation into practice, for the residents and for the staff. It was also this team that best represented the community to the internal and external world. Most importantly, it was this team that drove and managed the change.

The SMT membership altered as a result of change and a process of growth and development that occurred over the length of this study and, within this process, individuals grew as leaders. They learnt that values-based leadership would enable them to represent the values of the organisation and this became the framework of their leadership behaviour. Their account described their process of learning and the progress of the redevelopment in stages that they described as: forming a vision, building a vision and creating a vision.

The findings revealed that the SMT realised that there was still a lot of work to be done, understanding that the redevelopment would continue over several years. However, they felt confident that they had developed a number of key strategies that

would enable them to lead the organisation into the future and manage the impact of change. The SMT believed they had:

- better understanding of the elements of quality of life within the resident population,
- cohesion and commitment within the leadership team with a much better relationship with the Board,
- clear strategic direction and operational plans and improved business infrastructure,
- comprehensive community site development plans, and
- a vision of a model of care and framework for services that was aligned with the organisation's mission and values.

Understanding the organisation's experience of change revealed the importance of building organisational capacity for change through policies, processes and structures. This involved letting go of the past processes and relationships so that business foundations could be strengthened. It became apparent that developing a community with a range of flexible services could be achieved.

The realisation that the relationship between business accountability and social conscience was a particular challenge was significant for the change process. The business had to remain viable and the community of residents had to be cared for. This was particularly difficult in this community where many of the residents had lived for many years and, in some cases, influenced the past growth of the community. In some cases, residents were unable to accept that the different focus, direction and increased financial accountability adopted by the Board, was part of its way of ensuring the future of the community and its ability to provide quality accommodation, services and care. This study highlighted the significance of this challenge in terms of the redevelopment.

A further finding of this study was the realisation by the SMT, and to a lesser degree the Board, of the value and appropriateness of the action research process. It provided tools and processes that were used to plan, act, analyse and reflect on the many aspects of the redevelopment and change. It enabled the organisation,

principally the SMT, to reflect on the impact and influence of change that resulted from the process of organisational redevelopment. Action research emphasised the concept of co-researchers and stressed the notion of participation as fundamental to achieving more democratic processes and the realisation of practical, relevant outcomes (Stringer and Genat, 2004).

The SMT reported that the research process supported their individual development as leaders as well as the development of the team. The process of planning, collecting data, analysing data, reflection and action provide a structure and process that they used in management behaviour and deliberations, as well as situations that arose through the redevelopment process. They also reported that their ability to use the process to its best advantage grew throughout the study.

5.6 Summary of chapter five: key findings

This chapter provided a clear picture of the key issues that needed to be taken into consideration in developing effective and efficient accommodation and services within an aged care community. It revealed a range of issues of concern to the residents and provided insight into their specific needs that must be taken into account in the process of redevelopment and associated change. This chapter also provided a detailed understanding of the ways in which those responsible for such change managed those processes effectively and productively. In so doing, they were able to ensure that the redevelopment of the organisation proceeded in a managed way without compromising major stakeholders. The chapter highlighted the complexities associated with change in this type of organisation but revealed that, in some ways, change was a catalyst for growth and development. It produced new, improved practices and influenced accommodation and services.

The relationship with, and well-being of, residents is highlighted as a key finding. It is important to explore this concept further in the literature to understand the components of quality of life that ensure perceptions of well-being. The importance of leadership is also revealed in the findings. In this study, the SMT were particularly attracted to values-based, transformational leadership within the team. It is useful to explore the importance of leadership in aged care organisations. Finally, the

importance of establishing strong business foundations relevant to this sector was revealed and warrants further exploration in the literature. Discussion of the literature in relation to these key findings is the focus of Chapter 6.

CHAPTER 6 DISCUSSION OF THE FINDINGS IN RELATION TO THE LITERATURE

Exploration of the literature assists to clarify and enhance an understanding of the findings emerging from this study. The impact and influence of change on this aged care organisation is discussed under three key areas: the impact on the residents, the impact on the SMT and the impact on the organisation's business capability and capacity for change. This chapter explores the literature relevant to the findings in these three key areas.

The importance of quality of life and the impact of change on the residents' quality of life emerged as a key finding. The SMT gained an understanding of the elements of quality of life among the resident population and various issues and agendas related to the redevelopment that were impacting on resident satisfaction and well-being. This chapter explores the literature relevant to quality of life and the issues and agendas that were revealed as important, being, empowerment, ageing-in-place and social connection.

The need for good leadership also emerged as a key finding as well as the importance of a strategic plan to develop individual and team leadership capacity. Throughout the study, the SMT identified the need for a leadership style that supported organisational values and designed and implemented a leadership development model that assisted them to apply the organisation's values into leadership behaviour. Values-based leadership, transformational leadership and team development are highlighted as critical components of the leadership model. An understanding of the literature relevant to these critical components and how this can be applied to this aged care organisation will enhance an understanding of the significance of the findings of this study.

Developing organisational performance and capacity for change emerged as a necessary component of the redevelopment process. Characteristics and challenges within the aged care industry, as well as organisational culture and practice, impacted on the ability of this organisation to progress the redevelopment and manage the change process. Progress required that the organisation build its business capability,

balance business accountability with social conscience and develop a model of care and a service framework. The literature informs an understanding of these findings and how they relate to this industry.

While there is considerable literature on the characteristics and challenges associated with organisational change, there is little literature that discusses the specific characteristics and challenges of organisational change in residential aged care communities. Planning accommodation and services for a growing ageing population is of increasing importance to communities, governments and providers, and complicated by a need to respond to the needs of today's ageing population as well as anticipate the relatively unknown needs of future ageing populations. Shifts in population structures will bring about changes to physical and social environments, accommodation and services and the impact of such change needs to be monitored.

The aged care sector, and the associated retirement industry, recognise the importance of understanding the impact and influence of change on resident populations, on management and leaders and on organisational capacity. This study draws on current literature on organisational change and provides new perspectives on organisational change relevant to aged care communities, to understand the impact and influence of change

6.1 The impact of change on the residents: resident wellbeing

This study reveals that change impacted on resident wellbeing, with wellbeing described by residents as various elements comprising quality of life. The impact of change and elements of quality of life were expressed differently within the three sub-populations of residents but there were common elements and common reactions to change. Realising the elements comprising quality of life, and the impact of change on these among the resident population, highlighted the importance of the concepts of empowerment, engagement, ageing-in-place and social connection. Elements of quality of life and factors contributing to quality of life are discussed in the literature but not necessarily in relation to organisational change, as revealed by the findings of this study.

6.1.1 Quality of life

Understanding what residents considered to be elements of quality of life was a major feature of this study. Quality of life for older people is a concept that is discussed in much of the literature, particularly as it relates to residential aged care (e.g. Ball et al., 2000; Bidewell, Ledwidge, and Tan, 2003; Boldy and Bartlett, 1998; Bowers, Fibich, and Jacobson, 2001; Chou, Boldy, and Lee, 2002; Elovainio and Kivimaki, 2000; Kane, 2001; Kane and Kane, 1987; Kane, Kane, and Ladd, 1998).

Many attempts have been made to define quality of life. While there is no one consistent definition, there is agreement that it is multidimensional, has subjective and objective components and is often defined in domains. Such an approach is supported by this study, in which elements of quality of life varied across sub-populations of residents. Ball et al (2000) define quality of life as, “the ability to enjoy life and feel that it has meaning” (p305).

The World Health Organisation Quality of Life Group (1993) defines it in this way:

“Quality of life is defined as an individual’s perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relating to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person’s physical health. Psychological state, level of independence, social relationships, personal beliefs and relationships are salient features of the environment.”
(p153)

Rosalie Kane has written extensively on the concept of quality of life for older people in residential care (Kane and Kane, 1987; Kane, Kane and Ladd 1998, Kane 2001). Kane (2001) expresses quality of life as eleven domains, each an outcome for an individual rather than a structural feature or process associated with an outcome, as in accreditation. Each domain can be measured in both its negative and positive form, as quality is not just the absence of a negative outcome. Combined, they encompass two separate but complementary types of human needs – the need of the

individual as well as the need of the individual as part of a community. The domains are outlined as:

- A sense of safety, security and order about oneself in one's world: able to trust that they are living in a benign environment where people are well intended and rules are understood,
- Physical comfort: being free of physical pain and discomfort as well as comfortable in terms of the environment,
- Enjoyment: an attribute that is often ignored and yet it is fundamental to our joy of life,
- Meaningful activity: life is interesting and purposeful,
- Relationships: make life worth living, be they relationships of love, friendship or even rivalry, with family, friends and others,
- Functional capacity: as independent as they want to be within the limits of their physical and cognitive capacity,
- Dignity: is respected regardless of whether the individual can perceive only the indignities,
- Privacy: able to be alone, to be together in private and to be able to control personal information,
- Individuality: a sense that they are known as a person and are able to experience their own identity,
- Autonomy/Choice: able to make decisions and choices and direct one's own life, and
- Spiritual wellbeing: a religious connotation and a notion of inner strength and sense of inner peace.

This was reflected in how the residents revealed all categories of need within their accounts. While elements of quality of life varied between the three sub-populations of residents, elements of quality of life revealed as common related to both the individual and the individual's connection to a community environment. The significance of the issues revealed within the elements of quality of life became a driving force behind the rejection of the first site redevelopment plan and informed the foundations for the new site redevelopment plan. These eleven domains, as

expressed by the residents, also informed the development by the SMT of the principles of the model of care during this study.

The need to take quality of life into account is reinforced by Stone (1970) cited in Kane (2001), who explains quality of life of the older consumer, as the need for economic security in terms of shelter, housing and money, and socially, and in terms of status, friendship and belonging. They also want to feel valued for the contribution they make to their community and for their mental and physical capacity. They need responses from others, including friends and family, opportunities for adventure and new experiences, as well as predictability and 'sameness'. Stone claims that they need dignity, love and respect and the opportunity to relax and reflect during moments of solitude. In this study, these elements were expressed when residents in the independent living units talked about what quality of life meant to them. For them, quality of life was a balance between maintaining independence and accessing support when needed and was realised through social connection, friendships, security, physical health and personal space.

Bidewell (2003) suggests that quality of life is linked conceptually with subjective wellbeing or happiness but is not synonymous with satisfaction with life. Chou, Boldy and Lee (2001, 2002) discuss quality of life in residential aged care in relation to resident satisfaction and highlight room, home, social interaction, meals, service, staff care and involvement as six factors in a multidimensional construct. Bowers et al (2001) studied how residents defined quality of care as an indicator of quality of life. Their study identified three concepts: care-as-service, being efficient, competent aspects of care; care-as-relating, being affective aspects of care such as friendship; and care-as-comfort, being the maintenance of physical comfort. They suggest that how quality of care is perceived will influence perceptions of care. These concepts can be seen in conversations with the residents in the high care centres in this current study. Although their world was restricted by physical place and personal health status, they were still able to identify elements that comprised quality of life. Staff were important, as was basic physical care and well-being and communication between carers and family.

In Lawton's (1989) ecological model, well-being depends on the fit between the person and their environment. According to Lawton, well-being for older people involves a balance between two sets of needs: on the one hand, the increased need for physical, social and emotional security and on the other hand, the need for challenge, growth and variety of experiences. Lawson proposes four quality of life domains - behavioural competence, psychological well-being, perceived quality of life and objective environment. He goes on to describe characteristics of a retirement village that are most important or attractive. They are health support, companionship, independence, dwelling characteristics, dwelling cost/tenure, village amenity, village facilities and village location.

This concept was revealed by residents in this study when they talked about this community as family and the relationships they felt they had with other members of the community. This community had become home and family for many residents, who indicated that they felt better connected to other members of the community than to their 'outside' family. Residents also acknowledged the importance of looking after each other and how social connection added to their quality of life. Residents in independent units expressed concern that the redevelopment would disconnect them from the location and friendships that they valued as elements of quality of life.

Whether termed well-being or 'the good life', this concept is used to describe how people feel and function (Lawton, 1991; Steiner et al, 1996). Some residents living in the independent living units revealed initial apprehension and feelings of insecurity in response to change but, when they understood that changes would lead to greater long-term security and part of a plan for the future, they could enjoy the challenge of participation, and some became strongly supportive of the redevelopment.

The literature also identifies that among the major prerequisites identified as necessary for successful transition to a retirement community are the development of attachment to place and formation of strong social ties. Establishing strong social ties was identified as important by many residents, and an important characteristic of this community. Residents in low care talked about the social interaction that occurred in

the dining room and independent living residents talked about clubs, social groups, close neighbours and long-term friendships.

Sugihara (2000) examined the role of physical features in a retirement community in fostering place attachment and socially supportive networks among a group of new residents. He found that elderly residents who lived in closer walking distance to the central activity building, who were close to their neighbours and who shared enclosed, outdoor garden spaces, felt more attached. He described place attachment as a process that provides personal and group identity, fostering security and comfort with one's immediate surroundings. It is associated with residential satisfaction, positive affect and better adjustment. Social support directly and indirectly affects physical and mental health and can buffer adverse impact of stressors on well-being. Relocation can precipitate the loss of close physical proximity to friends and family, making new social support systems important. Sugihara suggested that the most powerful exogenous variable influencing place attachment and social support in any residential setting was duration of occupancy.

One of the findings of this study was the impact of feedback from residents on the physical features of the redevelopment plan. The community development plan that evolved through this study aimed to include many of these concepts evident in the literature. It aimed to create a physical and social environment that was connected by pathways, gardens and open space, as well as the buildings. It aimed to address security and safety, issues enhancing social connection but still maintaining personal space.

The literature also suggests that quality of life relates to a personal feeling of well-being (Ranzijn & Luszcz, 1999). A number of contextual factors have been identified as associated with well-being in older adults. They include health (assured and self-rated), functional ability, socio-economic status, physical activity, marital closeness, social support and interaction. However, all factors together only accounted for 15% of the variance of well-being, directing the research to explore psychological factors as well. Those identified include a sense of control, self esteem, need for personal growth, creativity, goals in life and feelings of usefulness. Residents in the high care centres identified many of these physical, social and psychological factors and

expressed them according to personal circumstance and health situation. They were aware of their limitations and restrictions and had accepted simple elements of quality of life related to physical and mental well-being.

Recent literature on ageing suggests that achieving a high quality of life and a sense of well-being may be viewed as successful ageing, a measure of an individual's ability to adapt to aggregate changes. The literature suggests that older people relate health with independence, freedom from pain or discomfort and the ability to maintain usual life patterns such as social activity and relationships. Chenoweth and Sheriff (2003) report on a study of 200 English speaking persons over 65 years of age in urban and regional NSW. The study also reports that many older people gauge their health in terms of independence, mortality, close relationships, social interaction and absence of pain and threatening illness. Maintaining a healthy life style would prevent illness.

Further, health, well-being and independence of older people can be sustained and enhanced by actions on the part of older people themselves as well as by a society that values them (PMSEIC 2004). The report stresses the importance of a multi-disciplinary and multi-sectoral approach to both research and action in promoting healthy ageing and delivers several important messages that have relevance for aged care organisations. The findings of this study reflect this, in that the resident population represents a diversity of health conditions and personal situations.

Residents were seeking the best quality of life that was possible for them in their situation and a process of healthy ageing. Some revealed that they were empowered to maintain their own wellbeing through activities and interaction, while others needed varying degrees of support to maintain well-being.

PMSEIC (2004) suggests that an organisation would facilitate healthy ageing and quality of life by providing services and an environment that recognises the importance of:

- Considering the social environment in which people live as well as the built environment and accommodation,

- Paying attention to risk factors for chronic disease, in particular diet and physical exercise,
- Adopting a whole-of-life approach to healthy ageing, never too late and never too early,
- Striving for small reductions in disease risk across a whole population which will have major benefits,
- Making healthy choices easy for older people,
- Adopting a multidisciplinary collaborative approach, and
- Supporting research into a better understanding of healthy ageing and hence quality of life (PMSEIC, 2004).

The SMT were able to reflect on the literature and the account from the residents to gain an understanding of the elements of quality of life and how these were affected by change. This understanding influenced the progress of the redevelopment and informed decisions about appropriate accommodation, creating a social and physical environment, providing flexible services, building and maintaining relationships that would support healthy ageing and facilitating quality of life for the resident population. The literature provided an explanation of key concepts and a framework on which to establish principles that would inform the site plan and redevelopment process. The findings of this study were congruent with existing perspectives on quality of life, particularly as expressed in residential aged care settings (high care). The findings from this study, in relation to residents in low care and independent units, add to the literature and provide new insights into the elements of quality of life and its importance to residents.

While the literature presents a comprehensive discussion on elements that support personal quality of life and a sense of wellbeing in residential aged care, it is yet to fully explore these elements within the context of the impact of these demographic shifts as population projected for the future. The literature focuses on residential aged care accommodation options of today that may change to meet the needs of future older generations. The findings of this study have expanded this body of knowledge because they reveal elements of quality of life and the significance of quality of life across a diverse population of residents in a large aged care community. They

provide a detailed understanding of the elements for each sub-population and how these elements relate to social situation as well as health. Further, they highlight how 'simple' the concept of quality of life can be, in terms of personal care and communication, or independence and assistance, or stability and security, and yet how complex it can become when individuals feel their quality of life is at risk, for example, during change.

Choice Village was endeavouring to anticipate future demand for accommodation and services, recognising that resident populations in future would not necessarily have the same health status, expectations, or be in the same financial situation. However, it also worked tirelessly to protect current residents, many of whom would remain members of the community throughout the entire redevelopment period. Many similar communities will face this task in the future and the knowledge from this study will inform other communities.

6.1.2 Empowerment

An understanding of the significance of the concept of quality of life, and the elements that contribute to quality of life, as revealed by the residents, highlights the concept of empowerment as significant. The findings reveal that when change impacted on quality of life, it also influenced an individual's sense of empowerment. Wellbeing reflected a sense of empowerment and engagement in the change process, by the residents in this study.

Empowerment is discussed in the literature as an abstract and dynamic concept that is fundamentally positive because it refers to resources and possibilities, not problems (Bendz, 2002; Heumann et al, 2001). Rappaport (1984) in Bendz (2002) defined empowerment as a process by which 'people, organisations and communities gain mastery over their lives'. Therefore, the opposite of empowerment can be seen to be powerlessness – loss of control over one's life. Zimmerman et al (1992) in Bendz (2002) focused on the intrapersonal (how people look at and perceive their capacity to influence their life), interactional (transactions between people and their environment) and behavioural (specific actions taken to exercise influence) components of empowerment.

The goal of empowerment is a state of mastery, a sense of control and a readiness to take action. It can also be a process by which people, organisations and communities can take control of what is happening to them and their lives. Heumann et al (2001) examined the impediments that frail older people face in securing and maintaining power over their own housing, health and social service needs and desires. They classified these under four groups (or 'limits') as follows: provider-based, environment-based, client-based, and societal-based. Health and community services can empower older people in several ways, for example:

- Provide adequate information and education about service options and choices,
- Involve the individual in decision making,
- Determine what the individual can do rather than what they cannot do,
- Foster independence,
- Provide choice,
- Accept the decision of the individual even if it is not what you think is the 'best' decision,
- Involve the consumer in planning and evaluation of services, and
- Act only with the consent of the older person.

As discussed previously in this study, the formation of the Residents' Advisory Council with representation on the Board empowered the resident population. Other initiatives that empowered the resident population, as seen in comments in the resident surveys, were resident meetings, forums and other opportunities for communication. The realisation that change could impact on a sense of empowerment, was an important lesson for the SMT. This study revealed what empowerment meant to residents in terms of their reaction to change and their desire to not feel powerless related to events that directly impacted on them.

The findings of this study reveal that a sense of empowerment came with involvement of the residents in the redevelopment process, where they were engaged as participants and consumers, using their experience and taking account of their opinion. In this organisation, the establishment of formal and informal means of communication (surveys, interviews, newsletters, forums) provided valuable

information and created opportunity for regular feedback. This helped to foster a sense of empowerment and engagement among residents.

In this study, residents reacted negatively to change when they felt they had not been informed, were not empowered to take informed action or to make an informed decision, especially if the change impacted on their quality of life. The literature recognises the significance of a feeling of loss of control in relation to change and identifies that this may be particularly significant for people who may be feeling vulnerable, as some of the residents in this community were feeling. In this study, when residents felt that they understood the reason for change, had time to process the event and the impact of the change and had been given the opportunity to participate in the process, they did not feel the same sense of powerlessness, nor felt dis-empowered. The SMT became aware of the importance of assisting residents to maintain a sense of control and fostering empowerment within the resident population.

6.1.3 Ageing-in-place

The concept of ageing-in-place is discussed widely in the literature on ageing and aged care (Heumann and Boldy 1993; Wilkstrom 1994; Ahnby and Osterstrom 2003). It is usually viewed as a positive approach to meeting the needs of the older person, supporting them to live independently, with some assistance, for as long as possible. It implies that most older people prefer to live in their own home, rather than an institution or care centre. However, there is little in the literature about the implications for the individual or their carers. In this study, residents expressed a desire to age-in-place and identified that balancing independence with a need for support enabled them to age-in-place, a critical element of quality of life. Finding ways to support residents to age-in-place was an important principle underpinning the model of care that was developed by the SMT during this study. The findings also reveal that there are some negative implications of the desire to age-in-place and this needs to be monitored.

Ageing-in-place is not a new concept. Heumann and Boldy (1993) state,

“interpreted correctly, ageing in place has the potential to provide more appropriate care at less cost than a move to a more specialized and sheltered facility. Alternatively, ageing in place can cause great harm if it becomes an excuse not to build and fund long-term care facilities” (p2).

The term implies that an older person is provided with the option of staying in their (own) home and out of a care institution, implying a sense of independence. To enable the older person to ‘age in place’, services must be available to meet their needs and to assist them to live independently (in their current housing and/or, their current neighbourhood and/or, a level of housing appropriate to their dependency), so as to avoid or prevent a costly, often traumatic and inappropriate move to a more dependent facility. This means that services need to maximise the person’s level of independence through support, management and physical adaptation and respond to increasing dependency over time.

Ageing in place has advantages for service providers. It can assist to prevent expansion of over-caring in costly institutions, facilitate coordination of an often complex and fragmented network of support services and assist older people to remain actively engaged in their own support to the full extent of their ability. However, ageing in place is not an option for everyone. In some cases, a desire to age in place (by the individual and/or their family) can delay access to necessary services and accommodation and diminish quality of life. Wilkstron (1994) describes well the ‘two sides’ to the intent of the term. He says, the term ‘ageing in place’ refers to the possibility of individuals staying in their own homes as long as it signifies something positive to the individual, relatives and to the society (in Ahnby and Osterstrom, 2002).

In Australia, the desire to assist older people to age in place has had an impact on government policy and funding for services. It has resulted in a greater emphasis more recently on low care facilities (hostels) rather than high care facilities (nursing homes), the introduction of multidisciplinary aged care assessment teams, development of a residents’ rights charter, and an increase in home and community care services. It has also had an impact on community and health professionals’ attitudes.

While ageing-in-place has been described extensively in the literature, this study revealed that the process to support someone to age-in-place is not as straight forward as it might be seen. While staff in this study supported the principle of ageing-in-place, they identified a concern that some residents were staying in the village (independent living) for too long so that, when they moved to the low care centre, they in fact needed a higher level of care. Some residents also revealed that they felt they may have tried to cope at home for too long and this had led to physical and mental exhaustion for both the person needing care and the carer. Exhaustion of the carer and compromised health status for the person needing care was of concern. By 'missing out' on a transition through low care, with its balance between support and independence, the adjustment to high care was harder for all parties.

With community expectation that most older people want to age-in (their)-place, there is a risk that those who choose not to do so will be judged unfairly, by family, friends, health professionals and others, including themselves. This perception of being judged for not coping, was shared by some residents in this study, as expressed by one resident, "I should have kept her (wife) at home longer and felt badly when I couldn't cope any longer." This highlights the importance of a flexible approach to services and viewing need as associated with the individual, not the accommodation or label. Understanding the desire to age-in-place along with the possible outcome of ageing-in-place for too long, with the implication for residents, a carer, staff and services, was revealed as a significant finding in this study.

The shift to increased funding for community and home based services, has been part of the Australian health and aged care policy for some years. While the philosophy is commendable, the industry is sometimes critical of the way this is unfolding and there is concern that 'governments' do not really understand what ageing-in-place means or the resources it demands (Hogan 2004). This study reveals that, though individuals and providers support the principle to age-in-place, it is a complex, multifaceted concept and needs to be managed well. The Australian government considers ageing-in-place as a preferred approach to care and supports it through current funding schemes and service allocation, through the current aged care classifications of high and low care.

It became apparent that the lines of demarcation between low and high care, and between independent living and low care, in relation to levels of dependence and the need for care, are not well defined and becoming increasingly blurred. It highlights the importance of having flexibility in the way that services can be funded and delivered to people and that they be determined on need. This emphasises need rather than accommodation classification and may encourage a more timely progression through the aged care system. Therefore, this study highlights a gap in the literature and a need for further research on the desire of older people to age-in-place, and the impact this has on the individual and/or their carer, over time.

6.1.4 Social connection

The importance of social connection as a key element of quality of life, regardless of social situation or personal health status, was revealed in this study. The literature on social connection has focussed more on community based older people, equivalent to those residents living in independent units in this community. This study adds to the literature by revealing the significance of social connection to residents in low and high care settings.

Social connection, that is, meaningful involvement in social activities and making a contribution to others, was identified by residents as a significant element of well-being. Older people report social involvement and encouragement as significant factors in leading healthy lives, and contribute to feeling good about oneself, even if experiencing illness and disability. The key is to continue activities and relationships that are important and to have social support. Feeling valued and appreciated has a critical bearing on wellbeing (PMSEIC, 2002).

Both work and social environment are major priorities for promoting the health and wellbeing of older people. With the ageing of the population, participation in the labour force and volunteering is becoming an increasingly important issue for individuals and the economy. The AIHW document 'Older Australians at a Glance' (2002, p12) identifies a number of categories of activity: personal care; recreation and leisure (including learning); domestic; purchasing goods and services; social and community interaction; voluntary work; employment; and child care (grandchildren).

When compared to younger people, older people (65 years or above) spend more time on passive leisure activities (reading, watching TV, audio-visual media, relaxing) They spend less time in social and community interaction but still 10% of their time visiting, entertainment, socialising, attending sporting or other events, related to community participation. If, because of illness or disability, an older person can no longer participate in those activities that have become part of their life, they may experience increasing feelings of isolation and loneliness. Some research suggests that social isolation and loneliness is a growing issue for older people.

The findings of this study show that residents in this community could identify different social and recreational activities that they participated in and, for many, social clubs and events were a major part of their life. Some were involved in volunteering at the care centres, while others enjoyed the companionship of friends at meal times and in other informal settings. For others, family interaction was more important and evidence of social connection. Recognising a range of interests and needs, and how they create and maintain social connection, is important (AIHW, 2004).

The literature discusses the importance of social connection in planning and design, but does not address its relevance to models of care. A particularly strong criticism of the first site development plan for this community was that it failed to place sufficient importance on environmental and social connections across the community. With its focus on buildings, it neglected to address those elements of quality of life identified by the residents. The accepted site plan, as well as the model of care developed by the SMT, were both informed by the findings of this study and recognised the importance of social connection as an element of quality of life. The redevelopment plan adopted aimed to enhance social connection through buildings, recreational areas, access and pathways, social centres and activity venues. The model of care placed its emphasis on meeting the needs of the residents regardless of physical location or designated dependence category and planned services to meet need and connect the residents with available resources.

An explanation of the concept of quality of life can be found in the literature, but not an in-depth understanding of the elements of quality of life across a varied

population of older people, in terms of empowerment, ageing-in-place, and social connection. The findings revealed through the residents' account are supported by much of the literature on quality of life. The richness of the vast body of data in this study expands on this understanding, with the descriptions from the three resident sub-populations. By recognising both the importance of these elements and the impact of change on them, the study adds to the body of knowledge informing the aged care industry.

6.2 The impact of change on the SMT: leadership in aged care

It is clear from the following discussion that there is substantive literature advising that every organisation needs leaders and numerous descriptions of leaders and leadership behaviour. A number of theories have been proposed to explain the concept of leadership and there is no shortage of literature to explain different leadership theories and their application within organisations.

Leadership theory is discussed in different ways, for example: natural leaders, presumed to be born with certain traits; leadership styles that focus on behavioural aspects; and leadership situation where individuals adopt particular traits and styles depending on the circumstances. The literature on leadership theory is also linked to other concepts such as, masculine and feminine leadership styles and organisational culture to support leadership behaviour (Lett, 1999).

Some literature discusses leadership in relation to type of industry or organisation, nature of product or service, or characteristic of clients and customers. There is a growing body of literature on leadership in health care and other service organisations and how this differs from leadership of other organisations and industries, such as mining and engineering. Much attention is given to the fact that the product is a service and the customer a consumer of that service, emphasising the 'people nature' of the business.

There is limited literature on leadership best suited to aged care communities. Porter-O'Grady and Wilson (1995) believe that a transformed health care organisation will address the particular characteristics and challenges of the clients they serve and

communities they create, with limited budgets and scarce resources, through its leadership style.

This study explores some of these unique characteristics and challenges faced by aged care providers and adds to a limited body of knowledge on leadership in aged care communities, particularly, leadership for change. It reveals the importance of leaders and leadership in organisational change. It reveals that this organisation came to life on a day-to-day basis through the SMT. They translated the mission and values into practice, for the residents and for the staff, and represented the organisation to the external world. The study highlighted that the Board also had an important leadership and advisory role that was best realised through a partnership with executive and senior staff. However, the day-to-day operations of the organisation were the responsibility of the members of the SMT, who were also seen to be the leaders of change.

6.2.1 Values-based leadership

Reflection on the findings of this study reveals the importance of building a leadership team and this informed an investment of considerable effort and resources to develop this within a structured leadership development program. The development of the leadership group occurred over time and realised a competent, confident cohesive senior team, with clear roles and responsibilities. This was revealed as integral to the redevelopment process. A values-based, transformational approach to leadership, based on values of trust, integrity and respect was adopted by the SMT as the preferred leadership approach to enable them to realise the future and facilitate the change associated with the process of redevelopment.

The literature on values-based leadership describes values as enduring and a guide for how people feel about themselves and their work. Values congruence within a team can result in joint commitment, individual and group satisfaction and can guide the implementation of organisational behaviour and decisions. Fairholm and Fairholm (2000) claim that leaders need a united and harmonious environment, characterised by mutual trust, to be able to lead. They assert that when examining trust as an essential element of organisation culture, it becomes clear that a lack of

trust permits discord and disharmony in organisations. Trust, essential in interpersonal relationships, is based on confidence and predictability of the actions of others as well as moral integrity and good will (Kouzes and Perron, 1995). The latter claim that most effective leadership situations are those in which each member of the team trusts each other. However, learning to trust others can take time. This is supported by this study and revealed in the SMT account where one senior manager described trust as 'a work in progress'.

Leadership and trust develop within a workplace when people choose to work together because they share common values, goals, practices and other work relationships (Porter-O'Grady and Krueger-Wilson, 1999). This sometimes occurs as a developmental process that builds on growing levels of trust where there is a commitment to build this trust within a work culture and to modify the leadership team's behaviour to meet evolving needs of group members. This is revealed in the findings of this study in which members of the SMT had to adjust and modify their own behaviours as the level of trust developed and the team consolidated, especially when membership of the team changed.

The literature suggests that individuals who communicate accurately and honestly, with commitment to organisational values within the organisation, develop trust. Fairholm and Fairholm (2000) suggest several forces can hinder the development of trust. At an individual level, they describe four forces.

- Interpersonal communication: interaction can bring communication about feelings, attitudes, problems and ideas and so a degree of risk exists;
- Apathy and alienation: our experiences in the past determine whether we accept or reject aspects of our work culture and these experiences will influence our level of trust;
- The risk of trusting others: although trust is risky and sometimes viewed as a sign of naivety, immaturity or lack of experience, high levels of trust will bring about dependability and reliability; and
- Leader sensitivity to others' needs: sensitivity is the ability to feel, perceive and acknowledge the mood of others and is an essential element of leadership.

At the organisational level, they describe four additional forces.

- A lack of effective accountability: we build trust on predictable known mechanisms that demonstrate what is and is not acceptable and by reacting to behaviour that is not acceptable; over controlling, restricting behaviour inhibits the development of trust, but failing to hold people accountable for behaviour also implies a lack of trust;
- An authoritative structure: the cumulative action of people in authority determines the culture of the organisation and imposing control through hierarchies or telling people how to do their job, shows disrespect and erodes trust; a leader's role is to structure authority so that it leads to individual development and group outcomes;
- A history of negative trust events: positive and negative experiences help define culture and an excess of negative experiences erodes the context of trust. Failed promises and inconsistent decisions can have a powerful effect on an individual's ability to trust others; and
- Organisational structure: trust thrives in work situations where individuals have the freedom to control much of their day-to-day work within a shared vision, sometimes referred to as empowerment.

Fairholm and Fairholm (2000) explain this when they state,

“Leaders foster commitment through the whole of the beliefs, ideology, language, ritual and many of the systems that they build into their culture. Success in building such systems lets members trust each other enough to work together” (p108).

Trust was identified as a critical value for the SMT in this study and many of the forces identified in this literature, at both the individual and organisational level, were evident in the SMT's struggle to build a values-based leadership model. This required many changes as they worked to create an environment of accountability, to remove unnecessary authority, to let go of past situations and relationships if they needed to and to create structures and systems that would support their leadership practice. They focussed on interpersonal communication, building trust and gaining

awareness of each others' strengths and values, and a growing level of trust within the group enhanced the effectiveness of the leadership team.

Brytting and Trollestad (2000) write that common values are the glue that binds an organisation together. Values motivate and create a sense of community. In a study involving two-hour interviews with small groups of managers, they explored how managers perceive the issues of creating common values, what change strategies they prefer and their self-reflection on values-based management. The SMT account in the current study shows that all interviewees stressed the importance of similar values and work being organized in a way to facilitate autonomy and cooperation. Frankness, honesty and decency were put forward as common, important values for an organisation. They considered that leading by values was not about the creation of common codes of conduct, but rather a question of inspiring a group of individuals to reflect on the moral assumptions of the organisation (mission and values) and to create an environment where common behaviours aligned to values and would be accepted and adopted by the leadership team.

The findings of the study reveal that the exercise to translate organisational values into behaviours was a critical step in the development of the SMT. The implications of change highlighted a lack of application of the organisational values to practice and revealed the lack of common bond and purpose within the SMT. Without this common bond and purpose, they were unable to present a unified position on the critical issues that arose within the redevelopment process. The development of the SMT revealed friction between some members at times, which resulted in issues associated with communication of information to residents and staff. The development process also highlighted unacceptable interpersonal conflict within the team, ultimately resulting in departure from the organisation.

Hood (2003) takes the issue of values in leadership further when exploring the relationship between leadership style and CEO values. Hood's study involved a sample of CEOs from 2000 small to medium size firms throughout the United States. Hood's study revealed clear links between values and ethical practices and how important it was to consider values within the leaders of an organisation as well as how values helped to shape leadership style. The values of the leaders determined the

ethical practices within the organisation. The findings in this study also show that the CEO in this organisation had a significant role in the development of the team as a leadership group. The leadership team needed a clear vision as well as an understanding of realistic steps to achieve the vision. The CEO was also the pivotal link between the Board and SMT and was the facilitator of the developing relationship. This is supported by the literature on the role of the CEO in an organisation.

Trevino et al (2003) also examined the importance of values in leadership. They completed a literature review to assess the state of current knowledge about executive ethical leadership, where ethics referred to the values held by members of the executive team. They found limited but increasing interest in the topic and a common view that executive ethical leadership is widely thought to be important, because of the impact leaders have on the whole organisation. The study went on to define the perceived content domain of executive ethical leadership. Their findings support the importance of honesty, trust and integrity as core leadership values and emphasise the importance of 'walking the talk', described by the SMT in this study as 'living the values', as leaders. The findings of this study also identified an association between ethical leadership and transformational leadership, characterised by concern for people and values-based leadership and the use of communication. Communication was a tool used by the SMT to assess progress, identify issues and resolve conflict.

During the course of this study, the SMT invested considerable time in reviewing the mission and values of the organisation and developing the culture of the group from the values, as part of a program of leadership development. The importance of culture built on trust is highlighted by a member of the SMT who reported:

"I think culture is very important in an organisation – it sets the scene for the organisation, for how people behave and places an emphasis on expectations in performance. I think trust, authentic trust, is really important. People often say they trust someone else, but they just mean the behaviour, their work. Authentic trust is being able to trust someone and also to be trusted. It is a two-way process. It means I don't have reason to doubt or question your

behaviour, your reason for a decision, because I trust you as a person – it is more a comment on your personal values.”

The findings of this study are, therefore, supported by existing literature on the importance of values-based leadership, they highlight the process of growth and development that occurred during the study to establish organisational values and associated organisational behaviours that would demonstrate to themselves, residents and staff that, as a team, they were ‘living the values’ as leaders.

6.2.2 Transformational leadership

The development of the leadership team was a key activity in this study and the process of development embarked on by the SMT was a primary focus of inquiry. Finding the ‘right’ leadership model for this team and this organisation was determined to be critical to the change process. The literature describes different approaches to leadership that have helped guide our understanding of the concept over the last 30 years. A number of models of leadership have been described (Sarros et al, 1999), including: the trait approach, behavioural approach, situational approach, contingency approach, transactional approach and transformational approach.

Transformational leadership has gained favour in recent years and has been discussed extensively in the health literature (Burns, 1978; Bass, 1995 and 1998; Porter-O’Grady and Krueger-Wilson, 1995; Krishnan, 2002; Barling et al, 2002; Hood, 2003). According to Burns (1978),

“Transformational leadership occurs when leaders and followers raise one another to higher levels of values and motivations that results in a transforming effect on both leaders and followers.” (p20).

Many elements of transformational leadership were evident in the approaches of the SMT to manage change. Transformational leadership encompasses a range of behaviours that motivate individuals to perform beyond expectation. Such behaviours include role modelling, inspiring, mentoring and challenging.

Burns (1978) considers the values system congruence between leader and follower among the most important characteristic of transformational leadership. Bass (1985) describes transformational leadership as one that motivates others to do more than they originally expected to do. This arises because transformational leadership broadens and changes the interests of others and assists them to be more aware of the purposes of the group. The 'good of the group' supersedes the interests of the individual. The movement of values, attitudes and motives brings about behaviour that is collectively more influential than the behaviour of any one individual. In the relationship of the leader with others, the personal values of all individuals need to be considered not ignored, but the connection that occurs within the group moves the individual to see beyond themselves and brings about a transformation of their individual position.

Values assume even more importance with transformational leadership as it results in changing the needs and relative values of others. Another characteristic of transformational leadership is its focus on learning. Dunoon (2002) refers to learning-centred leadership that emphasises processes such as discussion and reflective conversation, that build understanding and momentum for change. The term learning-centred leadership is used to distinguish it from charismatic leadership (a charismatic transformation of behaviour), not implying any one type of leadership, but rather a leadership approach. The concept comes from organisational learning theory and reflects the dialogue around the concept of the learning organisation (Senge, 1990; Dixon, 1994). Learning-centred leadership implies a dynamic process where conditions are created so that individuals can explore ideas, interpret issues and consider opportunities. The leadership is about capacity building where leadership is a values mode of operating. In this sense, that is assisting and encouraging individuals to reframe issues and opportunities and identify viable responses, learning-centred leadership can become transformational through its processes. Individuals learn by the process and by the support and coaching of others. Groups learn through hearing new ideas and perspectives and through reflection and collaboration. Organisations learn by increasing the capability of individuals and groups through an action learning process (Dunoon, p10).

In this study, transformational leadership, with its focus on developing a foundation of values, and the associated learning, was attractive to the SMT because it provided a useful structure to implement change. This component of learning-centred leadership was also illustrated in this study within the action research process.

The leadership development program was further influenced by the action research process, and enhanced by a process of discussion and reflection as the SMT sought to manage relationships with an understanding of their own emotions and the emotions of members of the team. The values of the organisation and the agreed behaviours that were developed from them called for an understanding of self and others as part of their implementation.

A values based, transformational leadership approach is reported in the literature as having particular application to service organisations, including health care. However, there is limited literature that discusses the application of any particular leadership style in aged care. This study adds to the literature as it describes the application of a transformational leadership approach and reveals how this informed the management of change associated with redevelopment of an aged care community.

6.2.3 Team development

The importance of team development was also highlighted by the findings of the study. The SMT was a mix of old and new members, in terms of employment and time with the organisation. Whilst some had been with the organisation for many years, the CEO was relatively new and there were some more recent appointments. There was also further change in membership during the study. The organisation was in the process of letting go of the past and embracing new ideas and processes and members of the group handled this differently. There had also been changes in the membership of the Board and the relationship between the Board and SMT was evolving. At times these changes were both disruptive to the team and unsettling to the development of relationships.

Team performance depends on viable relationships and a common purpose. Effective teams are able to add to this a disciplined approach, affirmation of contribution and diversity of mindsets and experience. It is not a case of being the same and agreeing with everyone, rather cooperating and choosing to work together. This makes teamwork a complex phenomenon (Mickan and Rodger, 2000; Wake-Dyster, 2001; Harris (Ed), 2002). In a literature review of effective teams, Mickan and Rodger (2000) discuss some key characteristics. They add 'appropriate leadership style and patterns' and 'a clear definition of necessary roles' to the characteristics identified earlier. Further, they suggest that formal and informal communication systems and consistent education and support for the team members, are also critical.

As is often the case, individuals do not develop at the same pace and do not necessarily react to change in the same way. They bring a variety of past experiences, knowledge, skills and personal reactions to the proposed redevelopment and associated change. As discussed previously, trust became a core principle within the SMT. Levels of trust varied among members throughout the study and a lack of trust between some members instigated some change in membership of the team and a period of unrest and discomfort for some. Different levels of development, adaptation to change and willingness to adapt to changing roles, along with comfort with and support for a transformational leadership style adopted by the group, affected the evolution of the team. However, while changes to membership and associated disruption may have caused some problems, all members of the SMT recognised the value of reflection and discussion within the team about events, and could see a continuing growth within the team.

The effective implementation of the redevelopment plan and the management of change within the organisation required a team approach and the findings of this study support the importance of this concept of team, as reported in the literature. The SMT identified that values-based leadership, transformational leadership and team development, were critical elements of the leadership model and these elements are also discussed in the body of literature on leadership. The findings of this study contribute to this important body of literature and expand this to apply to aged care organisations. Leadership in this complex, multi-faceted industry presents many

unique challenges and demands particular knowledge, understanding and experience in a range of leadership behaviours.

6.3 The impact of change on business capability: organisational capacity for change

The literature on organisational development reveals the need for strong business foundations and practices and highlights how this impacts on physical, financial and human resource allocation. Much of the literature relates to large corporations but does not address the particular service characteristics of health care organisations. There is limited literature on the particular business challenges and characteristics of aged care organisations or on the business implications and challenges faced by aged care organisations engaged in major change.

Choice Village had embarked on a redevelopment process that would bring about significant change to the organisation. The aim of this study was to explore the impact and influence of such change on the key stakeholders within the community and on the organisation's performance. The change process impacted on the accommodation and services provided for the resident population. Further, the findings reveal how change influenced the development of a new model of care and a framework for services, a key foundation of the redevelopment. In addition, change influenced the business foundations and brought about a review of many business functions and issues.

6.3.1 Business capability

Choice Village is a community oriented, non-denominational, 'not for profit' provider of aged care services and accommodation. This description creates certain assumptions among residents, staff and the wider community, which are revealed in the findings of this study to be:

- All profit will be returned to the community,
- Less fortunate older people will be looked after,
- Fees will be kept to a minimum, and

- The organisation (management) serves the community (residents).

While the principles underpinning these assumptions were not challenged by this organisation, their impact on the long-term viability of the business without significant change, was cause for concern. Government and the industry itself describe a distinction between ‘for profit’ and ‘not for profit’ providers within the aged care industry. The reality is that most providers who are labelled as ‘not for profit’ must also be ‘not for loss’ to survive. The not-for-profit status of this organisation gave rise to considerable criticism from some residents in relation to the proposed redevelopment that was seen to be challenging its status and business focus.

Church based, charitable and community based ‘not for profit’ organisations have long been providers of accommodation and services for older people in Australia. The key distinguishing characteristics of such organisations appear to relate more to the entity itself, not what it provides. The description implies reinvestment of any surplus back to the community, not elsewhere. Within the industry, most would claim they:

- operate according to a culture of concern for the most needy/vulnerable,
- create and maintain a sense of community,
- promote a sense of social belonging, and
- share risks so individuals are not disadvantaged, and engage volunteers to assist with services.

‘For profit’ organisations also have a long history in Australia and are reviewed in the literature as different because they distribute at least some of any surplus to the owners. They may be listed public companies, private corporations or owner-operated businesses. There is an assumption, considered unfair by some, that they are primarily in the business to make money, not to provide services. Many would claim they also subscribe to the same values as the ‘not-for-profit’ group.

This study was not about the difference between these two classifications, but it did highlight the issue of ‘not for profit’ status and the impact this had on the redevelopment. The perceived conflict experienced by some members of the Board,

some residents and some staff resulted in the view that the redevelopment was not in line with the culture and ethos of the organisation. The study revealed that the organisation was not aiming to change its philosophy and social conscience, but it was striving to make it a more efficient business so that it could better meet the needs of its residents and provide appropriate accommodation and services, now and in the future.

The study demonstrated that it was important to help the residents to see that the redevelopment would not take away, or redirect funding for services, nor compromise what they saw as the philosophy in the community. Once they realised that the redevelopment, and associated business expansion, was being funded from other sources, including the sale of new units, some became less concerned. For some staff it also required different thinking and they had to be assisted to understand the business plan and relationship of the redevelopment to current practices. The Residents' Advisory Council provided a valuable resource for communication between Board and resident population and became one of the main information conduits in relation to this issue. Public forums and presentations also worked well, as did newsletters.

The significance of this issue is not well understood and literature is limited. Current government policy perpetuates this distinction and the industry has been reluctant to debate the issue openly. Hogan (2004) highlights the complexity of the issue and reveals the impact this had on reporting and analysis within the pricing review completed with the industry. There is limited understanding of the long-term financial impact associated with this distinction among providers, but growing concern. This study reveals that further open discussion about this complex issue, within the industry and with government, is overdue.

6.3.2 Model of care

There is considerable literature on the principles underpinning aged care. Models of care and associated services are developed on a number of principles. Kane (2001) for instance, suggests that many view long-term care as any assistance or personal care given to an individual because of a chronic condition or disability that limits

their ability to function independently. Care can be provided to an individual at home, at a day care centre, in a nursing home or hospital, whereas long-term care can be considered as a mixture of tasks that enable the individual to flourish 'as much as is possible'. The tasks that are undertaken may be arduous, time consuming, tedious and unpredictable. Kane and others suggest that this is a limited view of long-term care, that it is much more than undertaking tasks. While these are key components of long-term care, this study revealed that they should not only be what determines services. It is important to first consider the ethical framework that supports the model and to clarify the goals and outcomes of a service before deciding on the 'tasks' (Bergman and Beland, 2000; Bergman et al., 1997; Carter, 2002; Kane, 2001; Kane and Kane, 1987).

Carter (1999) and Bailey (2002) suggest that the long-term care industry has developed a system that is supported by a range of professional disciplines, each with a long history of knowledge that is associated with individual disciplines. The whole system suffers from a lack of vision regarding the purpose and the ethical framework that underpins the nature of care. This ethical framework is not the ethics associated with clinical decisions (decisions made about medical treatment) but rather ethics that form the principles of the service. These principles will guide decisions that are made about characteristics of clients/residents, accommodation, services, staff and organisational structure.

To Carter (1999), beneficence binds the provider of services to seek the good and well-being of the client at all times. The best interests of the client are served to bring about a good outcome and to minimise harm. The system of long-term care, particularly within the nursing home environment, does not always make this achievable and, at times, decisions are made to suit the system not the resident. On the other hand, paternalism is the act of deciding and acting on behalf of another without their request or informed consent, to ensure harm is prevented or avoided. For example, an individual may really want to stay at home but their failing eyesight, forgetfulness and frailty may result in a decision being made to move them from the home without their consent. The family and/or professionals may act on behalf of the individual without their consent.

More recently the application of these principles has resulted in an ethical framework that encompasses the concept of 'personhood', preserving the integrity of the individual (Carter, 1999; Kane and Kane, 1987). Applying the principle of personhood to long-term care not only provides an ethical framework that cultivates dignity and respect, it provides a framework that allows for the formation of an industry standard with universal application. This application means that people will,

“act only in a way that the intent of the action is to maintain and/or restore individual dignity and respect for the other, and, be willing to be subject to such actions and to commit to such actions’ (Carter, 1999 p69).”

Marquis (2002) writes about relational ethics in long-term care and how daily relational experiences with staff influence residents' views on service quality. Her research involved interviews with residents and aged care workers in seven aged care facilities in Western Australia. It highlighted the importance of resident/staff relationships in residents' perceptions of receiving 'quality' services. Marquis determined that relational ethics is a guiding principle in creating quality services, where relationships between resident and carer may be at the centre of the quality of life of the resident. Attention to the 'person' becomes critical to that relationship. This suggests that an individual's perception of quality is dependent on more than the tasks that are performed (services delivered) and more about relationships.

Wolfe and Agree (2004) outline this concept further in relation to depression among recipients of informal care. In a study involving an age-stratified random sample of Medicare beneficiaries, a population of disabled older women aged sixty-five years and over, living in the community in the US in 1992, they examined the influence of informal care arrangements on depression among people receiving informal care. The results from this study suggested that:

“Informal care arrangements have a bearing on the psychological well-being of care recipients. Individuals in more reciprocal relationships and in relationships where they feel respected and valued are less likely to be depressed than their counterparts” (p179).

Understanding how organisational values can underpin a model of care and influence the framework for services has wider application. Before this study, the model of care aligned services according to current government policy that tended to relate resident need to accommodation type. It did not facilitate flexibility across the site or accommodate multiple needs among residents. Staff identified that the lines of demarcation between these sub-populations were becoming increasingly blurred in this resident population and felt residents did not necessarily fit completely into one category. Therefore, services allocated according to accommodation, as is common industry policy and practice, does not always align with resident need. The SMT explored different models of care and the organisation of services to find an alternative model that would better meet the needs of the residents and provide more flexible options for service delivery. Following considerable exploration and reflection, they developed their own model of care. As most services were previously allocated to residents in the care centres, the exploration of a new model of care directed the inquiry to consider a more flexible approach to the delivery of services to residents across the whole site.

Exploration of principles underpinning models of care for this community was an important activity for the SMT. Principles that are frequently cited in long-term care are often borrowed from medical ethics literature and do not necessarily have the same application. Common principles are autonomy, beneficence and paternalism (Carter, 1999). Autonomy implies an act of self-determination and describes the right of the individual to decide about, and be involved in, decisions about care. It implies that the individual is capable of determining for themselves and has the power and ability to follow through on decisions. Recipients of long-term care may not always be able to determine for themselves. The nature of long-term care often assumes a level of dependence and the inability to do for oneself as a need for services.

Residents in this study revealed the importance of relationships to their well-being. Whether in a high care centre or living independently in the village, they identified the importance of being connected to those providing care and /or a service. It was more than the tasks that were involved; people and their relationship with those people (carers) contributed to their quality of life.

The literature also reveals that long-term care has been influenced by a number of other service trends and principles of care over the last decade (Kane, 2001) First, is disability rights, where younger people with a disability have services designed around independence rather than dependence. Services for older people have focussed on their dependence, 'what can't you do for yourself anymore that I must now do', rather than, 'how can your independence be maintained or increased?' Second, it is consumer-directed care. Older people are purchasing services, selecting and engaging the carer who best meets their needs (their choice) and managing their performance, rather than having someone selected and sent to them. Third, housing and services are being unbundled. New forms of housing, assisted living arrangements and new designs in nursing homes are being developed, separated from services.

This means that services should be available regardless of where you live, and that where you live should not dictate the type of services available. Fourth, the culture within organisations is changing, particularly within nursing homes. Rituals and routines are being challenged, the whole person is being considered and residents are allowed to take risks and empowered to make, and be involved in, decisions about their care. Long-term care does not take over the life of an individual or place them outside the full range of human achievements and opportunities. Fifth, the physical environment is receiving attention. Environments that stimulate interest are encouraged, private space is protected, stress is minimised, relationships are encouraged and families are included in care. Assumptions are not made about how an individual wants to live. While some of these initiatives are more commonly seen in nursing homes, they have application in day care centres and within retirement villages.

This study highlights the importance of maintaining independence as an element of quality of life. Residents in the low care centre were keen to maintain a balance between assistance and independence. Residents in the independent living units valued access assistance to enable them to maintain independence longer. However, the idea of maintaining or even increasing independence rather than 'doing' for the individual and maintaining or even increasing dependence, might not sit well with paid carers who feel that 'doing' for others is their job. This concept is explained by

Wilken et al (2002) who sought to identify factors related to late life independence as a measure of quality of life, viewed through the concept of 'locus of control'. A sample of seventy-five functionally independent persons 85 years and over, were interviewed in their own homes. Content analysis was applied to the data. Locus of control emerged as a useful conceptual framework for describing the data that was grouped together as three aspects of locus of control. Internal locus of control involved thoughts and feelings, the things the individual does or has done. External locus of control involved past and present circumstances and powerful others. Integrated locus of control involved a combination of internal and external locus of control and associated factors.

Hudson (2002) expresses the challenge of designing services when he says,

“In a cultural environment that favours productivity and perfection over disability and dependency, in a medical research environment devoted to postponement, if not abolition of old age, is there a place for creative communities where we may age gracefully?” (p 5)

From this discussion, it is apparent that the literature reveals common themes that may guide an organisation to develop a model of care. However, this usually relates to the type of accommodation and services and not to the principles that underpin the way decisions are made, that form the basis of a model of care. If the principles are established first and they reflect the values of the organisation, they can provide a valuable guide for decisions about housing and services. This study provides an example of how the values of this organisation were translated into the principles for a model of care and how these then guided decisions about housing, services and physical and social environment. This approach is not common in the literature and it challenges existing practice by building a model of care based on organisational values first and then developing business structures and systems to support housing and services.

6.3.3 Service framework

There is considerable literature on approaches to service frameworks for the delivery of services to older people. This study necessitated an exploration of the literature and reflection on a number of different approaches that were perceived by the SMT to have relevance and application. Four approaches, with relevance to the findings, are discussed here. Key characteristics were identified, strengths, weaknesses and resource implications noted and possible application within the organisation, were considered in the review.

The first approach was the *On Lok Model*. The name *On Lok* means "place of peace and happiness" in Cantonese and reflects both the roots and philosophy of care (Bodenheimer, 1999). On Lok's mission, as a not-for-profit community organisation, is to provide quality, affordable care services for the well-being of frail elderly. This is done through '*On Lok Senior Health*', a fully integrated health plan that delivers medical and long-term care to those looking for an alternative to a nursing home. It began in the United States in 1971 as one of the country's first day health centers, a place that took care of older adults in the Chinatown, North Beach and Polk Gulch neighborhoods of San Francisco. They received hot meals, health and social services, and supervision, and returned to their homes in the evening. On Lok's goal is to keep members in the community but recognises that not all of its members can remain in their own home without continuous, round the clock support. To accommodate the needs of these extremely frail elders, and to prevent premature nursing home placement, On Lok operates several senior housing facilities. *On Lok House* is a low income senior housing program that is supported by Housing and Urban Development. In addition, On Lok operates (single room occupancy) senior housing buildings. At present, On Lok Senior Health helps older adults maintain their independence by providing all necessary primary and specialty medical care, adult day health care, in-home health and personal care, social work services and hospital and nursing home care. On Lok programs can be found throughout the US and report positive outcomes for older people and for service providers.

In this study, the On Lok approach introduced the concept of a day therapy service as part of the model of care, to provide a holistic, comprehensive package of services

for people who needed residential care, but were not living in a residential care centre. A day therapy centre was determined to be a key feature of the new model.

The second approach to be reviewed was a system of care called *PACE*, Program of All-inclusive Care for the Elderly, a model originally developed in San Francisco's Chinatown – North Beach area by a community agency. It is an adaptation of the On Lok program discussed previously (Gong and McCarthy, 2000; Greenwood, 2001; Larson, 2002; Lee et al, 1998). The centre of the program is the PACE Health Center, an adult day care centre that develops a care program for each individual and provides a range of services implemented by an interdisciplinary team. The clients are frail elderly people, at least 55 years of age, with multiple medical/health problems, assessed as eligible for nursing home care, needing a range of services to enable them to remain outside an institution, either hospital or nursing home. Individuals remain in the community, making the most of community services. This approach has wide application throughout the USA and Canada and in some European countries and reports considerable success, where success is measured in terms of client outcomes as well as cost effective, efficient service provision.

Again, the concept of an adult therapy centre had particular appeal to the SMT and offered a way to provide services across the site and to the wider community. While Day Centres exist in Australia, few offer the comprehensive suite of services identified within this model, nor operate in a true interdisciplinary, holistic model.

The third program to be reviewed was a Canadian program, *SIPA*, providing care for Canada's frail elderly population. *SIPA* stands for 'system of integrated primary care for the frail elderly' (Bergman et. al., 1997). Budget constraints, technological advances and a growing elderly population had resulted in major reforms in health care systems across Canada. This had led to fewer and smaller acute care hospitals and increasing pressure on the primary care and continuing care networks. The present system of care for frail elderly people, who were particularly vulnerable, has fragmentation, negative incentives and the absence of accountability. This in turn has led to the inappropriate and costly use of health and social services, particularly in acute care hospitals and long-term care institutions. Canada needed to develop a publicly managed community-based system of primary care to provide integrated

care for frail elderly people. SIPA is a community-based primary care system based on a patient-focused model, designed to meet the needs of the frail elderly and to assure comprehensive care, integration of all available services and continuity of care by all professionals and institutions involved. This approach had less direct application in this study, but introduced some valuable concepts associated with integration of services and articulation between hospitals and aged care facilities.

The final international approach to be reviewed was the Wellspring Innovative Solutions. This is an example of a partnership, a confederation of 11 freestanding not-for-profit nursing homes in eastern Wisconsin USA, called the Wellspring Alliance (Stone et al., 2002). It has a twofold purpose: to make a nursing home a better place for people to live by improving clinical care provided for residents; and to create a better working environment by giving employees skills they need to do their job, giving them a voice in how their work should be performed and enabling them to work as a team toward common goals.

The multidisciplinary care resource teams are empowered to develop and implement interventions that they believe will improve the care of residents. Evaluation has found that Wellspring successfully and intentionally meshes clinical and culture change together to meet goals. There is also an increase in retention rates of registered nurses and a decrease in turnover. It is not only a model but also a process of organisational change, a phased and deliberate effort by the leaders to rethink how care is provided and how staff relate to each other. Change to organisational culture occurs at unit level and across facilities. At unit level, there is an increased recognition of the importance of the contributions and input of floor staff and maintenance workers. There is also a shift from a hierarchical to a more lateral management structure, in which decision-making is distributed throughout the organisation. Across facilities, there is an increase in collaboration between facilities, to seek counsel and advice from each other.

This study highlights the importance of integrated, flexible services across the three sub-populations of residents, to meet their needs, and moves away from the allocation of services according to accommodation type. The research method enabled an exploration of different, integrated service frameworks within a process

of redevelopment. Several approaches with a focus on integration, the principles of quality of life and maintaining independence, were reviewed. There are some common principles behind this push for more integrated care (Bergman et al., 1997).

They include:

- Standardised assessment and entry criteria;
- A reduction in the collection of repeated information from different providers;
- Funding equity;
- Improvements in communication between professionals and across sectors;
- Agreed standards;
- Encouragement of case management and coordination between providers and professionals;
- Promotion of independence and maximum health with a focus on what you can still do for yourself rather than what has to be done for you; and
- A goal of 'active living' rather than existing until death.

Further review of different approaches by the SMT highlighted that the concept of a day therapy centre, and the interdisciplinary team approach, was particularly relevant to the needs of residents and goal of the organisation. The fourth approach reports attractive outcomes, but as it involves more than one facility/provider, it was considered to have less application. However, the exploration revealed the possibility of sharing expertise and resources with other providers in the future.

There is limited literature that explores approaches within Australia. Attention has particularly been paid to better coordination and integration of care across service sectors. Three examples are reported by Gibson and Griew in the contributing paper, 'New models and approaches to care' for the Myer Report (2002). The 'Bundoora Extended Care Centre' (North Western Health, Melbourne Victoria) focuses on keeping older people in their own homes as long as it is safe and practical, with in-patient beds as a backup. In addition, the Activities of Daily Living Display Centre acts as a bridge into the local community and there is strong liaison with local GPs and Aged Care Assessment Teams. The 'Pacific Care, Baptist Community Services and Hunter Area Health Services' (Hunter Region, NSW) is a traditional care model

that allows older people who are discharged from acute care to regain living skills and independence prior to returning home, or to a low care facility. High care beds are supported through Community Aged Care packages, which allows for flexible care while longer term support arrangements can be made.

The 'Advanced Care in Residential Living' (ACRL) – Adelaide, South Australia is a further example of an innovative Australian model. It is part of the National Hospitals Demonstration Program Phase 4, an initiative of the Commonwealth Department of Health and Ageing, Australian Research Centre for Hospital Innovations program. The program in South Australia involves a partnership between Helping Hands Aged Care, Royal District Nursing Service SA, and the SA Division of General Practice. The purpose is to improve health outcomes for older people living in residential aged care who experience an acute condition requiring hospital care and to reduce the number of days that the person may have to spend in a hospital. With coordination and good communication, the GP can continue to provide the medical care, RNDS district nurses can provide assistant for staff in the residential facility, equipment can be accessed for the facility if it is needed and laboratory and other services can be accessed. The focus is on the aged care sector rather than the acute sector perspective, to minimise the disruption for the older person. This model commenced its trial in March 2003.

The literature on the impact of demographic changes to aged care has been previously highlighted. Part of the process of determining a model of care required consideration of both current and future resident demographics. Understanding projected statistics and related data was revealed as important when determining services for the present and the future. The study enabled an understanding of demographic projections and characteristics of the ageing population in Australia. The literature tells us that the needs of Australia's ageing population are changing (Uniting Care NSW and ACT Ageing and Disability Service, 2002) and the mix and type of accommodation that will be required in the future is likely to change. A number of key characteristics of future older Australians are identified in this report:

- Australians are living longer and older people in the future will be fitter and healthier;
- There will be more who have a non-English speaking background;
- The incidence of dementia is increasing and being diagnosed earlier;

- The incidence of complex illnesses (co-morbidity) is also increasing, however, advances in medical technology and treatment will enable people with disabilities to live longer;
- Baby boomers (born in 1947 on) will be more aware of their rights and have higher expectations of life and aged care;
- There will be more overtly gay and lesbian older people; and
- Information technology will continue to develop and successive generations will be more familiar and at ease with both information and technology.

Following reflection, facilitated by the action research process within this study, the SMT developed a model of care and service framework for the future. The model adopted the eleven domains of quality of life outlined by Kane (2001), as outlined previously. The goals underpinning the model were to:

- Improve and maintain the health of the individual;
- Improve or slow down deterioration of functional ability;
- Meet individual needs for care and assistance;
- Enhance psychological well-being;
- Maximise independence and autonomy;
- Promote meaningful life; and
- Minimise restrictions.

The service framework outlines an *'integrated lifestyle and health status grounded on the visions, mission and values of the organisation'*. A range of services will be available to match resident need, choice and capability, regardless of accommodation location. It addresses the principles of an age friendly environment, ageing-in-place, empowerment of the individual, and social contact and connection. It aims to achieve better articulation with other service sectors.

Services will be provided to support residents with a high level of care need, those with a low level of need, and those with variable, intermittent and/or respite needs. Services will be available across the site within an integrated high and low care facility, serviced apartments, independent/adaptable living units or within a day therapy centre, with services available to residents and individuals living outside the

community. This represents a combination of a number of approaches. The outcome and the process to achieve this evolved over the length of the study and developed within the research process of action and reflection.

The importance of strong business foundations is well documented. The aged care industry brings unique challenges and requirements to this discussion and many of these are highlighted in this study. This study revealed additional critical business factors for this industry and highlighted some of the characteristics and challenges that are faced. In particular, it highlighted the challenge of maintaining a balance between business accountability and social conscience. While the literature recognises that there are two categories of providers, there is little discussion on the unique challenges faced by the labelled not-for-profit category of provider. This study adds considerably to this discussion.

The aged care industry recognises the need for different frameworks for service delivery and types of services, and innovative approaches are documented in the literature. In most cases, services are allocated according to accommodation type and funding category, but the inadequacy of this approach is being increasingly endorsed by aged care providers. Understanding how an organisation elected to build a model of care that was based on organisational values first and how this was used to establish a service framework that would ensure that services were flexible and available according to resident need, not accommodation category, makes a significant contribution to this discussion. The process of redevelopment to achieve this, as well as the challenges that *Choice Village* faced, may encourage others to embark on such projects.

6.4 The change process

The literature on organisational change is diverse and a number of organisational change models have been proposed (Galvin et al, 1999; Schaafsma, 1997; Ardem, 1999; London, 2001; Edwards, 2000; Chenoweth and Kilstoff, 2000). The work of the classical writers in organisational change have concentrated on the ability for growth in capacity and efficiency; however, this notion has been rejected by the human relations theorists, concerned with the social aspects of work and the

individual. The work of Lewin (1938, 1942, 1946, 1948) has embodied this school of thought. Lewin provided a psychological view of the change process and based his model on individual behaviour relating to driving forces and resisting forces of change. Many others have built on the work of Lewin, including Lippitt (1958) and Rogers (1983).

Systems theory adds to an understanding of change by viewing organisations as open systems that interact with the external environment (Emery and Trist, 1969;). This theory explains change as an interaction between external forces and internal adaptations. Social aspects of change and associated organisational behaviour look at the individual's reaction to the complexity of change and resultant organisational behaviour. Organisational change within health care is multifaceted, involving the inter-relationship between key stakeholders (McKee, 1997; Mackie, 2001). Health care organisations are complex systems and change needs to be managed with attention to all stakeholders, including clients and staff. This is evident in this study, where the organisation had to be viewed as a changing system that was influenced by internal and external factors.

The concept of a learning organisation and its relationship to developing a theory of change (Senge, 1990; Trofino, 2000) has gained considerable interest in health care organisations. A learning organisation may be described as one that is skilled at creating, acquiring and transferring knowledge, and modifying its behaviour to reflect new knowledge and insights (Senge, 1990). Learning organisations view change as a process of transformation. Transformational change builds strong organisations that have the ability to continue to change as part of the growth process. Porter-O'Grady (1995) identifies six priorities for transformational change integrating the health professions; building structures around the continuum of care, building services around patient populations; constructing good information architecture; building partnerships with providers along the patient pathway; and developing links to subscribers and/or payer networks.

Changes to the delivery of a system of integrated services by a facility requires transformational change in terms of organisational structure and function, model of service delivery and knowledge and skills of the workforce. Involvement needs to be sought from clients and their families, empowered to participate in organisations and

services. All levels of staff need to be involved in the planning and delivery of services through a cooperative model of management. The impact of change can be monitored and measured in terms of key indicators identified by the organisation, its staff and clients.

Major organisational change usually involves some loss, or at least a perception of loss, by those involved. Organisational change often falters not because the change is wrong but rather, that it is mismanaged. People progress through a transition process, a psychological reorientation, as they accept and adjust to change. Failure to prepare for and manage this period of transition can jeopardise the change, and perhaps the organisation, in the long run. Organisations facing the need for significant change must determine both a direction for such change and a strategy to realise it. A strategy for change may include systems such as structures, policies, processes, training and resource allocation.

The importance of leadership in a change process is clearly revealed in this study and supported by the literature. The leader, or leadership team, has the responsibility to align the change with the organisational purpose and direction and to ensure organisational resources are made available to support the process (Edwards, 2000). The CEO could not be solely responsible for managing the change process. Therefore, the SMT leadership group had to engage in the process themselves before they could assist others to negotiate the change that was proposed. The uniqueness of the process for this particular organisation is highlighted in the steps taken by the SMT to achieve their goals.

Particularly significant elements of the change process highlighted in this study were the commitment and capacity of the Board and the relationship that developed between the Board and SMT. The strategic and operational plans were also important elements, as were the organisational policies, processes and functions. Organisational culture was another key element of the process and the study provides an understanding of both the characteristics of the culture and the process of development to build a 'new' culture. Finally, the redevelopment plan and its evolution to a whole-of-site development plan was an important element of the

change process. This study demonstrates the importance of engaging the key stakeholders in its development.

6.5 Summary of the discussion of the findings in relation to the literature

This study sought to explore the impact and influence of change on an aged care community. Change is a complex process and brings many challenges as well as opportunities for growth and development to an organisation. This study has revealed the key elements and features of a comprehensive change process in an aged care organisation. Major elements specific to the resident population are highlighted, namely, quality of life, empowerment, ageing-in-place and social connection. While there is literature on each of these elements, this study provides a comprehensive analysis of the effect of change on individual elements and how the residents and their quality of life were affected by the redevelopment.

The importance of leadership within an organisation, leadership approaches and behaviours and components of leadership development are also discussed widely in the literature. This study enhances and broadens this discussion in its exploration of leadership as it applies to aged care, particularly as it responds to a future ageing population, as leadership becomes increasingly important.

As an exploration of the literature reveals, organisations sometimes embark on a significant change process with energy, commitment and great ideas, but fail to also ensure that the organisation has the internal capacity to manage the change process. It became apparent in this study that business capability, a model of care and service framework, were three critical elements for organisational capacity and this knowledge adds significantly to the understanding of organisational change in aged care.

Many of the findings of this study are discussed within existing literature along with some of the issues and challenges faced by this aged care organisation, as revealed in this study. The importance of understanding the elements of quality of life for residents and how change impacted on the elements identified as important to well-being can not be underestimated. The literature realises the importance of well-being,

expressed in the study as quality of life, empowerment, ageing-in-place and social connection. However, this study provides a comprehensive understanding of how difficult it is to keep those components in mind during a process of redevelopment and associated change and how this can be achieved. While the literature addresses the concept of ageing-in-place, this study expands the knowledge base regarding the complexities of the concept of ageing-in-place in aged care communities in terms of the potential impact on the individual, their partner/carer and the family.

The literature pertaining to leadership, in particular, values-based leadership, transformational leadership and team development, has been reflected on in relation to aged care. This study highlights particular issues and challenges for leaders in this complex industry and reveals a process of leadership development and strategies that were implemented as part of the research process to strengthen the leadership team. The importance of leadership, as revealed in this study, is supported by the literature but the discussion on the significance of a values-based approach to leadership, built on trust and supported by a transformational orientation, provides additional information.

The importance of establishing capacity for change is a significant finding in this study. The discussion of the literature relevant to those business factors revealed as important for change is limited and this study adds significantly to an understanding of the complexities within this industry. In particular, the balance between business accountability and social conscience, and the importance of a model of care to guide business structures and service frameworks, are not well understood and this study provides an important discussion around these issues.

The challenge of change is revealed through the findings of this study. It highlights particular challenges facing the aged care industry, related to organisational capacity and ability to manage a complex change process. Finally, the findings reveal the capacity of an organisation to engage in an action research process and the positive outcome realised by the organisation in general, as well as the participants. Illustrating the value of action research within the aged care industry, as revealed in this study and its findings, represents a valuable contribution to the literature.

CHAPTER 7 IMPROVING THE EFFECTIVENESS OF AGED CARE

Governments and policy makers face unique challenges within their responsibility to support a growing ageing population. Planning for accommodation and services for a non-homogenous older population with varied needs, expectations, family support and personal situation, is also a challenge for the aged care industry, and increasingly, for the retirement village industry. There is a considerable body of information about the current Australian aged care industry but a limited amount of information on how this industry will change in the future or how those changes will effect the operation of organisations or the delivery of services. Research across the industry is important but, as every aged care community will have unique characteristics, generalisation of information is difficult. This study has attempted to address this within a case study of one aged care community.

Chapter seven presents a discussion on the implications of the key findings from this study and highlights how they may inform the industry and a wider audience. It also reveals aspects of the action research method that was adopted, to highlight the significance and appropriateness of the method in exploring organisational change. The chapter concludes with recommendations for future research.

7.1 Finding solutions to complex problems in aged care

This study chose to engage with one aged care community over an extended period of time to develop a comprehensive understanding of the issues and challenges being faced during a redevelopment process, and the impact and influence of associated changes on the residents, leaders and organisational capability.

The findings reveal valuable information for providers of aged care accommodation and services. They also challenge some of the current principles and practices within the aged care industry by revealing the blurring of the boundaries between current categories – high care, low care and independent living. Alternative approaches involving a model of care and framework for services are revealed and highlight key

criteria to better meet the needs of older people in the future. Aged care providers and retirement village operators should view the findings enlightening if they are progressing down a path of redevelopment or considering the development of new sites.

Private, community and charitable aged care organisations are likely to see relevance and application within the findings. Those responsible for aged care need to ensure that they are aware of, and pay attention to, elements of quality of life as revealed by the resident population. They will also benefit from understanding how change impacts on quality of life and how this organisation addressed the issues and concerns identified by the residents in relation to the redevelopment and change. Many will be aware of the importance of leadership in aged care and how significant leadership is during change. The process of developing leadership behaviour and the preferred leadership approach adopted by this organisation provides insight into this important aspect of organisational behaviour. Many providers will be able to relate to the challenges faced by this organisation as it developed strong business capability and struggled to align business accountability and social conscience, to ensure it had the capacity to cope with the redevelopment process and its future. The implications of the key findings are now discussed in more detail.

7.1.1 Protecting quality of life

Those responsible for existing aged care facilities aim to support residents to maintain a good quality of life. All resident populations are different and, like the resident population that was a participant in this study, present with a variety of needs, expectations, issues and concerns.

The study provides a comprehensive understanding of the elements of quality of life for older people and reveals it as a complex, all-encompassing concept that takes into account physical environment, accommodation, services and social interaction, as well as individual health status and personal situation. While viewed as important by the whole resident population, elements of quality of life varied across the three categories of residents. It was important for the organisation to engage with residents to be able to understand the importance of elements of quality of life to resident sub-

populations and the impact these elements had on demand for accommodation, services, lifestyle and the social connection within the community.

Living in this community brought financial and personal security and safety, opportunity for social interaction, involvement and friendship and, for some, personal assistance and services. It was more than a residential address; rather, it was home and a way of life where residents lived seven days a week, twenty-four hours a day. Activities within the community, particularly those related to change, were viewed personally and the impact of change cannot be underestimated. While not always interested in all aspects of change, residents wanted to be informed and involved in organisational matters that they saw affecting their lifestyle and wellbeing. Attachment to history and past practices was strong with some residents but the majority were able to see the value of the redevelopment and were prepared to trust the administration to look after their current and future needs.

It was important for the SMT to establish ways to engage with residents and create and maintain formal and informal lines of communication and feedback. By building trust and creating ways to listen to residents' views, they were able to monitor the impact of change and keep the resident population informed. The creation of a Residents' Advisory Council, with representation on the Board, was a very successful initiative for residents, the Board and the SMT and made a significant difference to how residents felt they were being considered and included during this period of change. Aged care providers need to be mindful of the significance of understanding the elements of quality of life for their residents and ensure that this is well understood by staff, managers and Board members.

7.1.2 Creating a better model of care and service framework

Providing accommodation, resources, facilities and services calls for good planning and effective structures. The exploration of models of care and alternative approaches to accommodation and service delivery in aged care communities was a major activity for the SMT during this study. The current relationship between services and accommodation is not always appropriate and policy makers need to take into account the fact that demarcation between the three categories of residents, classified by accommodation type and level of funding, were becoming increasingly

blurred in this resident community. Staff also felt that some residents did not necessarily fit completely into one category. This calls for a different approach to funding and service delivery and resulted in the development of a model of care that would give more flexibility to the delivery of services across the community, and was based on resident need. The model became the foundation for a service framework for the future. The process of developing the model and the model itself was a significant outcome of this study. The application of this new model informed the redevelopment across the whole site, particularly in the design of a new combined low and high care centre, and influenced the design of the future community.

This approach and the model of care that was adopted, have implication widely within the industry. It is increasingly difficult to manage service demand within the current funding arrangements while government policy presumes a clearer distinction between high and low care than actually exists in practice, and does not recognise the degree of demand for services that exists among residents living in 'independent' living units.

There are implications for aged care providers and the retirement village industry from this study, in the exploration of the concept of ageing-in-place. Several terms have become common 'language' in aged care, including ageing-in-place, which is relevant to an individual's preference to live independently in his or her own home, rather than enter into residential care. Residents in this study expressed this view and talked about the importance of staying 'out of care' for as long as possible. This is achieved by many older people, but many others find that they need an increasing level of services to enable them to live 'in their own place', provided either by an external agency(s), or by a family member, friend or spouse.

While recognising the relevance of this concept, this study highlights two interesting complications to a preference to age-in-place. First, the spouse, family member or friend who may be providing assistance to enable the individual to live at home, can become increasingly affected by the role and this can progress to a stage where their health is compromised. Second, the person receiving assistance to stay at home feels obligated to 'soldier on' because so many people are helping them, when they may

be feeling exhausted. In both situations, there is a risk of creating feelings of guilt when the situation becomes untenable; 'I failed her because I couldn't cope any longer', or 'I am a failure because I can't cope any longer, even with all this help'. This study alerts the industry to review all situations individually, to recognise when gentle intervention in a situation might be the best outcome for all concerned, and cautions against placing over-riding emphasis on the importance of ageing-in-place when residential care might improve the health status of one or all parties. Balancing the ideals of ageing-in-place with the realities and impact of caring in personal situations is also a message for a wider audience.

7.1.3 Building leadership in aged care

Leadership is critical in change. A key issue in this study was the problem of management and leadership. While much of the literature provides details of the components of these concepts and roles, it became clear in this study that the complexities of the task in an aged care environment required careful attention to the development of leadership behaviour and leadership capability. This required that the SMT engage in a process of continuing reflection and development to acquire the capacity that was needed.

For the residents, this organisation came to life on a day-to-day basis through the senior management team. It was this team that translated the mission and values of the organisation into practice and represented the organisation to the external world. The Board had an important leadership and advisory role that was best realised through a partnership with the executive and senior staff. However, the day-to-day operations of the organisation were the responsibility of the senior management team, not the Board. Individuals on the Board had to adjust to this by adopting a more advisory role with less management influence. This took time, a significant process of learning, adjustment and new roles and responsibilities. The education of members and realignment of roles was revealed as critical to the redevelopment process. Boards and management teams need to invest in the development of leaders and the formation of leadership teams and to recognise the importance of common values and approaches. The industry would benefit from exploring the value of

engaging with education providers to develop programs of learning that pay particular attention to leadership knowledge and skill needed in aged care.

The SMT came to the view that a values-based, transformational leadership approach based on trust, integrity and respect was the preferred leadership model for them. It involved the team learning to translate the mission and values of the organisation into leadership behaviour that would guide their practice and demonstrate 'values-in-practice' to residents and staff. This was critical to the change process and required a process of growth and development for individuals as well as the whole team. It needed a structured leadership development plan that addressed individual needs as well as the needs of the whole team and allocation of time and resources for learning, beyond those that were committed by members in regular management of the organisation. A strong leadership team with common values and direction, particularly when an organisation is embarking on change and redevelopment, was revealed as critical to success. The importance of the team leader, in this case the CEO, with a clear vision of what the organisation wanted to achieve and the skill to facilitate its progress, was revealed throughout this study. However, because of the team approach to leadership and the emphasis that was placed on developing the team, the emphasis was not on the CEO. The importance of this position should not be underestimated and this study revealed how critical this role was and the qualities and expertise that was required, to realise the vision for the future.

Team membership, cohesion and internal interpersonal relationships influenced the progress of this leadership approach and addressing issues and relationships became critical to the management of the redevelopment. The process of resolving differences and issues was challenging but the process itself built trust within the group and facilitated open, honest communication. It also resulted in some change to membership within the team and the creation of new positions and adoption of new roles over time. The result was a competent, confident, cohesive senior team, with clear roles and responsibilities and a commitment to continuing learning and development.

7.1.4 Establishing organisational capacity

This study highlights the importance of effective, appropriate systems, policies and procedures that are essential for organisational performance and critical in an effective change process. Aged care providers like this one operate a complex, multi-faceted business that has grown far beyond the 'cottage industry' mentality of the past. A number of critical steps were identified as important to build organisational capacity to achieve organisational change, as part of the redevelopment. They were revealed to be: education and development of the Board and establishment of rules of governance and contemporary practice; development of an organisational strategic plan and translation of this by the SMT into an evolving operational plan; establishment of effective financial and functional policies, processes and responsibilities across the entire organisation; and implementation of an organisation-wide change management plan through a process of staff education and development. Organisations planning a process of redevelopment and significant organisational change may find this aspect of this study valuable.

There is a unique challenge within this industry, where providers must be able to manage a potential/perceived conflict between business responsibility and social accountability. The industry is artificially divided into sectors: for-profit and not-for-profit. This division brings different attitudes towards the business focus and responsibility among residents/clients, shareholders and the wider community. The pressure of social expectation and social conscience in this industry was revealed. In this study, this community based aged care provider faced a challenge to balance these two positions, so that it could assure its future economic viability. This was a significant shift in organisational culture and was the cause of some disruption and agitation among residents who were unable to see the necessity for change. It also necessitated a change of thinking at Board and organisational level and became a significant success factor in the organisation's growth. This challenge is experienced by many aged care providers and is an issue that warrants further investigation by organisations and policy makers.

The study demonstrates that the aged care sector has limited experience, but growing interest, in clinical and non-clinical evidence based practice. It illustrates possibilities

for collaborative research to facilitate organisational development and innovation. However, the nature of the work makes funding for such partnerships difficult. Government support for innovative approaches to organisational development, recognition of innovation and achievement and research partnerships is very important.

7.2 Facilitating growth and learning: the action research process

Action research provides a mechanism for participative, collaborative investigation. It provides a way for individuals to communicate and interact within a process that encourages and supports inquiry, learning and critical analysis. These behaviours may also be achieved in other ways (Lilford et al, 2003). However, the structure of the research process and its emphasis on reflection and learning from past action, is more likely to encourage individual and organisational growth and development. As a result, it has the ability to generate solutions to practical problems and engage individuals in inquiry and subsequent development.

Action research values the experience and knowledge of all participants. It is this inclusive practice that encourages individuals to become involved and supports them to engage in the research process. It is the philosophical base of empowerment and egalitarianism that leads to a holistic approach to the resolution of problems (Chenoweth, 2003). The success of action research depends on several factors. Participants need to be willing to work together, to commit time and energy, often beyond the usual workload, and to accept the action research process. These factors become the foundations of its success when individuals feel that they own the process and the outcomes.

In this study, it provided tools and processes that could be used to plan, act, analyse and reflect on the many aspects of organisational change. It enabled the organisation, principally the SMT, to reflect on the impact and influence of change that resulted from the process of organisational redevelopment. Action research emphasises the concept of co-researchers and stresses the notion of participation as fundamental to achieving more democratic processes and the realisation of practical, relevant outcomes (Stringer and Genat, 2004).

The action research method enabled an understanding of the complexities and challenges that the organisation faced as it embarked on a process of redevelopment and subsequent change. In particular, it provided:

- A structured process to explore new ideas and information;
- An opportunity for discussion and debate;
- A reason for reflection and review;
- A safe learning environment;
- Individual ownership of decisions and action; and
- A collective ownership of outcomes.

For the SMT, the research process supported their development as leaders as well as the development of the team. It also assisted them to identify and address issues and problems associated with change. The process of planning, collecting data, analysing data, reflection and action provide a structure and process that they applied to routine management behaviour and deliberations, as well as situations that arose through the redevelopment process. Their expertise in using the process to its best advantage grew over time. Individual managers identified value from the process and the structure, while the organisation recognised the value of the process as a facilitator of change.

Action research is 'done with' not 'done to' participants. Knowledge and power is balanced. The researcher may have knowledge of the process but the participants have knowledge of the setting. Action research calls for reflection and analysis of knowledge and action by all participants and consequently, has an educational function. This relationship is one of the strengths of the method. It is also one of the greatest challenges for the researcher. It requires a careful, measured balance between the role of researcher as a member of the 'team' and as a resource to the team because of wider knowledge and experience. As part of the research team, the researcher learns with the group. But the research process itself and inquiry that comes with being in a research role, brings additional learning. The researcher may gain knowledge and understanding and share it with the rest of the team without directing the process. The researcher remains slightly removed from the day-to-day

events of the organisation and there is the potential to 'see' things from a more external point of view. Despite these challenges, action research is a powerful research methodology with particular application in social research.

The role of researcher and common methods of collecting data (interview and focus group) also creates situations where the researcher may be aware of sensitive and/or confidential individual or organisational information. The researcher needs to be sensitive to this, maintain confidentiality at all times and be non-judgemental. The 'weight' of information can, at times, become heavy and the researcher needs mechanisms for debriefing and personal reflection. The nature of the action research process usually means extended periods of contact with the organisation and research team. In this study, the researcher was seen to be part of the SMT and therefore included in, and aware of, organisational activities, conflicts and issues. While this enhances the quality of the research, it places additional responsibility on the researcher. The closure of the relationship that develops also needs to be managed to include a planned process of withdrawal at the completion of the study. This may be as hard for the researcher as it is for the organisation.

Aged care organisations are facing a period of significant growth and development and it will be important to monitor and record this progress. Resource implications in this industry often mean that research is not viewed as an essential activity even though there is increasing recognition of the importance of evidence-based practice. Action research provides an opportunity for aged care providers to engage in research that facilitates growth and development while at the same time, enhancing the literature and strengthening the industry's research base.

This community has recognised the need for further research and has continued with several aspects of the research process, now incorporated into organisational development and practice. The organisation continues to monitor the impact and influence of change on the resident population and staff as the redevelopment continues, through ongoing communication and feedback processes. The practice of reflection and the cyclic action research process has been continued by the SMT. It is recommended that similar research be supported and encouraged more widely in the

aged care sector to further the understanding of the complex issues associated with this sector.

There is need for further research into the impact of the ageing population on the demand for, and use of, aged care accommodation and services. It is recommended that further exploration into alternative models of care and service frameworks that will facilitate the flexible delivery of a range of services across sectors, according to need, be encouraged

7.3 Concluding remarks

Within a highly regulated and continually monitored industry, efficient and effective aged care providers need good leadership and efficient ways to manage their organisations, while providing quality care and a range of flexible services for their residents. Policy makers and the industry will benefit from a detailed understanding of the dynamics, challenges and complexities that are being faced. This study is an example of this, extending the body of knowledge that speaks to the issues and provides policy makers, service providers and leaders with increased clarity about the factors involved and the process that needs to be engaged.

As the study makes strikingly clear, an aged care facility is not just a business. It is a home where the residents, regardless of personal situation and level of need, seek to maintain a quality of life, engage in meaningful activity and maintain social connections in accommodation that is appropriate. This brings about unique, important challenges for providers within the industry, challenges that are not necessarily well understood by government or consumers. Clearly, there are many examples of effective aged care organisations today, but it is also clear that there is a need to explore how a projected ageing population in the future, who may have different needs and expectations, will impact on the industry and how their needs can best be met.

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Appendices

Appendix 1 Independent Living Unit Resident Survey 2002

NB. Document is modified to de-identify the organisational

Independent Living Quality Of Service Evaluation Survey 2002

This survey aims to evaluate the quality of the services that are provided at this organisation. We would like to know how satisfied you are with the services and facilities that are available to you. **There are no right or wrong answers** – we want to hear from everyone and all answers are important. There is also space provided for you to make additional comments or suggestions at the end of each section of the survey. You may answer anonymously.

Please tick the box that best represents your opinion of the given statement. **Tick ONE box only for each statement.**

PART ONE

ADMINISTRATION SERVICES	
1. The current Administration hours of 8.30am – 5.00pm Monday to Friday are satisfactory	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
2. Staff members are welcoming, polite and helpful	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
3. If a staff member is unable to assist me, they help me to redirect my query to the relevant person	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
4. I am satisfied with the level of service provided by Administration	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
5. Residents are provided with enough information to keep them informed about what is happening within this organisation	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
6. Residents are provided with enough opportunity to share their thoughts, ideas and feedback with Management	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
7. I feel comfortable approaching staff or management if I have a question or concern	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
8. I am satisfied that staff do everything in their power to assist me to resolve my question or concern	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree

	<input type="checkbox"/> Strongly Disagree
9. On average I wait less than 5 minutes for service	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
10. On average I wait between 5- 15 minutes for service	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
11. On average I wait more than 15 minutes for service	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

We are interested in your comments or recommendations on how we can improve **ADMINISTRATION SERVICES**. Please give us your ideas in the space below:

OTHER VILLAGE SERVICES	
12. I am satisfied with the level of support and assistance I receive as an independent living resident of this organisation	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
13. I find the Resident Support Services staff friendly and courteous	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
14. I feel safe within the village with the current level of security	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
15. I feel comfortable contacting Security if I feel unsafe or have an incident to report	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
16. I find the security officers helpful and courteous	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
17. I believe the security officers carry out their duties to a satisfactory level	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
18. I know who to contact if I require assistance after hours	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
19. I know which phone number to call if I require assistance or medical attention	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree

	<input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
20. I know who to contact if I require assistance with transport	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
21. I think my unit is maintained to a satisfactory standard	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
22. I find the maintenance staff helpful and courteous	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
23. When a maintenance request is carried out, is it handled in an efficient and satisfactory manner	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
24. I am satisfied with the length of time it takes to process a request for maintenance service	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
25. I find the gardening contract staff helpful and courteous.	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
26. I am satisfied with the length of time it takes to process a request for gardening service	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
27. When a gardening request is carried out, is it handled in an efficient and satisfactory manner	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
28. I am satisfied with the services of the Grocery Store	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
29. I am satisfied with the services of the Hairdresser/Beautician	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
30. I am satisfied with the services of the Op Shop	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
31. I am satisfied with the services of the Medical Centre	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

32. I am satisfied with the services of the Podiatrist	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
33. I am satisfied with the Pharmacy Collection service	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
34. I am satisfied with the services of the library	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
35. In general the all staff are helpful and friendly	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
36. The opening hours of the services referred to in the above statements meet the needs of the residents	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

We are interested in your comments or recommendations on how we can improve **OTHER VILLAGE SERVICES**. Please give us your ideas in the space below:

COMPLAINTS RESOLUTION	
37. I know who to contact if I have a complaint	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
38. Complaints are handled by staff in a helpful manner	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
39. I am listened to if I bring a complaint to the attention of Administration	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
40. Administration responds to a complaint in a fair and open manner	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
41. I have frequent complaints about the services and facilities at this organisation	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
42. I have occasional complaints about the services and facilities at this organisation	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree

	<input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
43. When I have had a complaint it has been resolved to my satisfaction	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
44. The guidelines for resolving complaints are clear	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
45. Management listens to my complaints without judgment	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

We are interested in your comments or recommendations on how we can improve the **COMPLAINTS RESOLUTION PROCESS**. Please give us your ideas in the space below:

RECREATION/LIFESTYLE SERVICES & FACILITIES	
46. I use the J P Stratton Centre	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
47. I am satisfied with the activities held at the J P Stratton Centre	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
48. I use the coffee lounge facilities on the second floor of the Administration building	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
49. I attend events at the Auditorium	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
50. I use the recreational facilities within the village for personal use	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
51. I use the recreational facilities for meetings as a member of a club	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
52. I am a member of a club or group	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely

	<input type="checkbox"/> Never <input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
53. I am satisfied with the current level of events and activities	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
54. I find information about events and activities within the village is readily available	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
55. I am satisfied with the yearly calendar of events organised by the Social Club	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
56. I know who to contact if I want to join a club or group	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
57. I think the <i>Tidings</i> is informative and easy to read	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
58. I know who to contact if I want to submit an article for the <i>Tidings</i>	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
59. I read the <i>Tidings</i> when it is circulated	<input type="checkbox"/> Regularly <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Never
60. I would like to receive the <i>Tidings</i> via email My email address is: _____	

We are interested in your comments or recommendations in how we can improve **RECREATION/LIFESTYLE SERVICES & FACILITIES**. Please give us your ideas in the space below:

PART TWO

We are interested to hear further suggestions you may have on how Independent Living Services can be improved. Please give us your ideas under the following headings.

64. What additional services would you like to see within this organisation?

65. What clubs or activities groups are you involved with?

66. What other clubs or activity groups would you like to see established in the village?

67. How could the recreational facilities/activities be improved?

68. Do you attend the dining room for your midday meal?

Yes No

69. How often do you utilize this service?

- Everyday
- More than once a week
- On weekends only
- Occasionally

70. How often would you use this service if meals were more readily available in a convenient location in the village?

- Everyday
- More than once a week
- On weekends only
- Occasionally

PART THREE

There has been a lot happening within this organisation this year. We would like to know how you have been affected by the changes.

CHANGES TO THIS ORGANISATION IN 2002	
71. The changes will improve my lifestyle	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
72. The changes are being managed well by Administration	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
73. The changes have been explained well	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

74. I feel less concerned about the changes	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
75. I feel more positive about my future at this organisation	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

76. For residents who have been relocated to alternative accommodation as a result of the REDEVELOPMENT OF THIS ORGANISATION: We are interested in your comments or recommendations in how we can improve the relocation process. Please give us your ideas in the space below:

77. Is there anything else about the changes occurring within the village that you would like to comment on?

If you would like to talk with staff regarding any aspect of life here, please provide your telephone number.

My Name is:

My telephone number is:

Thank you very much for taking the time to answer this survey.

Your feedback is very valuable to us.

Appendix II: Independent Living Unit Resident Survey 2003

Independent Living (Village) quality of service evaluation survey 2003

Your feedback in the 2002 survey was very helpful to us. Now, we would like you to complete this survey for us, for 2003. The survey aims to evaluate the quality of the services that are provided at this organisation. We would like to know how satisfied you have been with the services and facilities that are available to you in 2003. Curtin University has been engaged to help us with the survey. The University will receive the returned surveys directly, will analyse your responses and provide us with a report. This means that your responses can be confidential.

There are no right or wrong answers – we want to hear from everyone and all answers are important.

You need to select **ONE** response from the code below for each question:

- SA STRONGLY AGREE**
- A AGREE**
- D DISAGREE**
- SD STRONGLY DISAGREE**

Please read each question and **MARK THE BOX (✓)** that indicates your answer for that question. **For example**

	SA	A	D	SD
There is sufficient parking on site for visitors	✓			
I am satisfied with the times that transport is available			✓	

There is also space at the end of the survey for you to make additional comments or suggestions or to ask for more information. You may answer anonymously or if you would like us to contact you, please write your name and telephone number in the space provided on the last page of this form.

If you would like someone to help you complete the survey, PLEASE CALL US ON 6250 0000 and we will come to your unit.

Please complete the survey, place it in the post-paid envelope and post to Curtin University. Or, you can place it in the sealed box provided at the Administration desk. **PLEASE COMPLETE AND RETURN BY DECEMBER 5TH**

ADMINISTRATION SERVICES	SA	A	D	SD
The current administration hours of 8.30 – 5.00 Monday to Friday are satisfactory				
I am satisfied with the quality of service provided by administration staff				
I feel comfortable approaching staff if I have a question or problem				
I am satisfied with the length of time it takes for me to				

be attended by administration staff				
Residents are provided with enough information to keep them informed about what is happening within this organisation				
Residents are provided with enough opportunity to share their thoughts, ideas and concerns with management				
I am comfortable approaching management if I have a question, issue or concern				
I am satisfied with the way the Resident Advisory Council is working				
I am satisfied that I have enough opportunity to share my thoughts, ideas and concerns with the Resident Advisory Council				
I am satisfied with the feedback I get from the attendance of the Resident Advisory Council on the Board				
GENERAL VILLAGE SERVICES	SA	A	D	SD
I feel safe within the Village				
I am satisfied with the level of security in the Village				
I feel comfortable contacting security if I feel unsafe, need assistance or have an incident to report				
I know who to contact if I have a security concern				
I know who to contact if I require assistance with transport				
I am satisfied with the transport service that is provided				
I am satisfied with the access to transport services available for me				
I am satisfied with the maintenance service				
I am satisfied with the gardening service				
I am satisfied with the services of the Grocery Store				
HEALTH & SUPPORT SERVICES	SA	A	D	SD
I am satisfied with the Resident Support Services that are available				
I am satisfied with the information about services that are available to me as a resident				
I would like access to housekeeping services if I need it				
I would like access to personal care services if I need it				
I would like access to a meal services if I need it				
I am satisfied with the services of the Hairdresser/Beautician				
I am satisfied with the services of the Podiatrist				
I am satisfied with the services of the Medical Centre				
I am satisfied with the Pharmacy collection service				
I am satisfied with the services of the Op Shop				
I am satisfied with the services of the library				
I am satisfied with the information that is available				

about community services outside the Village				
I know who to contact if I want information about health or support services				
I am satisfied with the way the Volunteer service is managed				
I think more people are interested in being a Volunteer				
I think Volunteers are necessary in the Village				
RECREATION & LIFESTYLE SERVICES	SA	A	D	SD
I am satisfied with the current level of activities and events				
Information about activities & events is readily available				
The club(s) I am interested in are available				
I would like more choice of clubs				
I know who to contact if I want information about activities & events				
I think <i>Tidings</i> is a good way to circulate information				
I am satisfied with the content of <i>Tidings</i>				
I know who to contact if I want to submit something for <i>Tidings</i>				
I am satisfied with the events that are held in the auditorium				
I am satisfied with the events that are held in the J P Stratton Centre				
I would support the introduction of a Pet Management Policy to allow residents to have pets with them in the village				
COMPLAINTS AND ISSUES	SA	A	D	SD
I know who to contact if I have a complaint				
Complaints and concerns are handled well				
Complaints and concerns are handled in a fair and open manner				
If I have had a complaint, it has been resolved to my satisfaction				
The guidelines for dealing with complaints and concerns are clear				
CHANGES TO SWAN VILLAGE	SA	A	D	SD
I have been kept informed about the building developments in the Village				
I have had an opportunity to contribute my ideas and/or concerns about developments in the Village				
I am unhappy about the developments in the Village				
I am happy about the developments in the Village				
I feel my future in the Village is secure				
I feel my future in the Village is not secure				
I feel my needs will be met in the future				

I like the design of the new units				
------------------------------------	--	--	--	--

COMMENTS

Please make any further comments here.

Name:

Telephone Number:

Thank you very much for completing this survey. Your comments are very valuable.

Appendix III: Independent Living Unit Resident Survey 2002 and 2003: Comparison of Results

The 2002 survey comprised a total of 77 questions and also provided opportunity for individual comments for each section. The 2003 survey was shortened to a total of 53 questions and provided opportunity for individual comment at the end of the survey.

Some questions remained the same for both surveys, however, some questions were combined, some were eliminated and some new questions were included in the 2003 survey. Therefore, comparison of results was not possible with all questions. Residents were asked to select a response to each question, from a Likert Scale of, SA (strongly agree), A (agree), D (disagree) and SD (strongly disagree).

The surveys asked questions in the following categories:

Administrative services

Complaints and issues

Health and support services

Recreation and lifestyle services

General (Other) Village services

Changes to Swan Village.

Using SPSS, questions within both surveys was analysed for frequencies, mean score and standard deviation. Reports were compiled for: Individual analysis for the 2002 survey; Individual analysis for the 2003 survey; Comparative analysis of both surveys (where possible).

Qualitative data (individual comments) was recorded verbatim and reviewed to identify additional issues/areas of concern.

Comparative analysis is presented in a table that compares results for questions within each section. Where necessary, results from individual questions in the 2002 survey have been placed in different sections, according to the 2003 survey, to allow comparison. Results show Mean and Standard Deviation for each question (where appropriate).

The response rate was:

2002	695 distributed	392 returned	56% response rate
2003	660 distributed	238 returned	36% response rate

Summary comments by section

Administrative Services

Overall satisfaction remains high (strongly agree or agree);
Small shift up in mean in Q8 - 'comfort approaching management if I have a question, concern or issue' indicates slightly 'less satisfied'.

Complaints and Issues

Slight shift up in mean in all questions indicating less satisfaction with knowledge of and handling of complaints.

Guidelines appear not to be clear to some residents.

Larger numbers of 'missing' responses were accompanied by comments that indicate the resident had not had a complaint and therefore did not have knowledge of the system.

Health and Support Services

High level of satisfaction with all services (strongly agree, agree), consistent with 2002 results.

Significant interest in 'additional services' if they were available, not asked in 2002.

Recreation and Lifestyle Services

Overall general satisfaction with activities and events within the Village. There seems little interest in additional clubs, with Q30 mean of 2.53. Questions about the *Tidings* were different in 2003, but the general satisfaction with the *Tidings* continues to be high.

The pet policy question (Q38) polarised the population, however, there was a clear trend toward a negative position on pets in the Village with a mean. 2.77. For interest, total statistics were:

Strongly Agree 48 = 21.6%

Agree 42 = 18.9%

Disagree 44 = 19.8%

Strongly Disagree 88 = 39.6%

Missing 16

Total Responses 222

General Village Services

Overall, 78.4% of residents feel safe within the Village (strongly agree or agree), with 62.8% satisfied with the level of security within the Village. Most respondents know whom to contact if they have a concern and feel comfortable contacting security after hours.

Residents are very satisfied with the Swanmobile.

Residents are relatively satisfied with maintenance services but less satisfied with the gardening services.

Changes to Swan Village in 2003

Questions in 2002 were different and cannot be compared to responses in 2002.

81.8% (mean = 2.10) feel they have been kept informed of building developments; 66% (mean = 2.16) felt they had an opportunity to contribute; 61% (mean = 2.45) are happy with the developments. 73% (mean = 2.13) feel their future is secure, and 70% (mean = 2.27) feel their needs will be met in the future.

36.7% (strongly agree, agree) like the design of the new units, with 19.6% do not (strongly disagree or disagree). However, many residents indicated they had not looked at the designs, or did not feel they were relevant to them.

Individual comments

All individual comments were recorded verbatim. In total, 123 residents made individual comments, and some were anonymous. The comments were not analysed, but those that

warrant a response (question asked) were highlighted. There was no significant data within the comments.

In summary, this survey in 2003 has again indicated that a large number of ILU Residents are satisfied with the Quality of Service provided by the organisation. However, there is always room for improvement and I am sure the management team will use the data wisely.

Report: Key [1 = Strongly Agree, 2 = Agree, 3 = Disagree, 4 = Strongly Disagree]

Question	Mean	N (valid resp)		
	2002	2003	2003	
Administration Services				
1	1.74	1.75	385	237
2	1.86	1.93	368	237
3	1.86	1.81	377	232
4	1.86	1.84	377	230
5	2.10	2.12	372	227
6	2.09	2.16	363	226
7	1.86	2.02	377	228
8 Resident Advisory Council		1.97	0	213
Complaints and Issues				
9	1.97	2.03	330	227
10	1.93	2.16	292	203
11	1.97	2.11	275	197
12	2.02	2.19	248	191
13	2.11	2.22	246	209
Health and Support Services				
14	1.95	2.37	367	237
15	1.79	2.14	368	226
16 Additional house/gard services		1.86	0	212
17 Additional personal care services		1.82	0	222
18 Additional meal services		1.78	0	214
19	1.69	1.84	281	191
20	1.75	1.80	224	170
21	1.76	1.90	280	174
22	1.45	1.49	274	194
23	1.53	1.59	305	208
24	1.67	1.59	269	193
25 Community services outside the Village		2.21	0	204
26	1.85	2.01	379	218
Recreation and Lifestyle Services				
27	2.07	1.75	356	219
28	1.86	1.82	345	222
29 Clubs interested in are available		1.82	0	211
30 More clubs		2.53	0	180
31	1.88	2.00	323	216
32 Volunteer		2.00	0	210
33	1.71	1.67	364	227
34 Content of Tidings		1.86	0	224
35	1.99	1.92	318	209
36 Events in the auditorium		1.84	352	221
37	2.16	1.93	196	198
38 Pet policy		2.77	0	222
General Village Services				
39	1.95	2.11	374	231
40	1.95	2.31	374	226
41	1.82	1.81	368	231
42	1.87	1.85	378	226
43	2.16	2.17	323	207
44 Swanmobile		1.72	0	213
45 Level of transport available		1.91	0	212
46	1.70	1.91	371	229
47	2.15	2.42	256	220
Changes to Swan Village				
48 Kept informed about building developments		2.10	0	220
49 Opportunity to contribute		2.36	0	191
50 Happy about developments		2.45	0	209
51 Future is secure		2.19	0	221
52 Needs will be met		2.27	0	208
53 Like design on new units		3.49	0	237

Appendix IV: Staff Survey 2002

Staff Satisfaction Survey 2002

Thank your for completing this questionnaire. All questions relate to you as an employee of this organisation. Please answer the following questions in a careful and honest manner. THEN, PLEASE RETURN YOUR QUESTIONNAIRE TO ONE OF THE COLLECTION POINTS IN THE ENVELOPE PROVIDED BEFORE xx

PLEASE ANSWER THE FOLLOWING QUESTIONS BY PLACING A TICK (✓) IN THE CIRCLE OR BY WRITING IN THE SPACES PROVIDED. IF YOU FEEL A QUESTION IS NOT RELEVANT TO YOU PLEASE MARK NR NEXT TO THE QUESTION

PART ONE	GENERAL INFORMATION	KEY	Office use only
I have worked in aged care	Less than 6 months 7-12 months More than 1 year & up to 2 years More than 2 years & up to 4 years More than 4 years & up to 6 years More than 6 years	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I have worked in health care <u>other than</u> aged care	Not at all Less than 6 months 7-12 months More than 1 year & up to 2 years More than 2 years & up to 4 years More than 4 years & up to 6 years More than 6 years	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
What other area(s) of health care have you worked in? Please tick ALL that apply.	No other areas Public Hospital Private Hospital Community Centre Doctors Surgery Home Nursing Other	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I have worked for this organisation for	Less than 6 months 7-12 months More than 1 year & up to 2 years More than 2 years & up to 4 years More than 4 years & up to 6 years More than 6 years & up to 10 years More than 10 years	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I am employed	Full time Part time Casual	<input type="radio"/> <input type="radio"/> <input type="radio"/>	

I am employed as a	Registered Nurse Enrolled Nurse Personal Care Assistant Cleaner Laundry Assistant Catering/kitchen Assistant Administrative Officer Support Staff (maintenance, gardener) Senior Manager Other (please explain)	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I work MAINLY in	Waminda Tandara Ningana Administration Independent Living Units Administration Centre Other (please explain)	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The <u>highest</u> level of education I have achieved is	No formal schooling Primary School Year 8/9/10 High School Year 11 (fourth year) High School Year 12 (fifth year) High School TAFE Certificate or diploma Trade apprenticeship/certificate Hospital Nursing Certificate/Diploma Bachelor degree or equivalent Postgraduate qualification	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I am	Under 20 years 21-30 years 31-40 years 41-50 years 51- 60 years over 60 years	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I am	Male Female	<input type="radio"/> <input type="radio"/>	
My first language is (eg, English, Chinese)	My first language is -		
I also speak other languages. Please list them	1. 2. 3. 4.		
PART TWO	EMPLOYMENT CONDITIONS		
In most weeks, I work at The organisation	Less than 10 hours 11-20 hours 21-30 hours 31 or more hours	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	

Most weeks I work mainly	Monday to Friday day shift Monday to Friday evening Monday to Friday night shift Weekend day shift Weekend evening shift Weekend night shift Combination of shifts	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
On average, how many hours of paid over time do you work each week (more than you are rostered)?	0-5 hours 6-10 hours 11-15 hours 16-10 hours more than 20 hours	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
Despite the time I spend at work, I still take work home with me	Yes No	<input type="radio"/> <input type="radio"/>	
On average, how many hours of unpaid work do you do at home per week?	0-5 hours 6-10 hours 11-15 hours 16-10 hours more than 20 hours	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
My pay & conditions meet my needs	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I would like more flexibility in my employment	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
There are opportunities and challenges in my work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
There are policies and procedures to assist me in my work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
On average, there are sufficient staff to enable me to do my work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation has an effective Employee Assistance Program	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	

There is discrimination (age, sex, gender, culture etc) in my workplace	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I experience discrimination in my workplace	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I experience harassment &/or bullying in the workplace	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In 2002, incidents of harassment &/or bullying have been handled effectively	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
PART THREE	JOB SATISFACTION		
In general, I am satisfied with my job	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In general, the physical working environment in the location where I work is good	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I have access to the equipment I need to do my job	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In general, I feel supported in my work place	Strongly agree Agree Neither agree or disagree Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In general, my work place is safe	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In my place of work I feel part of a team	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	

I have access to the information I need to do my job	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In general, there are no communication problems in my place of work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I feel I make a contribution to this organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
On most days, I am satisfied with my work load	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
On most days, I am satisfied with the pressure of my job	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
On most days I am satisfied with the quality of care the residents receive	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I feel valued by other staff in this organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I feel valued by residents in this organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I fell valued by management in this organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I fell my views are listened to	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
PART FOUR	ORGANISATIONAL CULTURE		

Staff behave according to the beliefs & values of the organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
Management behaves according to the beliefs & values of the organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation has reasonable expectations of its staff	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation recognizes individual staff for the contribution they make	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation values staff from different cultures and backgrounds	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I support providing work opportunities for people from different cultures & backgrounds	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I support providing work opportunities for people from Nyandi	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation rewards its staff	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation meets the needs of its residents most of the time	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation meets the needs of the families of residents most of the time	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	

The organisation has a strong senior (executive) management team	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
The organisation has strong leaders	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I have confidence in the leadership within the organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
Which of these words BEST describe the culture of the organisation (you can tick more than one word)	Caring Honest Fair Trusting Judgmental Blaming Supportive Warm Open Unfriendly	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
PART FIVE	GENERAL HEALTH		
I am able to cope with my work most of the time	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months, I have had emotional symptoms caused by stress at work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months, I have had physical symptoms caused by stress at work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months, I have had to seek help because of stress at work	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months I have had more sick leave than usual	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	

In the past 12 months I have used more substances than usual due to stress at work (e.g. over eating, cigarettes, medicines, alcohol)	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
The stress I have at work is unresolved	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
On most days I look forward to going to work	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
In the past 12 months the stress of my work has had a negative effect my family	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
When I am stressed by a work situation I can get support from colleagues	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
In the past 12 months there has been too much change in The organisation	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
In the past 12 months change has been managed well	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
In the past 12 months the reasons for change have been communicated well	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
I find change a positive experience	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	
In the past 12 months, change has been too sudden	Strongly agree Agree Uncertain Disagree Strongly disagree	0 0 0 0 0	

In the past 12 months I have had support to deal with the change	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months the change has had a negative effect on my job satisfaction	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months the change has had a negative effect on resident care	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
In the past 12 months the change has had a negative effect on staff satisfaction	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
PART SIX	EDUCATION & DEVELOPMENT		
I have a current job description	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
My job description matches my role	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I understand what is expected of me in my role	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I have the knowledge & skills needed for my role	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I receive regular feedback on my performance	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	
I have adequate opportunity to attend education in work time	Strongly agree Agree Uncertain Disagree Strongly disagree	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	

<p>In Which of the following CLINICAL topics would you like to have more education? Please rate the topics in order of importance where (1) is the MOST IMPORTANT</p>	<p>Dementia Care planning Medications and older people Managing wounds Dysphagia (swallowing difficulties) Dysphasia (speech difficulties) Special diets and nutrition Continence Palliative Care Sexuality & intimacy in older people Complimentary therapies Multiple sclerosis Parkinson's disease Strokes Vision and hearing loss</p>	<p><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	
<p>Please list any OTHER topics you would like included in the next 12 months – please print</p>	<p>1. 2. 3. 4. 5.</p>		

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE

Appendix V: Staff Survey 2002: Summary of Results

Responses by employment classification: response rate =22%

Classification	Total	Response
Registered Nurse	25	8
Enrolled Nurse	33	2
PCA/AIN	86	14
Hotel Services (cleaner/laundry, catering/kitchen)	95	16
Administrative	18	8
Support (gardener, maintenance)	11	8
Senior Management	8	8
Allied Health	2	2

Part One – General Information

Years worked in aged care

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	1.6	1.6	1.6
not at all	3	4.8	4.8	6.5
up to 1	6	9.7	9.7	16.1
more than 1 less than 2	5	8.1	8.1	24.2
more than 2 less than 4	10	16.1	16.1	40.3
more than 4 less than 6	9	14.5	14.5	54.8
more than 6	28	45.2	45.2	100.0
Total	62	100.0	100.0	

Years worked in health care

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	1.6	1.6	1.6
less than 6 months	6	9.7	9.7	11.3
up to 1 year	5	8.1	8.1	19.4
more than 1 less than 2	2	3.2	3.2	22.6
more than 2 less than 4	8	12.9	12.9	35.5
more than 4 less than 6	7	11.3	11.3	46.8
more than 6	33	53.2	53.2	100.0
Total	62	100.0	100.0	

Other health care areas worked

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	5	8.1	8.1	8.1
none	21	33.9	33.9	41.9
hospital	16	25.8	25.8	67.7
community	1	1.6	1.6	69.4
doctor surgery	3	4.8	4.8	74.2
home	5	8.1	8.1	82.3
other	1	1.6	1.6	83.9
hospital and home	7	11.3	11.3	95.2
multiple	3	4.8	4.8	100.0
Total	62	100.0	100.0	

Years worked at Swan Village of Care

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid less than 6 months	4	6.5	6.5	6.5
up to 1 year	10	16.1	16.1	22.6
more than 1 less than 2	9	14.5	14.5	37.1
more than 2 less than 4	11	17.7	17.7	54.8
more than 4 less than 6	8	12.9	12.9	67.7
more than 6	20	32.3	32.3	100.0
Total	62	100.0	100.0	

Employment status

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	1.6	1.6	1.6
full time	28	45.2	45.2	46.8
part time	24	38.7	38.7	85.5
casual	9	14.5	14.5	100.0
Total	62	100.0	100.0	

Employment classification or position

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	2	3.2	3.2	3.2
RN	8	12.9	12.9	16.1
EN	3	4.8	4.8	21.0
PCA	11	17.7	17.7	38.7
cleaner or laundry	6	9.7	9.7	48.4
catering or kitchen	2	3.2	3.2	51.6
hotel services	8	12.9	12.9	64.5
administration centre	8	12.9	12.9	77.4
support staff	4	6.5	6.5	83.9
senior manager	8	12.9	12.9	96.8
allied health	2	3.2	3.2	100.0
Total	62	100.0	100.0	

Main area (location) of work in Swan Village of Care

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid did not nominate	1	1.6	1.6	1.6
waminda	14	22.6	22.6	24.2
tandara	15	24.2	24.2	48.4
ningana	8	12.9	12.9	61.3
ningana and tandara	19	30.6	30.6	91.9
administration centre	2	3.2	3.2	95.2
all	3	4.8	4.8	100.0
Total	62	100.0	100.0	

Highest level of education achieved

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid .00	1	1.6	1.6	1.6
year8/9/10	8	12.9	12.9	14.5
year 11	6	9.7	9.7	24.2
year 12	8	12.9	12.9	37.1
TAFE certificate	12	19.4	19.4	56.5
apprenticeship	5	8.1	8.1	64.5
hospital diploma	11	17.7	17.7	82.3
bachelor degree	8	12.9	12.9	95.2
postgraduate	3	4.8	4.8	100.0
Total	62	100.0	100.0	

Age group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	1.6	1.6	1.6
	under 20 years	7	11.3	11.3	12.9
	21-30 years	3	4.8	4.8	17.7
	31-40 years	8	12.9	12.9	30.6
	41-50 years	18	29.0	29.0	59.7
	51-60 years	21	33.9	33.9	93.5
	over 60 years	4	6.5	6.5	100.0
	Total	62	100.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	1.6	1.6	1.6
	male	18	29.0	29.0	30.6
	female	43	69.4	69.4	100.0
	Total	62	100.0	100.0	

First (family) language

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	2	3.2	3.2	3.2
	english	55	88.7	88.7	91.9
	asian	2	3.2	3.2	95.2
	european	2	3.2	3.2	98.4
	5.00	1	1.6	1.6	100.0
	Total	62	100.0	100.0	

Other language spoken

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	45	72.6	72.6	72.6
	one other language	9	14.5	14.5	87.1
	two other languages	3	4.8	4.8	91.9
	three other languages	3	4.8	4.8	96.8
	4.00	1	1.6	1.6	98.4
	5.00	1	1.6	1.6	100.0
	Total	62	100.0	100.0	

Part Two – employment conditions

Hours worked per week

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	less than 10	3	4.8	4.8	4.8
	11-20	7	11.3	11.3	16.1
	21-30	10	16.1	16.1	32.3
	31 or more	40	64.5	64.5	96.8
	9.00	1	1.6	1.6	98.4
	34.00	1	1.6	1.6	100.0
	Total	62	100.0	100.0	

Rostered hours worked per week

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	mon-friday day	33	53.2	53.2	53.2
	mon-friday evening/night	3	4.8	4.8	58.1
	weekend day/evening	3	4.8	4.8	62.9
	combination	22	35.5	35.5	98.4
	6 00	1	1.6	1.6	100.0
	Total	62	100.0	100.0	

Hours of paid overtime worked per week

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	6.5	6.5	6.5
	0-5	51	82.3	82.3	88.7
	6-10	4	6.5	6.5	95.2
	11-15	1	1.6	1.6	96.8
	16-20	1	1.6	1.6	98.4
	5.00	1	1.6	1.6	100.0
	Total	62	100.0	100.0	

Hours of work taken home per week

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	1	1.6	1.6	1.6
	yes regularly	5	8.1	8.1	9.7
	yes sometimes	18	29.0	29.0	38.7
	no	38	61.3	61.3	100.0
	Total	62	100.0	100.0	

Hours of unpaid work per worked

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	35	56.5	56.5	56.5
	0-5	21	33.9	33.9	90.3
	6-10	3	4.8	4.8	95.2
	11-15	1	1.6	1.6	96.8
	16-20	2	3.2	3.2	100.0
	Total	62	100.0	100.0	

Part three – job satisfaction

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Pay and conditions meet needs	62	1.00	4.00	2.4355	.78136
Like more flexibility in employment	62	.00	4.00	2.3387	.82866
Opportunities & challenges in my work	62	1.00	4.00	2.2097	.81255
Policies and procedures exist	62	1.00	4.00	1.9877	.78860
Sufficient staff to do work	62	1.00	4.00	2.4516	.78254
Physical space	62	1.00	4.00	2.3065	.82161
Access to equipment	62	.00	3.00	1.8710	.61361
Safe work place	62	1.00	4.00	1.9677	.57167
Feel supported in work	62	1.00	4.00	2.0806	.81579
Feel part of a team	62	1.00	4.00	2.0645	.67438
Access to information	62	1.00	4.00	2.0000	.54321
Satisfied with workload most days	62	1.00	4.00	2.3871	.75433
Satisfied with pressure of the job most days	62	1.00	4.00	2.3065	.75939
Valid N (listwise)	62				

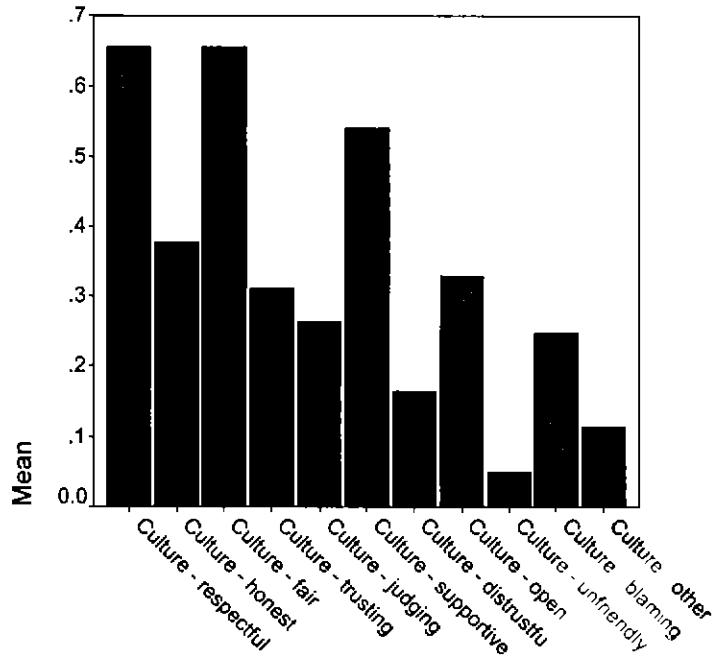
Part Four - culture of the organisation

Strongly Agree = 1; Agree = 2; Disagree = 3; Strongly Disagree = 4

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Every individual is valued	62	1.00	4.00	2.3065	.86059
I feel valued by residents	62	.00	3.00	1.6452	.62977
I feel valued by management	62	1.00	4.00	2.3226	.76339
My views are listened to	62	1.00	4.00	2.4194	.75852
Open and honest communication with each other	62	.00	4.00	2.4032	.81903
Organisation recognises staff contribution	62	.00	4.00	2.4516	.89950
Organisation rewards staff	62	.00	4.00	2.5000	.93651
People take personal responsibility for decisions and action	62	.00	4.00	2.3065	.89788
Respect for different cultures	62	.00	4.00	1.9839	.63998
Like working with people from different cultures and backgrounds	62	.00	3.00	1.7097	.61102
Organisation tries to meet the needs of residents	62	1.00	4.00	1.8226	.66590
Organisation tries to meet the needs of families	62	1.00	4.00	1.8710	.68912
Confidence in leaders	62	.00	4.00	2.0323	.76753
Consistent decision making	62	.00	4.00	2.3387	.86732
Truthful and sincere	62	.00	4.00	2.3710	.83438
I feel I make a contribution	62	.00	3.00	1.6290	.60690
Safe to say and think what you feel	62	.00	4.00	2.3548	.88885
Valid N (listwise)	62				

Words selected to describe the culture of the organisation



'Other' category included 'hierarchical' (2), 'authoritative' (1), 'varies with shifts and location' (1)

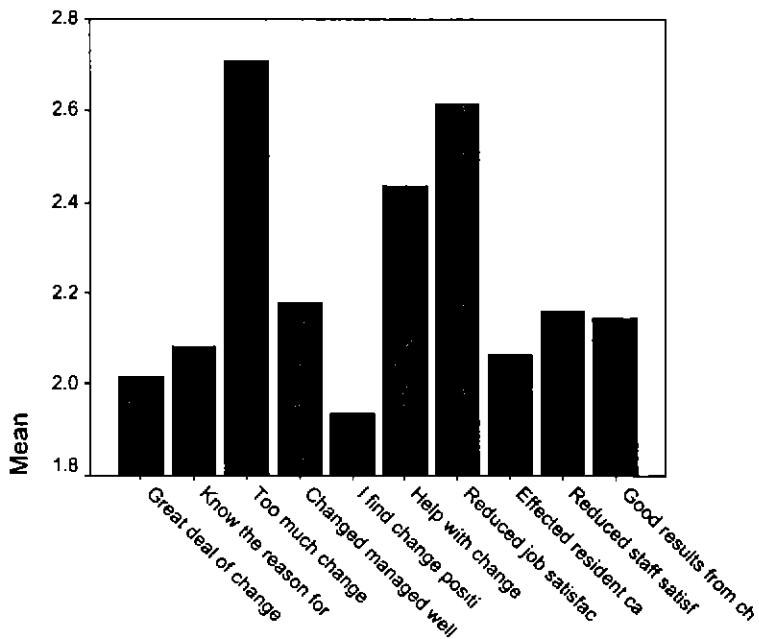
Part five – health and impact of change

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
I am able to cope with my work most of the time	62	1.00	4.00	1.7903	.83248
Physical symptoms of stress in last 12 months	62	.00	4.00	2.5645	1.03419
Emotional symptoms of stress in last 12 months	62	.00	32.00	3.0968	3.86964
Help because of stress at work in last 12 months	62	.00	4.00	2.9516	1.04689
More sick leave than usual in last 12 months	62	.00	4.00	3.0323	1.05532
Stress at work has affected my family in last 12 months	62	.00	4.00	2.8710	1.04777
Stress at work is not resolved	62	.00	4.00	2.8226	1.07923
Most days I look forward to going to work	62	1.00	4.00	2.0161	.75730
I can get help from colleagues or managers when I am stressed	62	.00	4.00	2.1290	.87748
My health has suffered because of stress at work in past 12 months	62	.00	4.00	2.9677	1.02378
Valid N (listwise)	62				

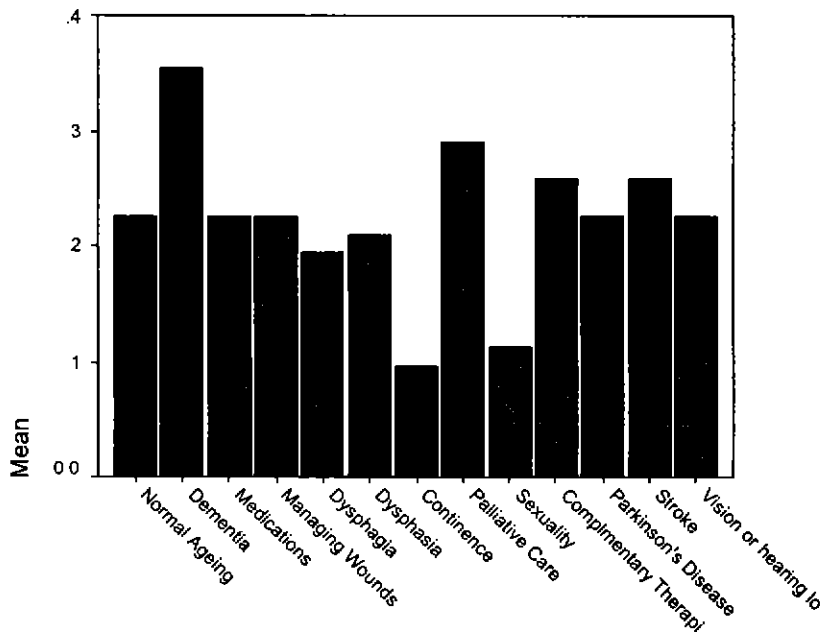
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
In the past 12 months there has been a great deal of change	62	.00	4.00	2.0161	.77865
In the past 12 months we have been told the reason for change	62	.00	4.00	2.0806	.89256
In the past 12 months there has been too much change	62	.00	4.00	2.7097	.96474
In the past 12 months change has been managed well	62	.00	4.00	2.1774	.82032
I find change positive	62	.00	4.00	1.9355	.62387
In past 12 months I have had help to deal with change	62	.00	4.00	2.4355	1.00198
In the past 12 months change has reduced my job satisfaction	62	.00	4.00	2.6129	1.13592
In the past 12 months change has had an effect of resident care	62	.00	4.00	2.0645	.97293
In the past 12 months change has reduced staff satisfaction	62	.00	4.00	2.1613	1.01131
In the past 12 months change has had good results	62	.00	4.00	2.1452	.93820
Valid N (listwise)	62				

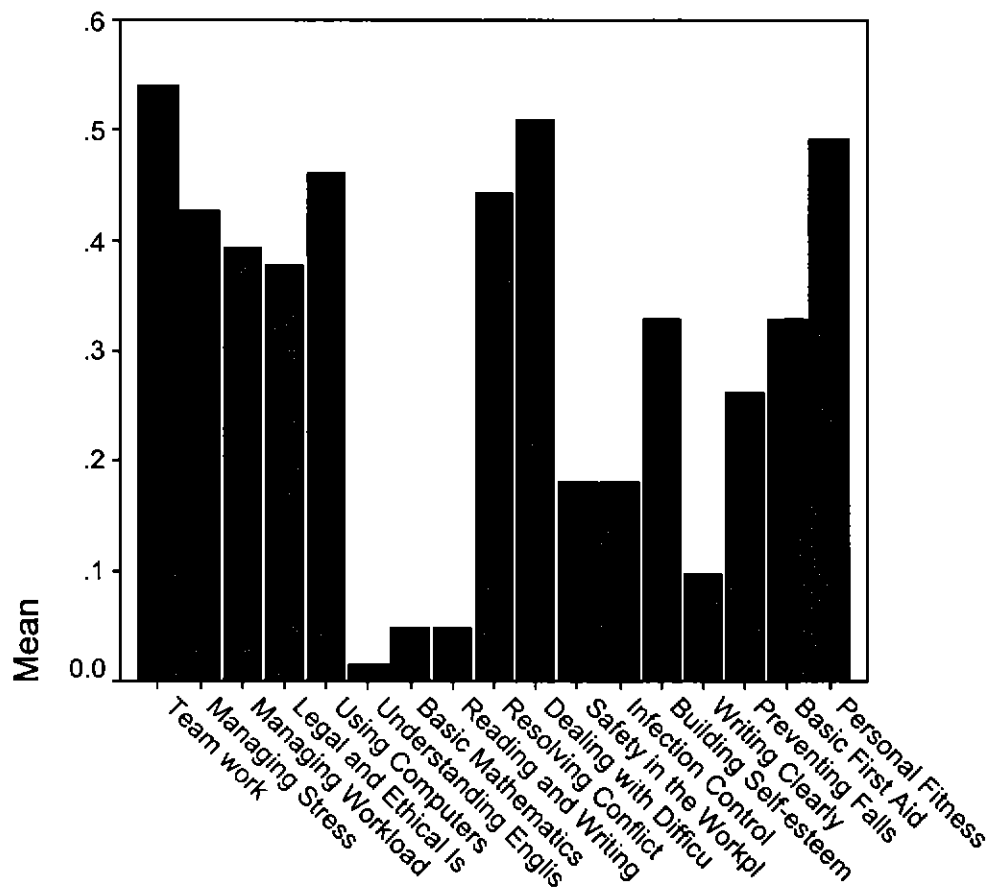


Part six – training and staff development

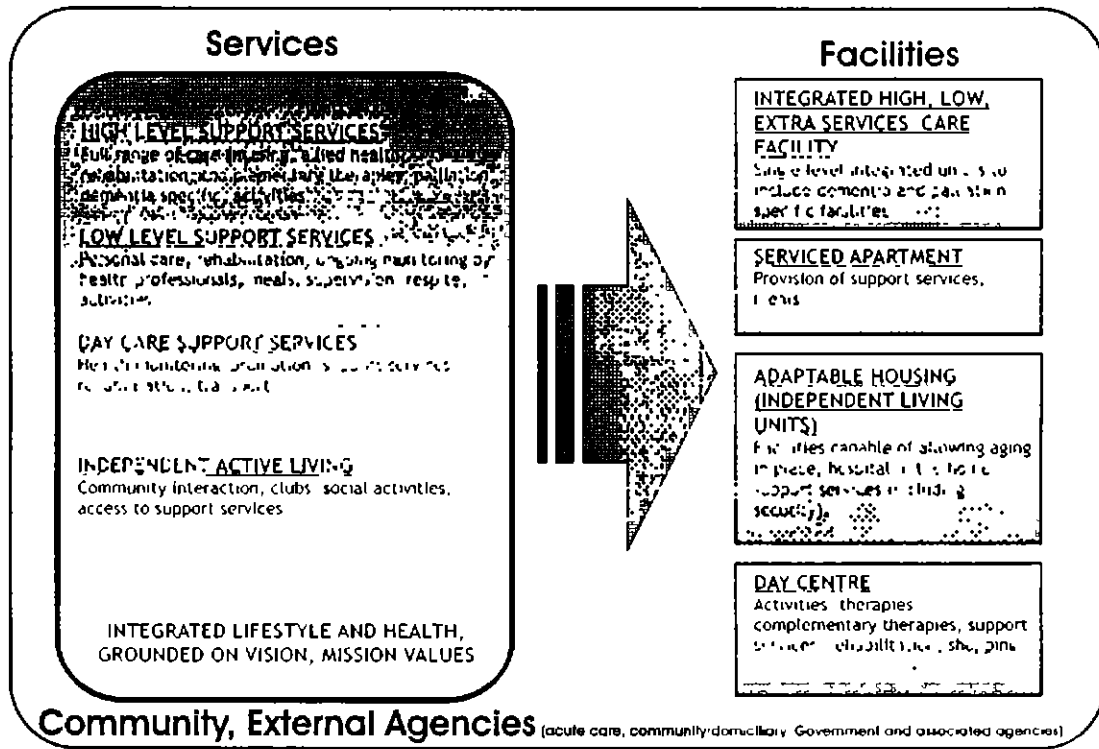
Preferred clinical topics



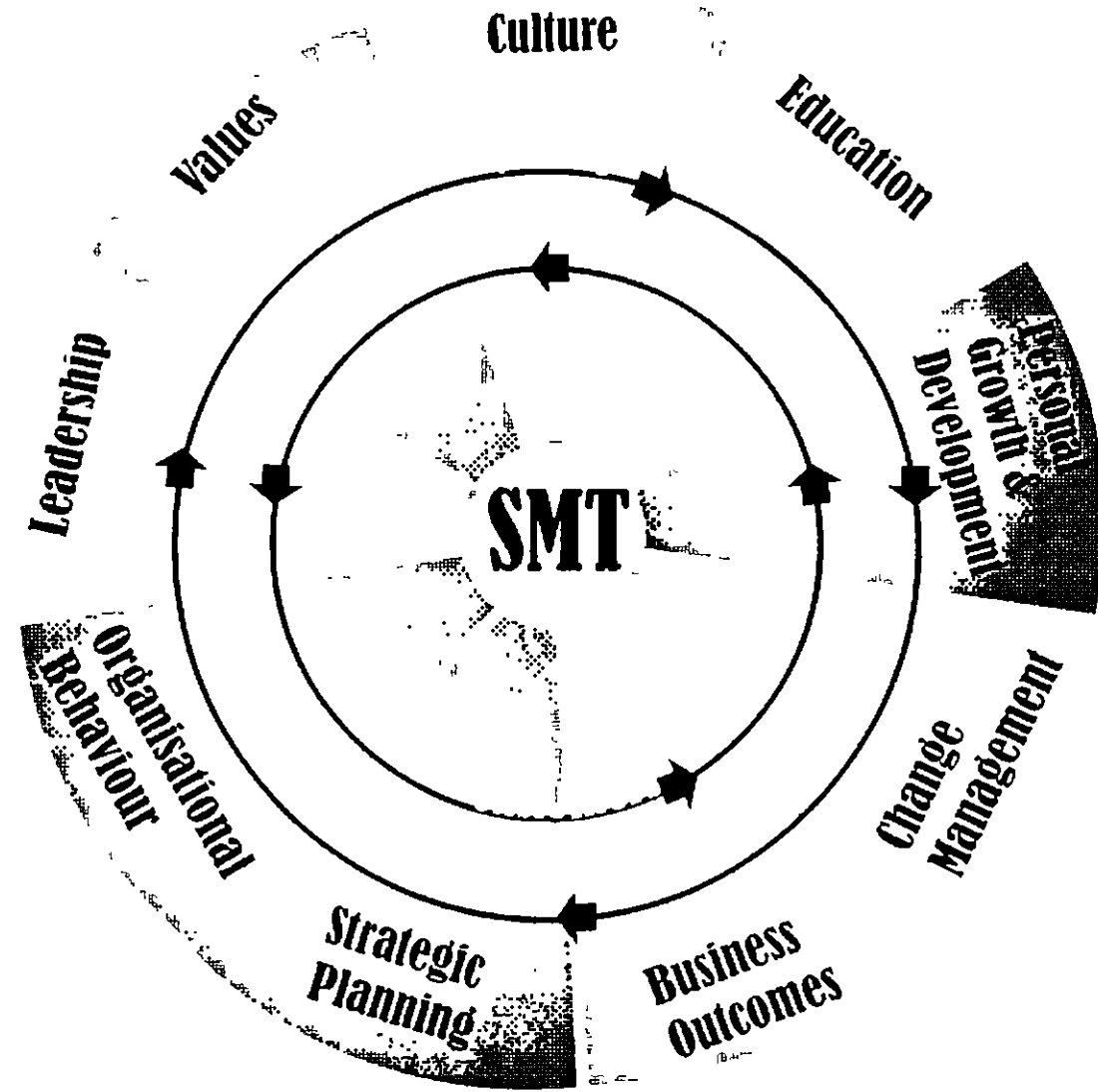
Preferred general topics



Appendix VI: Model of Care



Appendix VII Leadership Development Model



Appendix VIII: Publications, papers and presentations arising from the thesis

- Howat P., Boldy D., & Horner B. (2004). Promoting the health of older Australians: program options, priorities and research. *Australian Health Review* 27(11), pp.49-55.
- Grenade, L.E, Horner, B. and Boldy, D.P. (2004). Managing Residential Aged Care, in Clinton, M. (Ed.) *Management in the Australian Health Care Industry (3rd Edition)*, Frenchs Forest, New South Wales: Pearson Education Australia.
- Horner, B., Marshall, W. (2004) 'Building systems, staffing and organisational development in a changing environment'. Aged Care Standards and Accreditation Agency Conference, "Better Practice". Perth, WA, November 18-19, 2004
- Horner, B., (2004) 'The role of research in better practice'. Aged Care Standards and Accreditation Agency Conference, "Better Practice". Perth, WA, November 18-19, 2004.
- Horner, B. (2004) 'Changing Expectations in the care of the older person'. 13th National Conference on Incontinence, Fremantle, WA, November 10-13, 2004.
- Horner, B. (2003). "Health promotion for older people". Alberta Association of Gerontology Professional Series, Edmonton, Canada. June 2003.
- Horner, B., (2003) "Understanding human resource issues in aged care". Aged and Community Services Australian (ACSA) 16th National Conference & Trade Exhibition, Perth, Australia, October, 2003.
- Horner, B. (2003) "Research partnerships – building organisational capacity and supporting new directions in aged care". 1st International Congress on Innovations in Nursing (ICIN), Perth, Australia, October 2003.

Horner, B. (2003) "Examining a strategic partnership between a provider and a University to monitor and support organisational performance during critical stages of organisational change and development". IAHSA Conference, 'Global Ageing. Partnering in Service Solutions' Sydney, July

Horner, B. (2002) "Organisational change and development in residential aged care". IFA 6th Global Conference on Ageing: Maturity Matters, Perth, WA, October 2002.

Horner, B., Boldy, D., & Kinsella, K. (2002) "Influencing the research agenda". IFA 6th Global Conference on Ageing: Maturity Matters, Perth, WA, October 2002.

Horner, B. & Boldy, D. (2002) "Aged care services for the future - a case study of organisational change and development in residential aged care". 6th National Health Promotion conference, Victoria, BC, Canada. April 2002.