

Understanding the Hospital Environment and Older People:  
A Social Ecological Analysis

by

Belinda Bernice Parke  
BSN University of Victoria 1989  
M.S.N., University of British Columbia, 1995

A Dissertation Submitted in Partial Fulfillment of the  
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Interdisciplinary Studies

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## ABSTRACT

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## ABSTRACT

The complex health profile of older adults entering hospital presents staff and administrators with new challenges. In a climate of fiscal restraint, competing priorities and public pressure, it is necessary for acute care hospitals to rethink their views of caring for older adults.

This critical ethnographic study applies a social ecological perspective using the concept of person-environment fit to illuminate how problems arise from conflict between needs and expectations. Constant comparative analysis and coding techniques take account of hospital operations and the perspectives of hospital employees and older people together. Data included hospital observations, and interviews with older adults (N=11) and hospital employees (N=14). Procedures to ensure rigor included continuous reflexivity, participant selection, triangulating data sources, peer debriefing, multiple checks, and an audit trail.

Findings yield four areas of poor fit: architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude. These environmental features act in independent and cumulative ways to produce a disempowering synergy that erodes independence and confidence; produces stress, worry, and anxiety; and enhances disabilities when functional impairments exist. Incongruent relationships emerge only when non-ideal older people enter the hospital's cultural space. A lack of fit exists for those considered different either because of their personal functional attribute or because hospital employees judge them to be unsuitable or inappropriate for the unit or service. Being different is key to lack of fit in the hospital environment and the construction of problems. The study also contributes groundwork for identifying indicators of older adult-hospital environment fit, and by doing so, aids in defining quality of hospital services based on what older people need and expect compared with what the hospital provides and the demands it places on older people. This research has the potential to set the stage for assessing hospitals and ensuring policies are better suited to the needs of older people.

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## CHAPTER ONE:

### INTRODUCTION

*I have some trouble with this thing in my head. The doctor tells me we should leave it alone and I think he's right. This way, I at least know what's going on, hey, and it's not causing me any trouble. So I figure, the doctor says if it isn't causing any trouble, leave it alone and you know that makes sense to me – why fix something if it ain't broke? He's supposed to know you know, this doctor, so I think I better listen.*

*I'll have to have more tests; these tests, more tests. You go to the hospital and you wait your turn. A busy place, they don't talk to you until they want you to do something, it's like you're not there; you wait and wait and wait. But I guess that's okay because what else is there to do in a hospital? I'm an old man. Of course what do you expect when you're my age ... what else do I have to do, play golf – I guess? What are you going to do, so I sit and read my book and then the nurse comes and we do the test and I go home.*

*AM July, 2004*

To *be old* is a socially constructed phenomenon, an expression of age. The lived experience of age is a major dimension of social organization and a major force in how people organize their lives and experiences (Palmore, 1990). For example, we use chronological age as the marker for retirement and eligibility to vote, drink alcohol, and drive a car. Health care organizations also use age to determine eligibility for particular services such as admission criteria for geriatric services or eligibility for government-sponsored health prevention hearing and vision screening programs. Classifying people by age segregates older adults into a distinct social grouping, which creates reciprocal societal expectations and both positive and negative consequences (Butler, 1993; Katz, 1992).

The positive consequences have brought attention to the plight of old people. This attention has benefited older adults, as governments provide additional funding for special programming to support their needs. However, myths and stereotypes have also grown that project older people as a homogeneous group, which can be troublesome since older adults are not all the same, nor do they have the same needs, wants, desires, or aspirations (Butler, 1993).

Williamson, Shindul, and Evans (1985) suggest institutional practices based on values, traditions, or beliefs that segregate and classify people by differences can translate into discriminatory social behavior that can take the form of policies, procedures, and system processes. In such cases, institutional ageism or discriminatory practices become legitimized as “part of bureaucratic policy [that] can be justified as unintentional, beyond individual control or normatively based” (Williamson et al., 1985, p. 207). This occurs for example, when professionals – guided by hospital discharge policies and practices – facilitate the transition of older adults back into the community irrespective of their desires.

The dissertation research that follows is both a resting point and the start of a journey into new and perhaps uncharted perspectives for this researcher. It is a resting point because the curiosity and questions that have emerged from more than 25 years of clinical practice have settled into a place of dissatisfaction with the status quo. This has germinated into a need to explore and understand the dynamics operating behind older adults’ experiences with the hospital. The researcher anticipates developing a vision for action. The study also marks the beginning of a lively journey. The depth and breadth of the issues that affect being old in hospital are not simple, singular, and easily and fully

understood in a single study. As knowledge about older people in hospital grows and research questions are refined, knowledge in this area will grow. New knowledge combined with clinical work and service delivery will aid to narrow the existing gap between needs and expectations.

Critical ethnography is foundational to the dissertation research. Critical ethnography is conventional ethnography with political purpose (Thomas, 1993). Knowledge gained from this methodology aims to modify consciousness in order to gain social change; the researcher takes on the role of change agent.

For the purposes of this study, the researcher takes the position that being old in hospital – a fast-paced intervention system – is a complex phenomenon to understand. The complexity revolves around competing paradigms, shifting priorities, variations in need and expectation, and external forces that are laden with intricate relationships. The study must articulate contextual details and relevant features of the situation to make sense of being old in hospital. Making sense of the arrangements that exist in hospital will come from a thorough but critical examination of the many factors at play.

### **Background to the Problem**

Older adults are frequent users<sup>1</sup> of hospital services and are more likely than younger people to use such services (Statistics Canada, 2003). For example, in 1997-98, older adults accounted for 35% of the three million discharges from Canadian hospitals, 52% of the 21 million patient days, and nearly one-third of all primary diagnostic and surgical procedures performed in hospitals during this time (Canadian Institute for Health Information, 2000).

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<sup>1</sup> It is not within the scope of the dissertation to fully discuss utilization factors and their ramifications on hospital systems. It is acknowledged, however, that utilization research has shown that age, health status, bed availability, and physician practice are important considerations (Roos, 1989)

Hospitalization admission rates and age show a positive correlation; use of hospitals services increases with age. “The number of hospital separations for every 100,000 people aged 75 and over was over 70% higher than among those aged 65 to 74” (Colin, 1999, p. 65). In 1998-99, statistics showed that adults aged 65 and older were three times more likely than those aged 45 to 64 to be hospitalized, yet this cohort constituted only 12% of the population (Statistics Canada, 2003). Older adults also tend to stay longer in hospital. Averages in 1998-99 indicate that a hospital visit lasted 14 days compared to less than 10 days per visit for all age groups under 65 (Statistics Canada, 2003). Current demographics indicate there will be more older adults using hospitals in the future (Canadian Institute for Health Information, 2000; Hanlon, Walsh, Whyte, Scott, Lightbody, & Gilhooly, 1998). In the next 40 years the population of adults aged 85 and older is projected to quadruple, suggesting a corresponding increase in the demand for hospital services since the Canadian health care system is heavily dependent on hospital care (Eve, Pillai, Easterling, & Jones, 1995).

Hospital care has evolved from a place to avoid, to a place of high value with a technological imperative to cure disease (Weitz, 2004). Hospitals are institutions organized and funded to provide biomedical and surgical care and diagnostic services. They have become the place for solving medical and surgical problems (Chappell, Gee, McDonald & Stone, 2003). As institutions, they have bureaucratic functions similar to “total institutions,” such as prisons where rules and schedules govern patients’ behaviors (Goffman, 1961; Weitz, 2004). Their focus on technology reinforces “care of acute rather than chronic illnesses” (Weitz, 2004, p. 295).

This study examines how problems are created for older people in hospital. It adopts the view of many that hospitalization can be a risky experience (Baker et al., 2004; Clark, 2001; Courtney, Tong, & Walsh, 2000; Creditor, 1993; Sager et al., 1996; Illich, 1975). Palmer (1995) reports, "For many frail, elderly patients suffering from severe illnesses, the hospital is a dangerous place" (p. 117). This situation is particularly evident when older adults with chronic health concerns enter hospital. Spending time there can unintentionally create new problems or worsen existing ones (Illich, 1975).

The chronic health concerns experienced by older adults can represent functional crises in hospital (Creditor, 1993; Palmer, 1995). These crises are often seen as inappropriate for treatment in an acute care setting because they do not "fit" the mandate of the hospital, which is organized to respond to acute illnesses that require technologically dependent interventions.

At the time of admission, the patient's presenting complaint is translated to a medical diagnosis, around which all action, investigations, and treatment of symptoms are coordinated, which does not take account of functional crises. This perspective also can often lead to significant "unwanted physiological, social and psychological by-products of diagnostic and therapeutic" activities (Illich, 1975, p. 27), which hospital systems and processes, and rules and regulations compound.

Older adults also represent an economic burden in discussions surrounding utilization, efficiency, and effectiveness (Vincent, 1999). When hospitals place greater emphasis on utilization and efficiency, patients may feel rushed or unheard because the system places greater importance on "occupancy" of the bed rather than the "needs" of the occupant (Latimer, 1999). As Stein Gross (2001) suggests, "efficiency must always

be part of the conversations when resources are not infinite and citizens and governments have important choices to make among competing public goods” (p. 6). Critical scholarship, however, can uncover and understand how customs and traditions in acute care hospitals may disadvantage older people at a time when utilization, efficiency, and cost containment dominate the discourse of appropriate health care generally, and hospitals, in particular.

Critical scholarship is required not only to expose problems but also to illuminate how they arise from conflict between needs and expectations in present day hospital relationships. Sherwin (1992) contends that any discussion on the nature of relationships in health care must examine traditional assumptions regarding power and control among and between groups. She recommends examining the disadvantaged position of the dependent patient not as a dyad between physician and patient but rather as “overlapping networks of other relationships, which bind patients and physicians to their respective family members, other health professionals, neighbors, employers, health services administrators and so on” (p. 83). In this study, the researcher will critically analyze older adults’ encounters with the hospital environment. Analysis of these transactions reveals hidden dynamics in problem construction.

### **Problem**

The hospital can be a stressful and dangerous place for older people (Illich, 1975; Ulrich, Quan, Zimring, Hoseph, & Choudhary, 2004). The unfamiliar hospital environment, with its medical jargon, unfamiliar equipment, and disruption of life-long routines and habits, can be a significant source of stress. Hospitalization also interrupts social support networks (Shumaker & Reizenstein, 1982). The hospital environment

creates stress in older adults by challenging their adaptive ability. "Healthy people are able to attenuate the impact of their environments by leaving or changing them; sick people ... have neither the control nor the ability to alter unpleasant or dissatisfactory settings" (Shumaker & Reizenstein, 1982, p. 190). The older person, when frail, ill, and weak has less energy to manage and cope with the demands of hospitalization. They may also lack the social supports needed to maneuver through the hospital system.

The danger to older adults in hospital arises from traditional patterns of care that ignore normal physiological and social age-related changes (Creditor, 1993). The cumulative effect of multiple and chronic medical problems, use of medications, existing cognitive impairments, failure to recognize delirium, and de-conditioning creates vulnerability that places older adults at greater risk for an adverse event, which manifests as poor clinical and social outcomes (Inouye et al., 1993; Inouye & Charpentier, 1996).

An adverse event in the context of hospitalization is defined as an unintended injury or complication of medical management that results in disability at the time of discharge, death, or prolonged hospital stay (Thomas & Brennan, 2000). It is understood to result from the actions of hospital employees, and includes the influence of hospital systems and care processes rather than the patient's underlying disease (Baker et al., 2004; Thomas et al., 2000). An adverse event results from: (a) failure to diagnose or treat a medical problem, (b) incorrectly diagnosing or treating a medical problem, or (c) poor performance in the management of a medical problem. Baker et al. (2004) report an adverse events incident rate of 7.5 per 100 hospital admissions (95% CI 5.7-9.3) and that 37% (CI 32-41.8) were potentially preventable while 21% (95% CI 7.8-33.8) resulted in

death.<sup>2</sup> Thomas & Brennan (2000) note that greater complexity in care needs of older adults increases the risk for preventable adverse outcomes. This population they state, “often do not present with typical signs and symptoms of disease, thus making timely and accurate diagnoses more difficult; they take more drugs than younger patients; and they have impaired physiological compensatory mechanism and are therefore more likely to be harmed by errors in care” (p. 743).

The organizational culture in hospitals is technologically dependent on an expert model that deals with short-term, acute biologically-based illnesses (Longino & Murphy, 1995). The acute care model that hospitals ascribe to is based primarily on the premise that illness results from pathology in the body and that pathology, when treated through medication or surgery, leads to cure (Chappell et al., 2003; Dietz, 1995). Hospital customs and traditions shaped by this agenda place time-limited, acute interventions ahead of chronic health interventions. Consequently, dominance of the acute care agenda obscures older peoples’ chronic health and functional needs, placing them at risk. This approach is also the bases of the reporting of adverse events as described above.

The biomedical paradigm operating in hospitals underpins the assessment and evaluation of situations defined as adverse events. The construction of “what went wrong” or “how a problem occurred” is understood from this paradigm. For example, when a critical incident arises in hospital, adverse events are understood, investigated, and reported from the medical perspective (i.e., surgical event, drug or fluid related event, diagnostic, anesthesia related event, inappropriate symptom assessment, clinical

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<sup>2</sup> Although Baker et al (2004) do not distinguish their findings by age; they do indicate that patients who had adverse events were older than those who did not. The implications are significant given that the use of hospitals increases with age and large numbers of older adults currently use hospital services. Projections for the future show increased utilization by older people (Eve et al., 1995).

management error). Although important, this approach fails to uncover age related functional and social consequences for older adults and their families.

Poor clinical and social outcomes in older hospitalized adults are reported as longer lengths of stay, temporary disabilities, decubitus ulcers, falls with accompanying fractures, functional decline, nursing home placement, and lowered social function (Baker et al., 2004; Creditor, 1993; Dudek, 2000; Inouye et al., 1993; Satish, Winograd, Chavez, & Bloch, 1996). The current system for understanding how adverse events occur that result in poor outcomes ignores broader factors (i.e., speed of recovery, consequence of deconditioning, iatrogenic response to acute intervention, atypical presentation of disease and illness, consequence of limited social support, and the ambience of the built physical environment). Although the literature points to the existence of a lack of fit between older people and the hospital environment, less is known about how factors outside the biomedical perspective may or may not contribute to problem construction.

Being an older patient in hospital is a complex and dynamic process; it is an experience that cannot be measured simply in adverse medical outcomes, patient satisfaction or quality of care delivery. Investigations (Attree, 2001; Bull, Jervis, & Her, 1995; Dady & Rugg, 2000) of older adults' experiences in hospital offer important information about the problems they experience. At best, patients express sentiments of discontent, but the underlying reasons, causality, or dynamics of the discontent remain unknown. It is not clear how the dynamics of being old interface with hospital customs and traditions to contribute to creating problems for older people. Nor is it clear whether

achieving a “goodness-of-fit” between older people and the hospital environment would reduce their problems and improve patient satisfaction.

One could argue the culture in hospitals significantly affects *any* person admitted because of the stressful nature of hospitalization (Duffy & Iscoe, 1990). However, the hospital experiences of older people are distinguished by unique factors. First, hospitalization can accompany a wide array of other stressful events that tend to be associated with aging. These other stressful age-related events (e.g., death of spouse, loss of significant other, physical and sensory disabilities, and chronic illness) may coincide in any combination. More importantly, these events may occur at a time of diminished financial resources and psychosocial networks for support to maintain independent community function (Duffy & Iscoe, 1990).

Although hospitalization can affect any person, the unique circumstances that accompany an older person (outlined in the first column of Table 1) can combine to challenge the customs and traditions of the hospital environment. These customs and traditions revolve around the hospital’s acute illness paradigm, organizational culture, and the disempowering influence of relationships between patients, workers, and administrative processes (see the second column of Table 1). The collision of these factors is assumed by the critical paradigm to have negative consequences for older people in hospital.

Table 1: Older Person – Hospital Environment Fit

<b>Older Person Factors</b>	<b>Hospital Environment Factors</b>
<p><b><i>Chronic Health Needs</i></b></p> <ul style="list-style-type: none"> <li>• More prominent over acute needs</li> <li>• Psychosocial interventions have greater importance</li> </ul>	<p><b><i>Acute Illness Paradigm</i></b></p> <ul style="list-style-type: none"> <li>• Acute medical and crisis intervention</li> <li>• Psychosocial interventions have diminished importance</li> </ul>
<p><b><i>Vulnerability</i></b></p> <ul style="list-style-type: none"> <li>• Age-related physiological changes</li> <li>• Changing social circumstances</li> </ul>	<p><b><i>Organizational Culture</i></b></p> <ul style="list-style-type: none"> <li>• Expert model dominant</li> <li>• Bureaucratic system and processes to aid the professional</li> <li>• Technological dependence</li> </ul>
<p><b><i>Attitudes, Values, Beliefs</i></b></p> <ul style="list-style-type: none"> <li>• Cultural ideas and views</li> <li>• Personal views of aging and way of life</li> </ul>	<p><b><i>Relationships</i></b></p> <ul style="list-style-type: none"> <li>• Professional dominance</li> <li>• Disempowering (power, control, choice, and partnership issues)</li> </ul>

This study assumes that the needs of older adults and the priorities of hospitals do not fit. The result produces problems that may potentially harm older patients. Although scholars have examined older people’s experiences in hospitals, the research has not been conceptualized within a larger relationship of the hospital environment as a culturally based service delivery system. To focus exclusively on older adults’ hospital experiences is inadequate. It is also insufficient to examine only the hospital environment. Studying each alone ignores the powerful influences each has on the other; this study contributes by taking account of both together while each interacts with the other. Examining their combined interaction can help determine appropriate acute care service delivery for an aged population. This type of investigation is needed to understand how reciprocal relationships between older people and hospital customs and traditions contribute to problem construction.

### **Overall Purpose of the Study**

The goal of the study was to understand how problems arise between older people and hospital systems. To achieve this understanding requires uncovering the dynamics hidden beneath the surface of older adults' encounters with the hospital system. This understanding will help define the direction required to improve hospital services for older people who presently feel alienated and overwhelmed by the acute care experience. In particular, the dissertation will investigate how customs and traditions that are taken for granted negatively impact older people in hospital.

The dissertation examined transactions in acute care using the social ecological concept of person, in which the environment's fit is considered in the perspectives of older people and the organizational systems, processes, and providers working in hospitals. This approach will: (a) describe how a lack of good fit between older people and the hospital environment produces problems for older people; (b) expose organizational structures, systems, and processes that act to disadvantage hospitalized older people; and (c) illuminate, if and where they exist, positive aspects of existing customs and traditions. This approach will help develop foundational knowledge for change that could achieve a "goodness-of-fit" that will ultimately aid efforts to improve hospital responsiveness.

### **Significance: The Utility of the Dissertation Research**

Older adults are the primary users of hospital services, and given projected demographics, older adults' use of these services will only rise (Canadian Institute for Health Information, 2000). The dissertation research is timely because the goodness-of-fit between older people and the hospital environment is fundamental to achieving best

practice, patient safety, efficiency, effectiveness, and cost containment. More importantly, however, is the need to produce evidence-based recommendations to improve the quality of acute care services for older people.

Findings from this study will provide administrators with information to assess hospitals and create administrative policies better aligned with the needs of older people. This study will also set the groundwork for defining quality service based on the degree of congruence existing between what older people need and expect compared to what the hospital provides and the demands it places on older people. Such a focused examination will challenge hospital administrators to look at operations from the perspective of older people, rather than the status quo, which considers operations from the biomedical perspective of the system. Findings will challenge existing values about what constitutes “good care” for old people in hospital.

Finally, this study serves to set the stage for a potential research program to improve the hospital’s responsiveness to demographic changes. The dissertation constitutes the first phase of the program. Phase two could build on the knowledge gained from phase one by using quantitative methods to determine how common the experiences and concerns that arise in phase one are across areas of the hospital and between hospitals. A quantitative approach in phase two could compare, measure, and test the degree of congruence between older people and the hospital environment. This phase could involve larger scale surveys of older people and practitioners working within hospitals. Phase three would aim to test the efficacy of intervention strategies to improve the fit. Randomized clinical trials using comparison groups could then be employed to evaluate the efficacy of new approaches to improve older adult-hospital environment fit.

## The Research Question and Definition of Terms

### *The Research Question*

How do the customs and traditions in hospitals create problems for older people?

### *Definition of Terms*

The definitions of *custom* and *tradition* have been adapted from the dictionary and from anthropology literature related to culture. The researcher has also drawn on reflections of personal clinical experience in acute care hospitals for contextual examples to illustrate the critical attributes of each definition.

Spradley and McCurdy (1972) describe culture as “nearly everything that has been learned or produced by a group of people” (p. 7). This includes not only a group’s rules and practices but also any artifact made by a group. For the purpose of the dissertation, the concept of culture includes the customs and traditions of social behavior. “Behavior [or action] is social because this knowledge is shared by many other people in our society.... Recognizing and taking account of these things is a form of social behavior [and] their meaning in every society is taught to each new generation as a cultural tradition” (Spradley & McCurdy, 1972, p. 8).

In organizations Schein (1985) suggests that culture represents a “pattern of basic assumptions – invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems” (p. 9). These descriptions of culture resonate with the researcher’s view of hospital as a cultural space for clinical

practice – clinical practice occurs within a work place culture, which in turn is affected by the dynamics at play in that environment.

The Oxford English Dictionary (2004) defines *custom* as a “habitual or usual practice, a common way of acting ... or habit (either an individual or of a community)” (Oxford University Press, 2004, electronic version). The Cambridge Advanced Dictionary (2004) also includes the attribute of time (i.e., “a way of behaving, which has been established for a long time”) (Cambridge University Press, 2004, electronic version).

The term *tradition* is defined as a “belief, principle, or way of acting for a particular group of people at a particular time” (Cambridge University Press, 2004; Oxford University Press, 2004). Tradition by definition has the characteristic of being a long established and accepted method of procedure transmitted or handed down by word-of-mouth or by practice without writing. The Oxford English Dictionary (2004) indicates that traditions have the added distinction of being passed down by predecessors and generally followed with almost the same force as law.

Hospitals as bureaucratic systems have embedded within their culture, routines, schedules, and regular practices. As a reflective practitioner, the researcher draws on professional knowledge and hospital clinical experience to give contextual meaning to the dictionary terms that inform the dissertation.

The perspective of reflective practice (Schon, 1983) has relevance to the dissertation because a reflective practitioner explores clinical situations by “paying attention to phenomena and surfacing his intuitive understanding of them, his experimenting is at once exploratory, move testing, and hypothesis testing. The three

functions are fulfilled by the very same actions. And from this fact follows the distinctive character of experimenting in practice” (Schon, 1983, p. 147).

Schon (1983) suggests that the primary interests of an inquirer who reflects-in-action is to change a situation. Learning is based on reflecting on a situation’s resistance – testing a hypothesis and looking for a change, making a new hypothesis based on the change. The action—reflection, action—reflection sequence is referred to as move testing. The next actions depend on the changes produced by earlier moves. “The learning sequence, initiated by the negation of a move, terminates when new theory leads to a new move which is affirmed” (Schon, 1983, p. 155).

Reflective practice involves a systematic recursive turning over that amounts to a regular analytic approach to clinical work. In the process of exploring, testing, and re-testing clinical interventions, the researcher has turned back on itself those experiences to gain knowledge. As Schon (1983) suggests, the practitioner’s “relation to the situation is *transactional*. He shapes the situation, but in conversation with it, so that his own models and appreciations are also shaped by the situation. The phenomena that he seeks to understand are partly of his own making; he is *in* the situation that he seeks to understand” (Schon, 1983, pp. 150-151).

*To the Reader: A Personal Comment from the Researcher*<sup>3</sup>

I understand the hospital as a cultural space because this phrase inherently means boundaries that capture “the way we do things around here.” Cultural space also accommodates the move into and then out of a place. I think of hospitalization as an

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<sup>3</sup> I acknowledge that the customary writing style of ethnography is in first person. Aside from this personal comment, I made a decision to write this critical ethnographic account primarily in the third person because of the audience I hope to influence with my work (i.e., physicians, health service administrators, and government officials).

interval, an episodic event in a person's life. From my work, I know the hospital as a complex institution with a mandate to serve diverse user groups who have urgently competing needs and priorities. The hospital has a rapidly changing technological context that exists for the preservation of life by acting to interrupt biological crises.

Being an older person who comes to, stays in, and then leaves the cultural space of the hospital is fraught with events that may bring great relief, as well as others that are problematic. The personal accounts described in this dissertation represent these lived experiences. However, to tell their story requires a personal journey; my interpretation of the data is a journey of discovery. It is more than an intellectual exercise because, as social beings, over time we are affected by the social world around us. To talk and listen to older people and hospital employees about their experiences in hospital is a social endeavor that has influenced how I think about my own practice as a nurse. I cannot help but be influenced by what I have learned personally and professionally. The findings reported in chapter four represent my journey interpreting the journey others have taken.

From the reflective practice process, I have developed a critical awareness of how hospital activities are habitually enacted to form acute care customs and traditions. This experience has application in the dissertation because of the reciprocal relationship between the research, my role as a researcher, and clinical practice; each influences the others. As such, essential elements in a hospital situation intertwine with theory, fact, professional reasoning, and researcher *knowing*. This notion of reciprocal relationships is also in keeping with the dissertation's conceptual framework, the social ecological perspective, which is discussed later in the chapter. Therefore, hospital customs and

traditions in the context of the dissertation come in part from my clinical practice, and mean the following:

Custom – A habitual practice that imposes an organizational duty on the hospital employee and a corresponding required response from an older hospitalized adult. A habitual practice can occur at any point in the hospital experience. Some examples include: processes initiated on admission, routine care practices, or administrative directives that require the hospital employee or older adult to behave in a particular manner.

Tradition – A mode of thought or behavior that involves the passing down of written or unwritten information to the newly hired employee and others less familiar with the existing hospital culture. Hospital traditions are time-honored practices, opinions, and doctrines that formulate a pattern of thought and reoccurring action. For example, older adults with fractured hips require a surgical orthopedic *designated* bed, and oral patient temperature must be taken at 0630 before the end of a night shift.

Problem – In this study, a problem is defined as incongruence (Coulton, 1981; 1979) between older adults' needs, functional abilities, and expectations, and the demands present in hospital environments. This lack of good fit (Germain & Gitterman, 1996) represents a negative transaction, which when present, contributes to stress, conflict, and sentiments of discontent.

Older adult – Given that a single definition for older adult is absent in the literature, for the purposes of this study an older adult is an English-speaking male or female who is aged 75 years or older. The definition includes two inclusion criteria for the following reasons: (a) the researcher speaks and understands only English; (b) gender

differences are not a focal point in the dissertation; therefore, both male and female older adults are appropriate for the study. Targeting individuals 75 years and older was necessary because chronological age for an older adult can range from 55 to 85 years and beyond. Furthermore, needs and expectations can change with age, and frailty and the risk of an adverse event in hospital increases with age. Methodologically, an age criterion offered research design specificity by narrowing the scope of potential older adult participants to those more likely to be frail and experience chronic health concerns.

### **Assumptions**

The assumptions underpinning the study design and implementation are:

1. The concept of old age has been constructed over time by power relationships, socialization and professionalization processes, social policy, political ideology, advocacy groups, and vested interest groups;
2. The positive and negative attitudes people hold about older adults are embedded within the social systems;
3. Hospital systems and processes disadvantage older adults; and
4. Being old in hospital is a disempowering experience that can be harmful and produce adverse physical and social outcomes.

### **Conceptual Framework**

The social ecological perspective provides a conceptual framework for the dissertation research (Moos, 1979; Stokols, 1992; Stott, 2000). This perspective is guided by the understanding that relationships between people and their environments are “characterized by cycles of mutual influence” (Stokols, 1992, p. 8) that produce reinforcing consequences for both people and systems within an environment.

The social ecological perspective assumes:

1. People cannot be understood apart from the environmental context in which they behave. Therefore, predicting outcomes cannot be made only from information known about older people; information about the hospital environment is also essential.
2. Physical as well as social and organizational environments together must be studied; one without the other significantly diminishes the likelihood of fully understanding all relevant mediating factors that contribute to transactional reinforcing consequences and outcomes.

The concept of person-environment fit is central to the social ecological perspective. "Person-environment fit refers to the degree of congruence or correspondence between an individual's needs, capabilities and aspirations and the resources, demands and opportunities characteristic of the environment" (Coulton, 1981, p. 26).

Theoretical models of person-environment fit have been proposed by scholars of many disciplines and have been applied in a variety of contexts, which include community settings (Perkins & Baker, 1991), organizational development and work place settings (Hansson, Robson, & Limas, 2001; Kirsh, 2000; Werbel & Johnson, 2001), health care settings (Coulton, 1979; 1981; Germaine, 1979; Kirsh, 2000; Moos, 1987), nursing assessment (Cutillo-Schmitter, 1996), and educational settings (Moos, 1987; Moos & Lemke, 1994). Although the application of the concept of person-environment fit has varied between disciplines (e.g., application to employment practices, people with chronic health concerns, students in classrooms, and functional and occupational

performance), they share similar ideas. The similarity rests in three concepts: the person, the environment, and goodness-of-fit.

Letts et al. (1994) suggest models of person-environment relationships may conceptualize the person as an individual or as a member of a group. Regardless how a model conceptualizes people, “they all center on the person as he or she functions within the social and physical environment” (Letts et al., 1994, p. 609). People factors have been identified in the literature as personal attributes (e.g., attitudes, values, traits and expectations, needs, genetic heritage roles, and illness-related factors) (Moos, 1979; Stokols, 1992; Stott, 2000).

Theoretical models of person-environment fit have also emphasized different characteristics of the environment. Environmental factors are those elements found outside the person and include, for example, the physical design, social climate, organizational elements, and culture. Stokols (1992) makes a useful distinction by separating the “physical environment (e.g., geography, architecture, and technology) from the social environment (e.g., culture, economics and politics)” (p. 7).

The social environment can include political factors that represent confounding forces such as: ideology or philosophy of political ruling parties, government agendas, social worth of aged people, and available resources (Stokols, 1992). These types of forces must be taken into account because they affect the health care system and, in turn, local treatment settings such as hospitals.

“All theories [of person-environment fit] describe an interactive relationship between the person and the environment. The transactional nature of these interactions is often acknowledged, particularly as the interrelatedness of person and environment

affects research methods and measurement” (Letts et al., 1994, p. 609). The dissertation research applies the social ecological concept of person-environment fit as a lens to view and understand the complex and dynamic relationship between older people and the hospital environment.

Research relating to older adult-hospital environment fit was absent from the literature, however residential and sheltered care environment fit research (Moos & Smail, 1974; Moos & Lemke, 1994) provided direction for the research. This literature was deemed sufficiently relevant to the study because the reliability and validity of the dimensions of fit were tested in bureaucratic institutions that provide health services to older frail people, which are similar to the setting and population of concern in this study. This research has focused on numerous dimensions of person-environment fit for example, social climate (McKnight, 1987; Shumaker & Pequegnat, 1989; Moos & Lemke, 1994), policy and procedures (Moose & Lemke, 1994; Wells, 1997), the built physical design (Moos & Lemke, 1994; Parker, Barnes, McKee, Morgan, Torrington & Tregenza, 2004; Ulrich et al., 2004), and systems and processes (Germaine, 1979; Goffman, 1961; Moos & Lemke, 1994). These dimensions are consistent with the social ecological model underpinning the dissertation. Chapter three provides the contextual definitions of a four dimensional lens drawn from this literature and adapted to reflect the special features of hospitalization. This lens acts as a guiding framework for the dissertation research.

### **Summary**

This chapter has introduced the topic of older adults in hospitals, and outlined the problem, purpose, and significance of the dissertation research and the research question.

The conceptual framework employs a social ecological perspective to critically analyze the relationship between people and their environments. The cyclical nature of the relationship provides a way to understand reinforcing consequences that produce problems for older people in the hospital environment. The concept of person-environment fit central to the social ecological perspective will serve to uncover, explore, and understand problematic situations. Chapter two provides relevant background information on the topic and establishes the rationale for the study by placing the dissertation research in a socio-political context. Such a context promotes understanding of external forces that influence the relationship between older people and the hospital environment.

## **CHAPTER TWO:**

### **LITERATURE REVIEW**

This study starts from the position that being old in hospital is a disempowering life experience manifested in a multitude of institution-serving ways that are socially accepted and protected by the bureaucratic agenda of the hospital. Older adults' lived experience in hospital and the problems that exist for them are known, as are the effects of bureaucracies on people; what isn't known however, are the dynamics that underlie problem construction.

It is not the intent of the researcher to deny the potential for positive consequences or to suggest that evidence is lacking to support this view. It is acknowledged that the researcher adopts the point of view that hospitals are hazardous treatment settings for older adults. As a focal point for the provision of technologically-based acute care interventions, hospitalization may unknowingly create new problems for older adults or worsen existing problems. Guided by the critical perspective, the literature review that follows gives preferential attention to evidence that supports the negative consequences of hospitalization.

The dissertation contends that customs and traditions in hospital disadvantage older people. The literature review places this study in a socio-political context and addresses four topics: the disempowering nature of hospitals, older adults in hospital, the customs and traditions of acute care hospital services, and theoretical foundations.

## **The Disempowering Nature of Hospitals**

### *Empowerment*

Literature on empowerment as a process and/or outcome describes individuals with lesser power who gain control or mastery over their lives and influence the organizational and societal structures within which they live (Bolton & Brooking, 1996; Eisen, 1994; Gibson, 1991; Israel, Checkoway, Schulz, & Zimmerman, 1994; Rappaport, 1985). The process of empowerment enables the exchange of power between people in relationship with each other (individuals or groups) and is therefore transactional in nature (Gibson, 1991; Rodwell, 1996). Fetterman (1996) provides a comprehensive definition of empowerment as a process:

Empowerment processes are ones in which attempts to gain control, obtain needed resources and critically understand one's social environment are fundamental. The process is empowering if it helps people develop skills so they can become independent problem solvers and decision makers. (p. 4)

Viewed as an outcome, empowerment is the product of the process that enables people to control their lives and gain a critical understanding of their environment (Rappaport, 1985; Rodwell, 1996; Zimmerman, Israel, Schulz, & Checkoway, 1992).

Confounding our understanding of empowerment is the level of analysis applied to the concept, beginning with individuals, moving along the continuum to include collectives, organizations, and communities (Bolton & Brookings, 1996; Eisen, 1994; Gibson, 1991; Israel et al., 1994; Rodwell, 1995; Zimmerman et al., 1992). Individual empowerment is discussed as a person's right to self-determination, self-actualization, and self-advocacy. All culminate in self-efficacy. Self-efficacy denotes a person who is

successfully independent and able to influence their personal situation (Bolton & Brookings, 1996). This perspective suggests that empowered older people are competent, productive, and personally effective. This perspective does not, however, take into account the impact or influence of acute illness on an individual's ability to be competent, productive, and personally effective.

In contrast to individual empowerment, Fetterman (1996) suggests that empowerment outcomes are the "consequences of citizen attempts to gain greater control in their community or the effects of interventions designed to empower participants" (p. 4). Implied in this definition is the power of organizing people into groups to advocate for change in their circumstances. This type of organization represents collective empowerment, which denotes a group of people with similar interests and goals that organize themselves for common action.

Fawcett et al. (1995) make a distinction between individual and community empowerment by suggesting that individual empowerment is a process of gaining influence over events and outcomes of importance. Those affected by the event determine what is important. Empowerment at the community level is defined as the process of gaining influence over conditions that matter to many people (i.e., those who share neighborhoods, workplaces, experiences, or concerns). Biegel (1984) argues that (individual or community) empowerment is dependent on two related concepts: capacity and equity. Capacity is the ability to use power that solves problems and helps individuals gain access to organizations that serve the people. Equity refers to a citizen's investment being equal to his or her return, or a community organization getting its fair share of resources.

Israel et al. (1994) offer a similar definition that incorporates power and control with peoples' ability to understand and manage personal, social, economic, and political forces that will improve their life situations. Implied in peoples' ability to take action to improve their situations are what other authors have identified as the need to:

- make informed choices (Anderson, Funnell, Fitzgerald, & Marrero, 2000);
- effectively problem solve (Arnold, Butler, Anderson, Funnell, & Feste, 1995; Fetterman, 1996);
- become active participants in matters that affect their lives (Bolton & Brookings, 1996);
- build on personal strengths (Davis, Vander Meer, Yarborough, & Roth, 1999; Gibson, 1991); and
- make decisions (Israel et al., 1994; Labonte, 1990).

Therefore, being empowered means having the ability to bring about some type of change, achieved by targeting the abilities of individuals, groups, organizations, and social structures. Similarly, in the literature cited above, empowerment involves aspects of participation, collaboration, power, and ownership. The means to achieving these central elements varied considerably from author to author (i.e., coalitions, participatory action research methods, and adjustments to service delivery, organizational structures, and relationships).

Empowerment, whether understood as a process or outcome, or analyzed at an individual or collective level, is clearly a multidimensional construct. However, its common theme is characterized by an exchange of power that gives greater control to people. Empowerment creates a more equitable situation for those who are marginalized

or disenfranchised by their life circumstances. Individual empowerment requires personal efficacy and competence along with a sense of mastery and control – all of which are lived out in a partnership between the person and social institutions (such as hospitals) that influence the events that affect them.

Nonetheless, defining empowerment is difficult because “it takes on a different form in different people and within different contexts” (Gibson, 1991, p. 355). Given this variability, the dissertation research will adopt Gibson’s (1991) definition of empowerment as “a social process of recognizing, promoting, and enhancing people’s abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives” (p. 359). Using a multidimensional perspective, individual empowerment in the hospital will be understood as a process of assisting older adults to assert control over factors that affect their experience of coming to, being in, and leaving hospital. From this perspective, self-determination and having a voice in decision-making are paramount.

The study will employ its analysis of empowerment at an individual level because older adults are a heterogeneous group. To do otherwise disregards the individuality of older people and implies that one empowerment strategy will fit all. It would be naïve, however, to ignore the social and political influences of hospitalization that require collective empowerment strategies. One older adult alone will not create the kind of system change – or hospital reform – that is needed today. While this literature review speaks specifically to empowerment of older individuals when they are in hospital, the critical perspective of the dissertation research necessitates acknowledging that system change must occur concurrently to effectively improve the conditions facing all older

people in hospital. The characteristics of older adults using hospital services will change over time. Future generations of older adults will bring with them a different set of attributes and expectations to the context of hospitalization. Adopting a person-environment fit approach to empowerment initiatives will allow the flexibility required to adjust to corresponding changes in the characteristics and context of older adults in hospital.

*Empowerment and Hospitalized Older Adults*

Empowerment literature related to older adults is discussed in the context of autonomy, decisional control, self-efficacy, formal and informal support, and population dynamics to name a few (Cox, 1999; Cox & Dooley, 1996; Cox & Parsons, 1994; Donelan, 1995; McWilliam, Brown, Carmichael, & Lehman, 1994; Thursz, 1995). Discussions of empowerment and older adults in health care have been located in the context of community, long-term care (residential services), resource allocation, and in discharge planning processes from hospital to home (Cox & Dooley, 1996; McWilliam et al., 1994; Tolley, 1997; Wells, 1997).

Cox and Dooley (1996) conducted a study of care-receivers' perceptions of their role in care processes. Ninety-one older adults were interviewed regarding their role and their positive and negative perceptions of care giving and care-receiving processes; coping with disability, and loss of independence; use of caregivers, and other aspects of their situation. Findings suggest that older care-receivers maintain their independence by doing as much as possible for themselves, assisting caregivers to the best of their ability, and by learning new ways to achieve self-care. In a second analysis of the data, Cox

(1999) extrapolated respondents' descriptions to compile a series of themes regarding what older participants understood empowerment to mean. These themes included:

- being able to take care of one's self;
- not being a burden to others – especially children;
- having resources such as income, appropriate housing, and medical coverage;
- having friends and family members who care about them;
- having knowledge about services and programs, and how to deal effectively with professionals;
- being able to be useful and give something of value to others; and
- being able to change the environment, including professionals' behaviors, and service delivery problems, including content, access, and amount (p. 180).

According to these themes, empowerment implies elements of power, control, and informed decision-making. It also involves choice, effective problem solving, and being an active participant in processes that affect the person. Although participants in Cox's and Dooley's (1996) study were community dwelling and not hospitalized individuals, their experiences involved professional care-providers. Blair (1995) and Tolley (1997) also found that older adults in residential care facilities who make decisions have healthier and happier attitudes. In all, findings from these studies were congruent with the literature supporting personal empowerment as a means to self-determination and self-efficacy (Anderson et al., 2000; Arnold et al., 1995; Bolton & Brookings, 1996; Gibson, 1991; Israel et al., 1994; Labonte, 1990).

A literature review on the topics of hospitalization, empowerment, and older adults yielded limited results. One study by Faulkner (2001) aimed to develop a valid and

reliable measure of patient empowerment and disempowerment in hospital environments catering to older people. Nurses (N=38) were asked to identify empowering and disempowering acts that they believed were indicative of interactions between staff and older adults. Ninety-eight acts were identified and then subjected to a review by hospitalized older adults (N=20) who determined the extent to which the acts gave control or took control away. An act denoted staff members' actions toward an older person while in hospital. For example, do staff invade your privacy while you are performing a personal activity? Alternatively, do staff make themselves available after realizing that you need help?

Twenty of the highest scoring acts from each category formed the Patient Empowerment Scale (PES). The PES was administered to hospitalized older adults (N=102) on five in-patient units, representing medicine, surgery and rehabilitation areas. ANOVA showed significant differences between groups ( $F=8.593$ ,  $df 4$ ,  $P<0.01$ ) suggesting that the PES could be a "means of identifying hospital environments that place patients at risk for becoming dependent, or which facilitate increasing independence" (Faulkner, 2001, p. 683). Items from the PES correlate with factors from previous research denoting attributes of empowerment.

In another study, Loft, McWilliam, and Ward-Griffin (2003) conducted a phenomenological investigation to understand empowerment at home after hospital discharge. Results suggest that older adults showed strong deference to the traditional professional expert model. Participants in this study "expressed no expectations for empowerment or equity in relationships [with professionals]" (Loft et al., 2003, p. 46). They did, however, have expectations for a personal, equitable, and more empowering

relationship with nonprofessional care providers, suggesting that older adults discriminate between professional and nonprofessional relationships by having different expectations between these types of caregivers.

The literature review was extended to empowerment of families of hospitalized children for two reasons. First, the initial search on the combined topics of older adults, hospitalization, and empowerment yielded limited results, and secondly, empowerment experiences of hospitalized families could be extrapolated to older adults because of similarities between the populations. The similarities revolved around the consistency of hospital bureaucratic systems and the dependant nature of being a child or a frail older adult with a chronic disability.

One study by Gibson (1993) explored empowerment in mothers of neurologically challenged and chronically ill children in hospital. In this study, mothers developed and employed the necessary knowledge, competence, and confidence to make their voices heard by professionals working in hospitals. Building on the work of Keiffer (1984), Gibson re-conceptualized empowerment as participatory competence: the ability to be heard by those in power. Gibson argued that employing principles of empowerment is of greater importance than definitions of empowerment. According to Gibson, the principles of empowerment in action are what promote self-determination, decision-making capabilities, and self-efficacy. The principles Gibson applied to mothers with children in hospital are easily transferable to hospitalized older adults. Translated, the principles would include:

1. Older adults have capacity and are competent to make decisions about issues that affect them;

2. Social systems have the potential to create or obscure opportunities for the competencies of older adults to be displayed; and
3. Older adults require information to make informed decisions.

This researcher would add a fourth principle: older adults hold expert knowledge about the experience of coming to, being in, and leaving hospital. When acknowledged, the fourth principle becomes relevant to the dissertation because it suggests that older people hold a body of knowledge that is as meaningful to successful hospitalization as the professionally held knowledge that governs hospital activity. Nevertheless, how do two different kinds of knowledge (the professional's and the patient's) interface to ensure that problems are avoided and decisions are made from the perspective of what is important to the older adult? In the hospital setting, professional knowledge currently supersedes patient knowledge. The next section of the literature review examines older adults' views of hospitalization, and the problems they experience as they journey from admission to discharge.

### **Older Adults in Hospital**

Literature pertaining to older adults in hospital can be organized into two subtopics: risks associated with acute care hospitalization, and the experiences of older adults in hospital.

#### *Risks Associated with Acute Care Hospitalization*

The literature is replete with examples of how hazardous acute care hospitals can be to the health of older people (Creditor, 1993; Dudek, 2000; Palmer, 1995). The risk of experiencing adverse medical events (Baker et al., 2004; Thomas & Brennan, 2000; Tsilimingras, Rosen, & Berlowitz, 2003), developing functional disabilities (Inouye et al.,

1993), or acquiring unfavorable physical and/or social outcomes (Creditor, 1993; Tsilimingras et al., 2003) relate to the preponderance of chronic health needs in conjunction with advancing age that accompany older people to hospital (Palmer, 1995).

Chronic illnesses tend to accumulate with age; deterioration in function and a rise in disability and dependence are common in older people (Longino & Murphy, 1995; Martel, Belanger, & Berthelot, 2003). In 1996, 82% of all older adults living at home had a chronic health condition; 28% were limited in at least some activities because of the chronic condition. In addition, 25% of all older adults living at home, and 45% of those aged 85 and older had a long-term disability (Colin, 1999; National Advisory Council on Aging, 1999).

Heart disease, hypertension and stroke, respiratory illness, diabetes, and digestive problems are prevalent in older populations (Canadian Institute for Health Information, 2000; Segall & Chappell, 2000). Thirty-seven per cent of older Canadians suffer from arthritis (National Advisory Council on Aging, 1997). In addition, “later life is typically characterized by increasingly complicated co-morbid patterns (in other words, older adults often experience three or four different chronic health problems at the same time)” (Segall & Chappell, 2000, p. 140).

Chronic pain and discomfort are part of the health profile of older adults. “In 1996-97, one in four seniors (25%) living at home reported they experienced chronic pain or discomfort, compared with just under 21% of those 55 to 64 and only 12% of those between the ages of 25-54” (Colin, 1999, p. 62).

Sensory impairments are also prevalent in an aging population. For example, more than 40% of men and women living in institutions are hearing impaired; 89% of

those require a hearing aid. A natural decline in smell and taste begins after age 60. Visual impairments affect 9% of older Canadians, and 38% of these people become functionally impaired (Statistics Canada, 1990; 1996).

The chronic health needs of older adults can result in barriers to autonomy, chronic pain, fatigue, loss of stamina, incontinence, and impaired mobility. Consequently, as functional ability declines from sensory impairments (e.g., vision and hearing), serious acute illnesses (e.g., cancer, stroke), and cognitive changes (e.g., Alzheimer's disease, dementia), more comprehensive care is required that is more psychosocial in nature and less medically oriented (Longino & Murphy, 1995).

In conjunction with chronic illnesses and functional disabilities, many older adults require prescriptions or over-the-counter medications. Together these factors make older adults more vulnerable to adverse functional outcomes linked to age, general health status, medical problems, function and cognitive status, and nutritional state (Clark, 2001; Karp & Koval, 1998; Thomas & Richie, 1995). This is due in part to a decrease in physiological functional reserve, a natural consequence of the aging process (Creditor, 1993; Tsilimingras et al., 2003). Longino and Murphy (1995) point out that people with chronic health needs are vulnerable and continually at risk for adverse physical and social outcomes; the critical variable in their experience, however, is the degree of risk that exists.

In addition to risk and vulnerability associated with chronic health concerns and the use of prescription medication, professional intervention can sometimes exacerbate existing problems for older adults when they act as "pathogens or sickening agents" independent of older people's personal characteristics (Illich, 1975). Illich (1975) and

Freidson (1970) both argue that iatrogenic harm is likely to occur in any treatment setting where people seek professional intervention. Research specific to hospitals indicates that vulnerability increases susceptibility to adverse outcomes in individuals with any of the following: vision impairment, severe illness, cognitive impairment, dehydration, malnutrition, greater than three medications, immobility, substance abuse/misuse, and advancing age (Boult et al., 1993; Heruti, Lusky, Barell, Ohry, & Adunsky, 1999; Inouye, 2000; Inouye et al., 1993; Liebergall et al., 1999; Tsilimingras et al., 2003; Wakefield, 2002 ; Winogard et al., 1991).

Inouye and Charpentier (1996) found five precipitating risk factors. The use of physical restraints, malnutrition, use of more than three medications, use of urinary catheter, and any iatrogenic result from treatment were indicative of vulnerability during hospitalization. The contributions of baseline vulnerability and precipitating risk factors were found to be interdependent and statistically significant (validation cohort =  $p < 0.001$ ). The authors concluded that the findings validated predisposing risk factors (older person factors) and precipitating risk factors (those occurring in hospital) to create a climate that contributes to adverse outcomes “in independent, substantive and cumulative ways” (p. 259). Hence, although older person factors contribute to adverse outcomes during hospitalization, precipitating risk factors suggest that being in hospital may act as an independent factor in and of itself.

In another hospital setting study, Inouye et al. (1993) conducted two prospective cohort studies to develop and validate a predictive risk index for functional decline based on the personal characteristics of older patients. Using four independent baseline risk factors for functional decline (decubitus ulcer, cognitive impairment, functional

impairment, and low social activity level), researchers developed a risk-stratification system by adding the total numbers of existing risk factors identified on admission to hospital. Rates for functional decline for low (zero risk factors), intermediate (1 to 2 risk factors), and high (3 to 4 risk factors) were 8%, 28%, and 63% respectively ( $p < 0.000$ ) in the first development cohort group. Functional decline occurred in 51 of 188 (27%) patients in the development cohort.

To validate the predictive model developed in the first study, an independent second cohort sample of older patients was assembled. The corresponding rates in the validation cohort, of whom 24% (34/142) developed functional decline, were 6%, 29%, and 83% ( $p < 0.000$ ). The study concluded that the risk of functional decline increased with a corresponding increase in the number of risk factors, “suggesting that the predisposition to functional decline may result from the cumulative effects of multiple impairments” (Inouye et al., 1993, p. 650).

This section of the literature review indicates that, even with the best intentions to achieve positive outcomes, being in hospital can be hazardous for older adults. Hospitalization itself is shown to be an independent risk factor (Inouye & Charpentier, 1996). When accompanied with chronic health needs and physiological consequences of aging, being in hospital can set up a cascade of events for older adults and their families that unintentionally lead to poor clinical outcomes and functional disability (Creditor, 1993; Illich, 1975; Inouye et al., 1993).

#### *Experiences of Older Adults in Hospital*

Research pertaining to the encounters of older adults with hospital systems report sentiments of discontent that suggest their experiences have been troublesome. For ease

of discussion, these sentiments can be organized into two categories: (a) gaps in attention to needs and expectations, and (b) problems, complaints, or concerns. These categories are closely related and at times overlap.

*Gaps in attention to needs and expectations.*

The first subset of literature examines quality, and how older patients perceive satisfaction with continuity of care. Holloway, Smitii, and Warren (1998) examined the interface between acute hospital care and return to home in relation to the older person's perceived ability and preparedness to manage and cope at home. Questionnaires were administered to 119 older patients at the time of discharge, and then at a six-month follow-up. Findings indicated "a large number of patients reported experiencing considerable difficulty with activities of daily living, particularly instrumental activity of daily living prior to and especially after discharge.... Despite large numbers of patients experiencing functional limitations, few were referred to hospital or community-based therapy services" (p. 132). Similarly, Mistiaen, Duijnhouwer, Wijkel, de Bont, and Veeger (1997) found that 80% of participants mentioned the need for more information. Housekeeping tasks caused the most difficulty; overall, 40% of participants left hospital with an unmet need, defined "as the wish of the patients to have more assistance in performing some activities or for more support/advice in dealing with physical or emotional complaints" (p. 1235).

Van der Smagt-Duijnste, Hamers, and Abu-Saad (2000) studied the experiences of relatives of stroke patients. Families reported that information was key in their ability to maneuver through the system. The need for information becomes critical to "make sense" of health care experiences such as hospitalization. Higgins, Fiveash, Parker, Lay,

Rutter, Wansley et al. (1997) argue that older people “explore and seek clarification and understanding about how and why the illness event occurred” (p. 18). In addition to information needs, Delbanco, Stodkes, Cleary, Edgman-Levitan, Walker, Geiteis et al. (1995) found that communication, emotional support, alleviation of fear and anxiety, and pain management were care concerns expressed by medical patients.

The need for information was a consistent finding in studies of older adults’ experiences in hospital. However, the type of information requested by older people differed (e.g., better knowledge of hospital systems, routines, and processes for diagnostic testing). Watson, Marshall, and Fosbinder (1999) found that although emergency room patients identified the need for information, they did not “mention [their] need for information regarding care or support at home following discharge from the emergency department” to hospital staff (p. 89).

In studies undertaken in the hospital setting, older adults reported being discharged from hospital before they perceived themselves ready. When they were home, some did not have access to the resources required to meet their needs and assist their recovery. These unfulfilled needs included activities and instrumental activities of daily living (Clark, Steinberg, & Bischoff, 1997; Freeman & O’Connor, 2002), participation in decision-making, resuming a pre-admission lifestyle (Shih & Shih, 1999), lack of information about the course and signs of recovery, and assistance with functional limitations and housekeeping tasks (Mistiaen et al., 1997).

McKnight (1987) examined perceptions of care in an effort to identify key criteria with which to evaluate quality care. Expectations of “good quality care” were “characterized as individualized, patient focused and related to need; it was provided

humanistically, through the presence of a caring relationship by staff who demonstrated involvement, commitment and concern. Care described as 'not so good' was routine, unrelated to need and delivered in an impersonal manner, by distant staff who did not know or involve patients" (McKnight, 1987, p. 456).

The nature of care that was noted to be important but problematic to older people included involvement in decision-making, acknowledgement of and provision for individuality, anticipation of need, and, finally, willingness of staff to assist the older patient in care activities (Attree, 2001). Gaps identified in interpersonal aspects of caring included communication, sharing information, rapport and knowledge of the patient as a person, and overt demonstrations of kindness, concern, and sensitivity. Informants in Attree's study described staff taking time with patients, answering requests for information, and relationships between professional staff and patients as important factors for positive health care experiences. Similar factors emerge from studies conducted in rehabilitation settings (Cowger, 1994), acute care medical/surgical areas (Forbes et al., 1997), cardiology (Shih & Shih, 1999), the emergency unit (Watson et al., 1999), long stay geriatric settings (Higgs, MacDonald, & Ward, 1992), community dwelling seniors (Gallagher & Hodge, 1999), and home services (Samuelsson & Brink, 1997).

*Problems, complaints, or concerns.*

Older adults reported problems, complaints, and concerns in three areas: care processes, communication, and the structure and treatment setting of the built environment (Dady & Rugg, 2000; Douglas & Douglas, 2004; Forbes et al., 1997; Mistiaen et al., 1997; Shih & Shih, 1999; van der Smagt-Duijnsteet et al., 2000). Care

concerns that cross settings included: wait times, doubts about professional competency, lack of physician attention, and not promptly addressing symptoms such as pain. Similar to studies cited in the first category, gaps in attention to needs and expectations, insufficient information about routines, and lack of guidance about care activities were concerns across treatment settings.

Studies undertaken by Bull, Jervis, and Her (1995), Dady and Rugg (2000), Higgs et al. (1992), Lyytinen, Liippo, Routasalo, and Arve (2002), and Wells (1997) all reported that structures and processes in hospital environments raised concerns for older adults and their families. Their concerns revolved around issues specific to admission and discharge processes, facility design, participation in decision-making, lack of control and influence over their care, and having greater say and choice in care procedures.

Using observations and interviews with patients 75 years of age and older and the relatives who accompanied them to hospital, Kihlgren, Nilsson, Skovdahl, Palmblad, and Wimo (2004) identified six core variables related to the experience of waiting in the emergency department. Waiting was a disagreeable event described by participants as unpleasant, unnecessary, lacking good routines, suffering, evoking bad feelings, and that nursing care provided while waiting was performed to meet medical and technical demands not the older adults' views of their needs (Kihlgren et al., 2004). Similarly, Yen, Chen, and Chou (2002) report the concerns of hospitalized older adults as multi-dimensional, involving physical condition (i.e., treatment-related physical concerns, and disease-related physical concerns), promptness and effectiveness of nursing services, health professionals attitudes (i.e., caring attitudes, interactions with hospital staff, and

responsibilities), and the environment (i.e., infection control, spacing, temperature and noise, limited choice).

In a related study, Li (2005) found four categories of worry experienced by caregivers during hospitalization of older family members. These categories included worry about the older person's condition, care provided by the professional team, care requirements provided by the family following discharge home, and finances. This study points to the idea that hospitalization is a family-centered event characterized by emotional turmoil, concerns for the older patient, and future impact on the family.

In a study to determine the number, instigators, nature, and outcome of complaints over a one-year period, Anderson, Allan, and Finucane (2000) found people 65 years and over accounted for 23% (127 of 505) complaints, giving a rate of 1.44 per 1000 occasions of service (95% CI, 1.19-1.69). These complaints were characterized as communication and treatment related issues. Treatment issues captured under the "absence of care" category included complaints about wait times, access to hospital beds, or outpatient clinic treatments. Poor professional communication or interpersonal skills often contributed to older patients' perceptions of events. In such cases, older patients reported rude, discourteous behaviors and negative or patronizing attitudes of professional staff.

Caution must prevail when interpreting the meaning of complaints and/or reports of satisfaction. Just because an older adult fails to request services or report a need, this does not mean that no need exists. Nor does the absence of a complaint mean a patient is satisfied. Such assumptions fail to consider the varied values and attitudes of older people (Donelan, 1995; Thursz, 1995), the disempowering effect of professionally dominated

systems (Latimer, 1999) and the social-cultural aspects of aging (Gadacza, 1994; Latimer, 1999). For example, reluctance by some older adults to report their concerns or need for support may not mean they are unwilling to practice self-determination. This reluctance may stem from fear rooted in a lack of knowledge or confidence in their ability to make decisions. It may also result from a lifelong pattern of deferring decisions to others (i.e., families, children, professionals, and spouses) (Anderson et al., 2000).

In addition, older adults have reported fear of repercussions, particularly in treatment settings where they are dependent on caregivers for assistance. For example, Nelson (2000) used social exchange theory to examine the relational dynamics in the nursing home environment, and concluded that power imbalances evoke dysfunctional conflict and submission. The nursing home's organizational structure encourages compliance and control and in turn, "perpetuates the nursing home's power structure" (p. 43). Resultant feelings of powerlessness prevent residents from positioning themselves outside the nursing home's norms. To do so when the older adult is dependent on the organization may place him or her at risk for punitive consequences.

Nelson (2000) cites numerous studies that found retaliation in the form of ridicule, delay in care, manhandling, forced discharge, physical or chemical restraint, and verbal and physical abuse. Although the research was conducted in nursing homes, the findings have relevance for hospitals because both are bureaucratic organizations with professionally oriented systems and processes (Latimer, 1999; Wells, 1997). One cannot assume, therefore, that the absence of reported complaints represents satisfaction or a goodness-of-fit between what older adults want and need, and what the hospital system provides (Anderson et al., 2000). Researchers must consider whether an older adult's

tolerance of the hospital environment actually means acceptance, resignation, or submission. It is also important to consider what the accounts of older adults' hospital experiences do *not* tell us and why.

Anderson et al. (2000) also found that advocates – not older adults themselves – made 73% of reported complaints. This is a critical finding because who and what defines a problem can influence the range of acceptable and/or available solutions. Therefore, if funding is defined as the problem, the solutions will be seen as economic in nature. If access is the problem, then the answers may be found in resource allocation and program or service development. Likewise, if the older person in hospital is viewed as “inappropriate” for a particular treatment setting, the person may be defined as the problem, and the solution may be to move the older person from the treatment setting.

The literature on problems, complaints, and concerns expressed by older adults raises many questions. For example, why were 73% of complaints in the Anderson et al. (2000) study made by advocates of older adults? Why did older adults not come forward with their complaints? Is there something in the nature of being old in a system of care that affects the older adults' ability to report problems? Is it the characteristics of older adults themselves, the hospital environment, or differences between older people, hospital staff, and family caregivers in their views of needs and expectations?

In another study, Hancock, Chang, Chenoweth, Clarke, Carroll, and Jeon (2003) used a survey method to investigate three aspects of hospitalization: (1) the important aspects of nursing care as perceived by hospitalized acutely ill older adults, their family members who observed care performed by nurses, and the nurses who performed care; (2) satisfaction levels for nursing activities performed in hospital; and (3) the correlation

between nursing care priorities and satisfaction expressed by the three groups.

Completing doctors' orders ranked first as the most important aspect of nursing care for each group. Physical care, psychosocial care, and discharge planning followed. Nurses and family members rated physical care, psychosocial care, and discharge planning more highly than did older patients, suggesting that needs and expectations can vary between these three groups. Similarly, Rose, Bowman, and Kresevic (2000) also found a lack of agreement between nurses and family members when investigating nurse and family caregiver perceptions of health status, needs to maintain health, and self-care problems at admission and discharge. These findings suggest that identification and reporting of problems is influenced by those who may have a vested interest, whether they be a family member, friend, or professional. This may account for who reports problems and concerns and the variability in patterns of reportable incidents (Anderson et al., 2000).

Obtaining perspectives of both health care providers and older patients regarding their concerns is important because any misunderstanding of the issues experienced by either group may lead to further problems, complaints, and poor satisfaction (Chang, Chenoweth, & Hancock, 2003). Expressed in customs and traditions, hospital culture subsumes the inherent nature of bureaucratic organizations, which culminates in operationalized services rendered by the hospital. Thus, hospital culture may further exacerbate the issues of discontent expressed by older adults.

These studies are relevant to the dissertation because problems defined as system issues rarely take into account individual values. When problems are defined in system language, older adults are disadvantaged because they do not speak about their issues in policy language; they express personal experiences, which are the consequences of policy

implementation. The literature presented thus far on older adults' experiences of hospitalization serve as examples of these consequences. The next section examines hospital customs and traditions in the environment that influence the consequences of being old in hospital.

### **Customs and Traditions of Acute Care Hospital Services**

Although hospitals are integral to the operation of today's medically dominated health care system, this was not always so. It was not until the early twentieth century, during the era of "institution building" and with the advent of medical technology, that convenience brought the hospital into the center of health care business (Chappell et al., 2003).

This section of the literature review will focus on bureaucratic forces and professional power, technological dependence, and the ideological conflict between acute and chronic care philosophies. It will be argued that these forces combine to exert a disempowering influence, one that is exemplified in hospital customs and traditions that together disadvantage older people.

#### *Bureaucratic Forces and Professional Power*

Bureaucratic forces and professional power shape hospital customs and traditions that create pressure to conform to the rules and regulations of the system (Goffman, 1961; Latimer, 1999). Professionals, those "skilled and learned experts who apply their knowledge to the affairs and in the service of others, are traditionally held in high esteem" (Illich, 1987, p. 9). Their power comes from their knowledge and socially sanctioned and valued monopoly over particular modalities (Freidson, 1970; Kuhn, 1970; Turner, 1987). Medical professionals, for example, have managed to convince society

that their special knowledge can define public issues as problems or needs (Chappell et al., 2003).

“Professional power is a specialized form of the privilege to prescribe. It is this power of prescription that gives control” to employees of hospitals (Illich, 1987, p. 17). For example, the illness model associated with medicine defines health as the absence of disease and illness. Illness is understood as “(1) deviation from normal, (2) specific and universal, (3) caused by unique biological forces, (4) analogous to the breakdown of a machine, and (5) defined and treated medically through a neutral, scientific process” (Weitz, 2004, p. 124). Physicians, with their specialized body of knowledge, determine what is wrong with a sick or injured person and, with the help of technology, interpret the person’s needs (Evans & Stoddart, 1990; Weitz, 2004). “Hospitals [have] become the place of medical care” (Chappell et al., 2003). The five doctrines, as noted above, form the philosophical foundation of hospital care.

Overall, professional dominance in the hospital system creates pressure to conform to the rules and regulations of the system (Chappell et al., 2003; Goffman, 1961; Latimer, 1999; Moos, 1974; Sherwin, 1992). This type of dominance is exemplified in existing structures and processes supported by bureaucratic power sources. In the hospital system, physicians rule; they control admission and discharge processes, access to long-term care and community resources, diagnostic and laboratory testing, prescribing of medications, treatment referral arrangements, and weighted<sup>4</sup> participation in decision-making and treatment choices (Brown, 1987; Lewis, 2005; Thorne, 1993; Turner, 1987; Wells, 1997).

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<sup>4</sup> The problem is not that professionals participate in health care decision-making. Their participation is required; they hold an important body of knowledge. Participation becomes a problem when it supersedes the right of the patient to decide (Kaufman, 2000; Wells, 1997).

Physicians and other professionals occupy a privileged position at the top of the hospital hierarchy (McKinlay & Stoeckle, 1988). This is exemplified in the functional organization of the hospital into medical specialties, such as pediatric, geriatric, and orthopedic services. Their control over functional operations is also entrenched in the governance structure of the hospital through professional practice committees and legislated self-governing bodies such as medical advisory committees, a required element of hospital administration under the provincial Hospital Act in British Columbia (Brown, 1987). The position of professionals in the hospital hierarchy legitimizes their power and enhances their ability to influence organizational policy toward support of an acute intervention using an illness-based model of service delivery (Weitz, 2004).

Hospital processes are built around the needs of health care professionals rather than the needs of the patients they serve (Weitz, 2004). Discipline-specific care practices and communication between patients and professionals are examples of processes created to support professionalization in hospital operations. Upon admission, all action, investigations, and treatment of symptoms are coordinated around the patient's diagnosis as determined by physicians.

Health care bureaucracies also have a natural tendency to create elite power by professionalizing leadership roles (Freidson, 1970). Hospitals form part of the bureaucracy found within the health care system, which like all bureaucracies forms a social organization that enables professionals to play specialized roles; their purpose is to instill efficiency, speed, and precision into organized human effort (Freidson, 1970).

Bureaucratic power is maintained in hospitals through two organizational devices: maintaining a monopoly of expertise and the capacity to carry out policies made to

influence people and control structures and processes. This is exemplified in the role of discharge coordinators and case managers who “operate as links between the measurement of need and the resources of service systems” (Dill, 1995, p. 453). The professional is “vested with power and decision-making [authority] by the bureaucracies that employ them – making decisions for people rather than responding to the wishes of their clients” (Thursz, 1995, p. xiii). In such situations, the clients’ wishes are always a consideration, but bureaucratic mechanisms (i.e., pathways, admission criteria, waiting periods, bed-hold time limits, or classification systems) usurp client wishes because flow-through<sup>5</sup> is the system priority.

The disempowering application of this “power-over” decision-making authority implies that older adults with chronic health needs, for example, are seen as “cases” to be managed, thereby dismissing their personhood. In the end, the actions of professionals, such as case managers and discharge coordinators, become controlling when, out of often-altruistic motives, they intentionally abdicate to the pressures of the organization.

In the case of institutional ageism, discriminatory practices become legitimized as “part of bureaucratic policy [that] can be justified as unintentional, beyond individual control or normatively based. Individuals carrying out discriminatory policies may or may not themselves be prejudiced” (Williamson et al., 1985, p. 207), but they are influenced by bureaucratic power to conform to the needs of the organization. There are observable professional practice behaviors or activities (resulting from bureaucratic forces) that unwittingly place older adults’ needs subservient to the needs of the institution. These professional practice activities are not consciously designed with an

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<sup>5</sup> Flow-through is an industry term in acute care capacity discussions that denotes movement of patients through the system.

ageist agenda, but rather are a consequence of bureaucratic powers. Ageism within professional practice may exist, for example, in hospital discharge planning or case management processes. In such cases, older patients may be placed in activities or facilities of care designed to help them comply with organizational expectations for being a 'good patient' (Breeze & Repper, 1998; Latimer, 1999). Professionals control these decisions, due to their role and function determined within the bureaucracy by organizational job descriptions. These guide what professionals do, and to some extent how they do their work.

The disempowering qualities of bureaucracies are evident in hospitals. They tend to overpower older adults through their regulations. For example, policies and procedures often limit choice and time spent with older clients (e.g., number of visits made, number of visitors allowed, access to resources using eligibility criteria that may reduce the amount and type of assistance provided).

Studies have found "dependent behaviors can result from bureaucratic routines imposed on the residents and by care practices that discourage the expression and exercise of self-determination" (Whitler, 1996, p. 226). For example, routine care is most often provided between 0700 and 1200 hours when the majority of staff is working. However, this may not be when an older patient requires attention. Choice is limited by what works best for staff, even when residents would prefer other options (Blair, 1995; Tolley, 1997). Holloway et al. (1998) also report, "while patients seem to have too much time 'on their hands', professionals are 'pressed for time' ... professionals often use the pressure of time to enforce their authority and power" (p. 464). Similarly, West, Barron

and Reeves (2005) found time pressures interfered with nurses' ability to address patients' anxieties and concerns, or give patients and relatives information.

In a study of patients in mental institutions and prisoners in long-term detention, Goffman (1961) argues that total institutions create dependency by deliberately eroding people's sense of self. This process begins by disrupting the person's sense that "he has some command over his world – that he is a person with "adult" self-determination" and choice (Goffman, 1961, p. 43). Similarly, Nelson (2000) uses social exchange theory to argue that asymmetrical power-over relationships contribute to dependence and control in nursing homes, which hinders fair bargaining between staff and patients, and causes inequities in care delivery.

Not all institutional treatment settings exhibit the same degree of bureaucratic power, nor do they exert the same influence on individuals. Research has found that the degree of control exhibited by professionals will vary across treatment settings (Moos & Smail, 1974; Goffman, 1961). For example, older adults living and receiving care in the community report more autonomous health care experiences (Iecovich, 2000). According to Iecovich, (2000), "whenever the care is provided in a short-term and acute setting, the professional-patient relationship will be more authoritative, more distanced and more oriented to the professionals' culture, while as someone moves toward more long-term care and homecare the relationship moves toward more collaborative sharing of control and responsibilities" (pp. 80-81). Other studies have also found that treatment settings influence the balance of power, responsibility, and control among older people, family members, and lay care providers (Hasselkus, 1988a ; Levine & Giltin, 1993; Reed & Stanley, 2000; Sankar, 1986 ).

These findings are significant to the dissertation research because the social ecological perspective asks not only what type of treatment settings produce problems for older adults, but under what circumstances. This perspective assumes that environmental dynamics may vary within treatment settings that are constructed differently. They may provide varied manifestations of positive or negative transactions based on factors such as the degree of control older adults retain when they encounter the health care system.

Other studies have found that treatment settings can shift the balance of power, responsibility, and control among older people, family members, and lay care providers, suggesting that when tensions arise, they are contextually influenced. Hasselkus (1988a) conducted four ethnographic interviews with 15 family caregivers and found that professionals dominate in hospital or rehabilitation settings. However, when the person was moved to a long-term care setting, relationships began to equalize. By the time the person returned to community living, control of care was predominately individual or lay.

Reed and Stanley (2000) using interviews and focus groups of older patients and their families, found that older participants did not exercise choice over nursing home options when discharged from hospital, while older adults who received health care services at home reported greater autonomy and control. Similarly, Levine and Gitlin, (1993) found greater success when occupational therapists “surrendered” power and control to older patients receiving care in their own homes. Sankar (1986) also found that physician control decreased in the home setting. Control has been shown to be a factor in discharge planning, treatment choices, access to information, and care routines in long-term care facilities and hospitals (Blair, 1995; Iecovich, 2000; Reed & Stanley, 2000; Sankar, 1986; Tolley, 1997; Wells, 1997).

### *Technological Dependence*

Customs and traditions also support hospitals' dependence on technology to deliver acute interventions. According to Franklin (1999), technology is a system far more influential than individual material components; the rise of technology involves a mindset. As an agent of power and control, Franklin (1999) argues technology has changed social and individual relationships, creating professions who can claim "exclusive right to certain tools and to certain technologies" (p. 8). In the health field, technology reinforces social dependence on the biomedical model by focusing on bodily systems and functions, rather than on psychosocial interventions.

While "[t]here's no question that the Age of Technology has furnished the medical profession with powerful tools to improve its ability to detect and treat disease," (Rachlis & Kushler, 1989, p. 76) it has also fostered dependency on investigative technologies, diagnostic laboratories, and equipment to provide the information required to determine the problem and achieve the goal of reversing illness. For example, when technology standardizes measures of bodily functions, disease and illness are seen to be predictable, *only* to be understood with the precision of diagnostic testing (e.g., laboratory and x-rays). When diagnostic testing takes place in a particular location and is conducted only by specially trained health care practitioners, people tend to become dependent on the acute care system. The professional is in total control of the process (Franklin, 1999).

The acute care model encourages dichotomous thinking based on expectations of what is and what is not normal. When normalcy is associated with objective criteria, the subjective or lived experience of the older person becomes less important in the diagnostic process and treatment decision (Longino & Murphy, 1995). Longino and

Murphy (1995) argue that technology has positive benefits, but there are also drawbacks because the hospital system depends on medical care that relies heavily on technology to the exclusion of other approaches. They argue subjectivity is curtailed by the pervasive use of technology.

On the surface, this may not present a problem. Hospital processes are built around the needs of physicians and other health care professionals to deal efficiently with acute problems that rely on a scientific-objective paradigm and deal with problems that are located in diseases found within the body and, when they are treated, lead to cure (Dietz, 1995; Chappell et al., 2003). This paradigm, however, does not capture the psychosocial needs of older adults with chronic health concerns because by nature these concerns such as arthritis, cardiovascular disease, degenerative neurological afflictions, and frailty are not amenable to cure (Thorne, 1993).

Franklin (1999) and Navarro (1986) contend that the hospital must organize its customs and traditions around the needs of professionals to support the technologies central to its service activities. In this way, technology influences the social relationships between individuals and organizational systems (Franklin, 1999). Navarro (1986) argues technology has “determined the underlying assumptions of practitioners and patients, but most importantly the organization of medicine” (Navarro, 1986, p. 20).

Technology dependent acute care interventions are also tied to capitalistic endeavors. Capitalist ideology maintains that the economy benefits when more people are well and able to work. From this perspective, “the health care system is viewed in the context of the larger capitalist socio-economic system, which has to guarantee to give greater priority to the profit-making capabilities of corporations (capital accumulation)

than it does to the well-being of its citizens” (Coburn, D’Arcy, New, & Torrance, 1981, p. 7). Vested interests are often tied to political influence and economic gain. The media, supported by corporations, such as pharmaceutical companies, can manipulate public sympathy. These factors are interconnected; their powerful influence culminates in a co-dependant synergy.

Longino and Murphy (1995) contend that a structural dualism is present in health care. They argue that only technologically dependent scientific approaches to healing derived from biomedicine are considered legitimate, while other approaches are not. Canada has laws that determine who has a legitimate right to treat patients and under what conditions. To illustrate, practicing medicine, performing surgical procedures, or prescribing controlled substances without a license is considered a crime. “The purpose of such laws is ostensibly to protect the public. One result, however, is that the power, privilege, and resources of biomedicine are protected” (Longino & Murphy, 1995, p. 6). Such power and control translated into the hospital setting affords health care professionals a legally supported mandate to control hospital practices. The result is “an approach to health that is illness based, framed in absolutism, exclusiveness and where resources are involved, privileged” (Longino & Murphy, 1995, p. 6). For older adults with chronic health needs, this means they may be denied the opportunity to access other health modalities that treat functional disabilities often associated with chronic health issues. Such modalities might include homeopathy, occupational therapy, healing touch, or acupuncture.

An ideological conflict emerges when the hospital's mandate to render technologically efficient, acute intervention services is juxtaposed to the chronic health needs of older adults. The next section examines differences in chronic and acute care.

*An Ideological Conflict: Acute Care Versus Chronic Care Philosophies*

Powerful forces found within the health care environment create an "ideological conflict" (Clark, 1990) between proponents of the acute care, illness-based model and the chronic health model. From an ideological perspective, conflict often involves submission of one set of beliefs to those with power and control (Clark, 1990). The following section of the literature review illustrates that biomedical interests are the foundation of technologically dependent hospital systems and, as such, they produce reinforcing consequences that support the acute care model to the detriment of older people who have various chronic health needs that are often ignored in hospitals.

Chronic and acute care models each play an important role in meeting the health care needs of older people; however, their unique foci are in opposition to each other. Harris-Phillips (1996) suggests the differences between acute and chronic care can be found by comparing the five parameters outlined in Table 2.

Table 2: Dueling Models: A Comparison Between Acute and Chronic Care

<b>Acute Care</b>	<b>Chronic Care</b>
1. Episodic pattern	1. Continuous life-long pattern
2. Needs reacted to	2. Needs anticipated
3. Focus on cure	3. Focus on function
4. Reliance on diagnostic testing	4. Reliance on care management
5. Diagnosis driven	5. Whole patient care

(Constructed from information published by Harris-Phillips, 1996)

Chronic health models accommodate a trajectory of illness and wellness that is cyclical in nature and measures success using quality of life indicators (Strauss & Corbin, 1988; Weitz, 2004). This means people afflicted with chronic conditions manage a course of illness that is ever-present, even in periods of wellness (Strauss & Corbin, 1988). Because the chronic illness is life-long, the experience happens at home with occasional hospitalizations for the most acute phases (Strauss & Corbin, 1988; Thorne, 1993). The afflicted person manages the conditions day-to-day with the support of a network of friends, family, and health workers. In contrast, the acute illness model is defined from a biological pathophysiological perspective, managed in health care settings such as a hospital or a doctor's clinic. Success or failure is measured in terms of morbidity and mortality (Longino & Murphy, 1995).

Chronic illness has a profound effect on "the lives and identities of the ill and their families" (Strauss & Corbin, 1988, p. 5). The illness permeates all areas of the person's life and, therefore, the needs of those who are chronically ill go beyond hospitalized medical intervention (Weitz, 2004). A chronic health model must take into

account medical, functional, psychological, social, environmental, and spiritual care services that enable the person to optimize his or her functional independence and wellbeing (i.e., the whole person) (Harris-Phillips, 1996). Consequently, treatment settings such as hospitals are less able to deal with persons with chronic health concerns because they often present with functional crises, rather than medically defined biological crises (Thorne, 1993). As noted earlier, hospitals are organized, equipped, and resourced to deal with acute illness. They are specifically oriented toward the biological and pathological: signs and symptoms, and control and management of time-limited disease with a focus on cure.

Older adults become disadvantaged in the current system because it favors treatment of acute illness. Difficulty emerges because solutions offered by the acute care model that dominate the hospital system are less able to manage the symptoms affecting quality of life associated with frailty and chronic health needs. More appropriate chronic health approaches, such as psychosocial interventions are significant to an aged population but considered less legitimate in the acute paradigm (Longino & Murphy, 1995; Palmer, 1995; Thorne, 1993; Weitz, 2004). The acute care model also places less emphasis on eliminating or reducing risk factors that may impede quality of life, especially when the chronic disease is an integral part of the older person's life, and cure is no longer an option.

Customs and traditions in hospitals revolve around a technology-dependent acute intervention model of health service delivery, and, as such, operations must support this ideology to keep the hospital functioning. This is evident in clinical assessments and decision-making processes in hospital discharge activities. These processes are based on

what works best for the system and are measured by indicators of success that reflect utilization efficiency, effectiveness, access, appropriateness, and clinical indicators – morbidity and mortality – that represent the biological medical model (Evans, 1984). Although important, these indicators fail to take account of chronic health needs, functional disabilities, and the use of psychosocial interventions in hospital.

The following section examines the interrelated activities of clinical assessment and decision-making in the hospital setting. The discussion is intended to serve as an example of the dynamic relationship between the factors discussed above and how they are operationalized in practice and contribute to the hospital experience.

*Example of a Custom and Tradition: Clinical Assessment and Decision-making*

Hospital customs and traditions are exemplified in professional clinical assessment, decision-making, and communication activities that exert a combined influence on older people and their families. It will be argued that these activities are more compatible with acute care interventions than with the chronic health needs of older adults. For example, the tradition of assessment has been developed for the purpose of diagnosing and treating presenting acute care problems; assessment has not been intended to build on strengths and abilities to foster management in chronic care situations (Cowger, 1994).

When assessments by professionals (e.g., social workers, physicians, nurses, and physiotherapists) are concerned with individual inadequacies and are weighted toward diagnosing pathological conditions, they tend to foster views of older people as weak and dependent. For example, Clemens and Hayes (1997) found that professionals form first impressions based on client characteristics, and label older adults with descriptors such

as: sweet or crotchety, wise or possessing bad judgment. “This label then tends to subsume other risk factors in practitioners’ assessments of particular clients. A practitioners’ use of labels tends to preclude the inclusion of new evidence ... and closes off objective weighing of evidence” (Clemens & Hayes, 1997, p. 11). These professionals also simultaneously made judgments about older clients’ mental competence and compliance with the care plan – separate from evidence to the contrary.

In British Columbia, for example, the designation of ALC (alternate level of care) is used to denote in-patients who are no longer acutely ill but remain in hospital longer than anticipated because post recovery service plans are not in place to facilitate discharge (Rock & Auerbach, 1994). On the surface this may not appear to be an issue. However, Clemens and Hayes (1997) found that professionals form impressions based on the characteristics of patients designated as no longer requiring acute care. Once the older acute care patient is labeled ALC, the plan of care is adjusted because the individual is no longer viewed as a priority. Labeling the individual affects access to resources during hospital care.

During hospitalization Jacelon (2003) found older adults maintain their personal integrity by making decisions on how they would interact with professional to manage their health, dignity, and autonomy. Similarly, in an ethnographic study conducted by Latimer (1999) titled, “The dark at the bottom of the stairs: Performance and participation of hospitalized older people,” pressures to conform were found to be part of a process of “making-it” in hospital. Latimer (1999) determined that older people conduct themselves in a way to gain a positive identity when admitted to hospital. By “lying low and effacing their distinctiveness as individuals and as social beings, some older people are able to

maintain their inclusion in positive medical categories” (Latimer, 1999, p. 186). The study also illuminates the consequences for older patients when they and their needs do not fit the dominant acute care model operating in the system; patients are often categorized as less important, and they have their personal identities stripped away. In a period of initiation, Latimer states:

there is a symbolic cleaning away of some of the materials through which a patient’s self and social identity are signified. Although this clearing away helps to give the medical staff direct access to patients’ bodies, it also accomplishes something else: it communicates the idea that ... the medical gaze is uncluttered by the social markers of patients’ identities. The medical gaze is pure and objective. (pp. 199-200)

Latimer’s observations, like those of Goffman (1961), indicate that professionals in power “convey how patients are to behave *as* patients. [Therefore], it is up to the patients to fit in” (1999, p. 201). When patients insist on claiming their individuality they risk being labeled and identified as unable to conform, comply, and govern themselves.

Breeze and Repper (1998) found a similar phenomenon. They studied the care experiences of “difficult” mental health patients using focus groups and unstructured interviews, and found that patients in this setting also learned how to “succeed” in the system. Findings from these studies also suggest that patients learn to be quiet or passive to fit in. Those who did not comply (knowingly or unknowingly) in professionally sanctioned ways were labeled difficult, non-compliant, and deviant. They ran the risk of “having their illness interpreted on other than purely medical grounds and risk[ed] being

assigned to a category that is considered by staff to be inappropriate in the hospital” (Latimer, 1999, p. 201).

McKnight (1987) contends that professional services define need as a deficiency and communicate disempowerment in three “propositions to the client: you are deficient, you are the problem, you are a collection of problems” (p. 82). Emphasizing deficits, Cowger (1994) argues, reinforces vulnerability and highlights the unequal power relationship between professionals and older adults. The custom and tradition of problem- and/or need-based clinical assessments of older people in hospital, for example, often label the patient as the problem, particularly when their needs fall outside the repertoire of concerns acceptable for the particular diagnosis or treatment setting. Dill (1995) argues that when a need is defined as an individual attribute, remediable through intervention, professional dominance determines what type of information is relevant.

Dill (1995) suggests that professionals will construct a problem based on their specialized system of knowing and will translate the problem into a need – one framed by the hospital’s formal instrument for assessment. They will bring their clinical understanding to the situation to interpret the story told by the older adult. On the other hand, the older adult will offer information according to the meaning of events. Their knowledge reflects culture, folk knowledge, and their unique lived experience. Their construction of events may or may not fit the assessment frame used by the professional. The information that does not fit the frame is “deemed at best noise to the proper functioning of the assessment process” (Dill, 1995, p. 458).

Traditions that surround assessments can be particularly problematic for older people. When important information is overlooked, clinical decisions can increase an

older adult's risk for adverse outcomes. Decision-making in hospitals revolves around clinical evidence framed by the experts' experience and knowledge, based on the efficacy and outcome of treatment, and the likelihood of recovery or curing the disease (Thorne, 1993). This information can often supersede the older adult's experience and knowledge of their own chronic health needs.

Information relevant to personhood, if not found on the assessment form, is often not considered in the delivery of care. This is a problem because, as noted earlier, customs and traditions in the current system rest in the acute intervention paradigm. As such, all health-related issues are framed as objective biomedical problems, often to the exclusion of subjective perceptions of strengths and abilities, which are foundational to managing chronic health concerns. This is important because the environmental pressures in hospitals encourage the professional to understand older people's health related issues not as chronic health concerns with an acute exacerbation of an existing and/or new illness, but rather as scientifically-defined biomedical problems that are remediable to acute intervention options.

The problem rests in the tendency of professionals to choose acute intervention treatment options over chronic health psychosocial treatment options. Acute intervention options have a valued and important role when an older adult is experiencing an acute illness (e.g., stroke or myocardial infarction). It is not only clinically and ethically appropriate to rely on acute interventions in such situations to interrupt the medical problem, it is a moral imperative. The difficulty arises, however, when acute intervention options are privileged over equally appropriate psychosocial interventions. This is a significant issue because the preponderance of chronic health concerns experienced by

older people in hospital are often remedial to psychosocial interventions not only to acute medical interventions.

Kaufman (2000) offers an example of how the expert model dominates decision-making in hospitals. Using participant observation on adult medical wards elicited through conversations and interviews with physicians, nurses, social workers, chaplains, patients, and family members, Kaufman studied palliative care transactions over a 12-month period. Findings suggest that confusion is prevalent in the relationship between aging, disease, decline, and medicine's technological imperative; they combine to produce a muddled decision-making framework, in which "the value of prolonging life by technological means competes with the value of allowing death to occur without invasive medical intervention" (Kaufman, 2000, p. 2).

From Kaufman's (2000) perspective, this muddled decision-making is in part the result of a "variety of viewpoints and different kinds of knowledge and interpretive frames brought to bear on the telling of a tale and the understanding of a set of events" (p. 4). This becomes particularly troublesome in the hospital setting that is characterized by multiple doctors, each with his/her own approach to the older patient's condition. This confuses the older patient and his or her family; they receive conflicting information based on the physician's specialized knowledge about the efficacy of the medical intervention and the likelihood of recovery from the medical problem. Other professionals are drawn into the fray to provide opinions and advice – again from their expert way of knowing.

To give depth to the point, Kaufman (2000) describes an exemplar case where a family was asked to talk about the hospitalization of their mother. The adult children

discussed the issue of the insertion of a nasogastric tube for their mother on the fourth day of hospitalization. However, the father was concerned that the tube was a heroic measure. The family reported that they had never before considered the meaning and gravity of such a decision. The family had difficulty trying to figure out the whole situation; they reported that the doctor said: “you want to do this because you don’t know what will happen, you can’t tell how much your mother will recover, and you will feel guilty if you don’t” (Kaufman, 2000, p. 9). The family agreed the doctor was probably correct about their feelings of guilt, but they were alarmed by the lack of discussion about alternatives. Even though their mother left no written instructions, the family felt she would not have wanted what had happened. “In retrospect, the family spoke about how good they thought their mother’s hospital care was. But in the end they remarked, they were alone in making decisions because the medical staff had one perspective – to save life, and they had another – to consider their mother’s existential condition” (Kaufman, 2000, p. 9). In this case, the professional could only contribute partly to making the best decision for the patient. It suggests further that the best decisions include information held by professionals, older patients, and their families.

Artificial feeding is yet another example of how customs and traditions in hospitals influence decision-making practices. Artificial feeding can be understood as a professional intervention and the decision could be based solely on criteria related to appropriate medical care, futile treatment, and potentially irresponsible allocation of health care resources. The dilemma of older patients and their families demonstrated in the case above centers on decisions made by professionals that only take into account professional knowledge.

Customs and traditions that exclude either patient or professional knowledge are inappropriate. To disregard the professional's knowledge is potentially dangerous to the older adult; it incorrectly assumes the patient knows all the options when faced with medical problems (e.g., pain and infection) (Kaufman, 2000). Conversely, disregarding the older adult's knowledge assumes that the professional operates from the same set of values and beliefs and therefore understands the meaning of events for the person and his or her family. Alone, neither way of knowing is adequate; both must come together to ensure the best decision is made for the right reasons.

Clinical assessments are intrinsically linked to professional decision-making and serve to unify both professional and bureaucratic objectives within scientific biomedical imperatives. As such, customs and traditions in hospital systems, processes, and procedures (e.g., admission processes, discharge planning) are usually made to increase efficiency because this is what is deemed best for the bureaucracy. These systems ultimately support professional autonomy and act to reinforce the strength of acute care intervention-based hospital systems, further diminishing relevant aspects of chronic care. Dominance of the acute care model severely limits choice, particularly when those choices lie outside of the acute care hospital-based environment.

The issue is not whether older adults should rely on professional interpretation of clinical information (after all, who else is qualified to interpret such information, if not the professional?). The point is that customs and traditions can exclude other types of information often relevant to the chronic health model, but not considered because it is deemed unimportant to the professional's work in the acute care, crisis intervention paradigm.

Incompatibilities between the acute care and chronic care models create obstacles in meeting the hospital service needs of older people. These obstacles result from customs and traditions that promote a lack of goodness-of-fit at the individual and hospital system level. Though the system serves the professional well, it is critical to understand how the customs and traditions create problems for older people.

Given the sophisticated relationships between older people and the hospital environment, goodwill alone cannot achieve the depth and breadth of change required to uncover, correct, and ultimately prevent ageist practices. The challenge of reconciling incompatibilities is more difficult, in part because stakes are high; the vested interests of professionals and businesses are increasing with the growth of technology-based health care. Power relationships and competing priorities also exist. Diminishing fiscal resources, an aging population, and a corresponding rise in chronicity are external forces that complicate matters. The theoretical foundations needed to understand the complexity of the situation outlined above are presented next.

### **Theoretical Foundations**

The social ecological framework introduced in chapter one emphasizes that relationships between older people and the hospital environment are circular and reinforcing (Colin, 1999; Moos, 1979; Stokols, 1992; Stott, 2000). This perspective is relevant to the research for two reasons: (a) the complex nature of confounding socio-political factors external to treatment settings play a critical role in understanding the sentiments of discontent identified in the preceding literature review; and (b) it provides a means to highlight the special features of older people while also considering hospital

factors. The approach helps illustrate the dynamic interplay that exists between elements of the hospital environment and older people.

Although the social ecological perspective is considered appropriate for the dissertation because it permits understanding of “the complexities of social systems and the conflicts created in man’s relationship to them” (Binder, 1972, p. 904), it lacks a critical perspective. To address this shortcoming, the dissertation also draws upon conflict literature and critical theory to provide explanatory power to help analyze this dynamic social relationship.

This section presents the theoretical contributions of conflict and critical theory, and outlines their relevance to the study. These theoretical foundations have shaped the research design and shed light on the researcher’s ontological and epistemological beliefs.

### *Conflict Theory*

Using a social ecological perspective, the literature presented earlier in this chapter demonstrates that conflict – fully manifested or latent – is a phenomenon that occurs from a lack of fit within the hospital environment at both the individual and system levels. Incompatibilities in the system are evident when older adult factors and hospital environment factors are juxtaposed, suggesting that conflict occurs when older adults encounter the hospital. The needs of older adults are often incompatible with how the hospital system responds to those needs; the ideological conflict between the chronic care model and acute care model reinforce and perpetuate services that disadvantage hospitalized older adults.

The next section briefly introduces the concept of conflict, clarifying the meaning of the term and its relevance to the dissertation. Positioning the research within conflict literature will help demonstrate how a lack of good fit exists between needs, expectations, and mediating factors in the hospital system, making conflict an inevitable consequence.

*Conflict as a concept.*

The word conflict has an applied usage in an assortment of contexts. Miall, Ramsbotham, and Woodhouse (2000) illustrate the diversity that exists in the literature, pointing out topics that examine:

- Types of conflict (e.g., international relations, inter-group studies, intergenerational issues, domestic politics, industrial relations, and between individuals);
- The application of approaches to handling conflict (e.g., arbitration, mediation, alternative dispute resolution, interest-based approaches, and negotiation);
- The practice of conflict or dispute resolution (e.g., assessment strategies, conflict analysis models, and neutral third party approaches – mediation, arbitration);
- Discipline-specific theoretical approaches to explain human behavior and social interaction that denote intra/interpersonal conflict;
- Research on international crises, internal wars, social conflicts, and intergenerational disputes.

There appears to be no unifying theory or set of theories to delineate the critical attributes of conflict or to denote the term as separate or different from other descriptors

such as dispute, fight, war, or disagreement. The word conflict is often used interchangeably with these descriptors (Tidwell, 1999). There are also numerous discipline-specific schools of thought (i.e., within sociology, psychology, law, political science, and anthropology) that consider conflict either a destructive and/or constructive force or a transformational learning opportunity (Deutsch, 1973; Tidwell, 1999).

Despite the lack of clarity and consensus among disciplines regarding the meaning of conflict, common elements have emerged in the literature that would suggest conflict represents dynamic and contextually based interactions. These interactions are grounded in the belief that incompatibilities exist, and the acquisition or exercise of power-over is more predominant than power-with in the relationship (Deutsch, 1973; Fisher, 2000; Mayer, 2000; Parker-Follett, 1973). Together these common elements suggest that conflict is not simply a matter of misperceptions or misunderstandings, but rather a phenomenon that exposes real differences between people and social systems that result in human action.

Table 3 illustrates how diversely conflict is understood in the literature and its application to understanding relationships between older people and hospital systems. The literature reviewed here is not intended to be comprehensive, but rather a brief sampling of authors' opinions, illustrating their diversity in thought, and demonstrating the varied philosophical underpinnings that exist. Because the term conflict is represented in numerous ways in the literature, its use in the research requires a declaration of meaning.

Table 3: Authors' Views About Conflict

Authors	Views About Conflict
Coser, L. (1967), cited in Tidwell (1999)	Conflict is a struggle over values and claims to scarce status, power, and resources. The aims of opponents are to neutralize, injure, or eliminate the rival. Conflict can positively serve specific and useful social functions, for example, to maintain relationships by expressing hostilities.
Miall et al. (2000)	Conflict is an intrinsic and inevitable aspect of social change. It is considered an expression of differences in interests, values, and beliefs that arise when change meets constraints. Essentially, conflict occurs between groups that are in pursuit of incompatible goals.
Galtung, J. (1969), cited in Miall et al. (2000)	Conflict involves an (actual or perceived) incompatibility of goals where there is a mismatch between social values and social structure that results in a clash between group interests. Conflict is seen as a dynamic process where the elements are constantly changing and influencing one another.
Fisher, R. (2000)	Conflicts arise from differences identified as incompatibilities. These can be economic, value, or power differences.
Follet, M. (1942), cited in Fox & Urwick (1973)	Differences can have positive gains for organizations.
Lewin, K. (1997), cited in Tidwell (1999)	Need satisfaction is a source of tension in conflicts. An unfulfilled need produces tension, particularly with basic human needs.
Deutsch, M. (1973), cited in Tidwell (1999)	Conflict is a social phenomenon that exists whenever incompatible activities occur. "Deutsch has been a forerunner in emphasizing the subjective nature of conflict. The subjectivist view holds that if somebody believes a conflict exists, then there is a conflict" (Tidwell, 1999, p. 68). Three factors influence the probability of conflict manifesting: "contact and visibility of differences, perceived incompatibilities, and perceived utility of conflict" (Tidwell, 1999, p. 68).

Simmel, G. (1955), cited in Tidwell (1999)	“Conflict has an integrative nature ... is a socialization process, reducing tensions between group members” (Tidwell, 1999, p. 62). Conflict is viewed as a positive social function, a source for social cohesion and creativity.
Tidwell (1999)	The distinction between a dispute and a conflict is seen as a continuum, based on degree: i.e., disputes are usually less intense over time and have a greater degree of negotiability. Conflicts are more intense over time and have a lesser degree of negotiability.
Burton, J. (1990)	Conflict arises from unsatisfied basic human needs.
Curle (1971), cited in Miall et al. (2000)	Conflict involves transformation. Conflicts occur where there is asymmetry – unbalanced power and unsatisfied need. Increased awareness, mobilization, and empowerment can reduce conflict. The aim is to transform asymmetrical relationships into balance.

*Conflict as a descriptor in health care topics.*

A database search (e.g., Medline, Ageline, Social Science index) using “conflict” as a key word, subject heading, or descriptor along with different treatment settings (e.g., hospital, community care, and long-term care) produced the following categories of information:

- Elder abuse (e.g., physical, emotional, financial); related subtopics included advance directives and guardianship legislation
- Intergenerational conflict (e.g., retirement, dependency, family care giving issues); related subtopics included resource inequity, public policy, and age conflict as a social phenomenon
- Access to health care resources (e.g., long-term care placement choices, discharge planning)

- Conflict of interest (e.g., physician and vested interest groups)
- Care giving and receiving conflicts; related subtopics included negative interactions between families and older adults, resolving complex care differences in nursing homes, and role conflicts among adult daughter caregivers
- Conflict among health care professionals; related subtopics included relationships between care aids, physicians, nurses, and facility administrators, techniques for sorting out the complexity of issues, and ethical decision-making and risk taking
- Disabling and disempowering effects of care environments related to issues of autonomy, control, and participation in decision-making in hospital and nursing homes

Conflict as a descriptor in hospital research literature is limited. Based on the categories of information noted above, searching the literature for research on conflict and older adults' encounters with hospitals requires specificity; one must ask: conflict in what context or setting, regarding what topic, and with whom? For the purpose of the dissertation research, conflicts in hospitals arise from the natural tension of dynamic relationships when there is a lack of fit evidenced by divergent goals, needs, and expectations. Conflict is recognized to be contextual, occurring where social circumstances and relationships between people and systems directly result in (actual or perceived) significant incompatibilities. Therefore, where older persons believe their needs, goals, and expectations are incompatible with the interests of a health care

organization (or treatment setting), policy or governance model, a conflict exists not at an interpersonal level, but at a system level (Mayer, 2000).

*Substantiating conflict in a social ecological perspective.*

The social ecological perspective considers the special needs of older adults in conjunction with the hospital environment (see Table 1: Older Person – Hospital Environment Fit). The dissertation has identified three categories of older person factors: chronic health needs, vulnerability, and attitudes, values and beliefs. Hospital system or environmental factors include the acute illness paradigm, organizational climate, and relationships. It is necessary to point out the special features of both older people and the hospital environment for two reasons. First, as noted earlier, conflict has been accepted as a contextually based relationship of incompatibilities. Relevant factors form part of the context and provide an explanation for why conflict (manifest or latent) represents the problems older people experience in hospital. Second, the relevant factors could become the variables that improvement strategies target to reduce conflict. As a result, the features unique to older adults and the hospital environment are not only relevant factors, they are critical to understanding the dynamics of interactions because they influence and/or act as mediators in the relationship.

*Critical Theory*

Freedom, choice, and self-determination are fundamental rights and values recognized as part of the Canadian identity. These fundamental rights have become expectations enshrined in Canada's Charter of Rights and Freedoms, social systems, and democratic judicial institutions. To some degree, these rights and expectations are taken for granted and assumed by the populace to be present and operating equally for all

people. Likewise, it can be assumed that these rights guide the behavior of professionals and the institutional policies and procedures that govern their work, thereby enabling the recipients of their attention to live fully empowered lives (Thursz, 1995). Critical theory<sup>6</sup> questions this sort of democratic egalitarianism; in the case of the dissertation, it would suggest beneath the surface of assumptions often taken for granted lies a view that being old in hospital is a disempowering life experience manifested in a multitude of socially-accepted, institution-serving ways that protect the bureaucratic agenda of the hospital.

Critical theory is most notably associated with the Frankfurt school,<sup>7</sup> which examined injustice and the hidden nature of power to influence the populace by encouraging people to abide by rules that privilege some while disempowering others (Kincheloe & McLaren, 2000). The critical perspective has always been concerned with social structure and the notion and nature of social inequity, power, culture, and human relationships and actions.

Kincheloe and McLaren (2000) argue it is difficult to precisely define critical theory because “(a) there are many critical theories, not just one; (b) the critical tradition is always changing and evolving; and (c) critical theory attempts to avoid too much specificity, as there is room for disagreement among critical theorists” (p. 281).

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<sup>6</sup> The researcher has adopted Jurgen Habermas' perspective on critical thought in the dissertation. Habermas introduced the concept of the “public sphere,” a space to pursue ideas of openness, inclusiveness, equality, and freedom, but also argued that these were only ideologies or illusions. In principle, Western societies may be open, but in practice they are not. His work linked individual freedom to capitalistic democratic institutions; his interests were in identifying “the social and institutional conditions that foster autonomy” (Finlayson, 2005, p. 15).

<sup>7</sup> The Frankfurt school refers to ‘cultural criticism’ connected to Social Research at the University of Frankfurt. Most noted critical theorists of the time included Horkheimer, Adorno, and Marcuse. The influence of Marx, Kant, and Weber were acknowledged in their philosophical and social thought. Their teachings arose from Germany's post-World War I economic depression; they embraced the belief that injustice and subjugation contributed to the disempowering nature of lived experiences (Kincheloe & McLaren, 2000).

Irrespective of the diversity of critical thought, numerous authors (Carspecken, 1996; Finlayson, 2005; Harvey, 1990; Kincheloe & McLaren, 2000) accept that critical theory is based on the following assumptions:

- Power is social and historically based where certain groups are privileged;
- Social structures are maintained through political and economic power;
- Political and economic power serve as repressive mechanisms and are legitimized by ideology;
- Facts are associated with values and ideological beliefs;
- Relationships between people and institutions are in motion, related to political and capitalistic endeavors, and never fixed;
- Language is central to subjectivity; and
- Oppression is “reproduced when subordinates accept their social status as natural, necessary or inevitable” (Kincheloe & McLaren, 2000, p. 291).

Based on these assumptions, the critical perspective is “concerned with the broad social and historical context in which phenomena are interrelated. It is concerned with revealing underlying social relations and showing how structural and ideological forms bear on them” (Harvey, 1990).

Enlightenment in the context of critical theory is achieved through “ideological criticism”<sup>8</sup> (Finlayson, 2005; Habermas, 1973; Hammersley, 2001). This is necessary because ideology or worldview can prevail over other views and distort perspectives within social structures and relationships. In such cases, ideology can “prevent oppressed groups from seeing their true situations and interests” (Hammersley, 2001, p. 100).

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<sup>8</sup> Ideological criticism according to Habermas (1973) is the exploration of false beliefs assumed true by the citizenry. Critique, therefore, involves exposing unknown social influences by considering historical context, power relationships, and social arrangements.

Ideology becomes a major force in sustaining oppression. Critique of ideology can expose the false reality operating in our social world. This exposure leads to awareness, and an awareness of being aware. Together, depth and breadth of awareness leads to enlightenment and understanding and when each of these is accompanied with empowerment strategies, control shifts to the people (Kincheloe & McLaren, 2000; Hammersley, 2001; Harvey, 1990).

Habermas (1971; 1973) suggests that ideology represents false beliefs (i.e., false-consciousness) that are inherent in social structures, but present with enough influence to convince citizens to hold views about themselves. These false beliefs “are very widely assumed to be true, because virtually all members of society are somehow made to believe them” (Finlayson, 2005, p. 11). So widely accepted are these false beliefs that they exert an unknown influence that supports institutions that dominate people in their relationships with each other and with manmade institutions, structures, and systems (Finlayson, 2005). Within hospitals, the socially accepted health care ideology based in the professionally dominated acute care model disadvantages older people.

Critical theories aim to emancipate “oppressed groups through enlightenment, that is by enabling members of such groups to recognize their interests” (Hammersley, 2001, p. 100). Critically oriented research is value based and directed “toward positive social change” (Carspecken, 1996, p. 3). The researcher assumes the role of advocate. The critical researcher not only wants to show what is happening but also wants to understand how it happens in order to change the existing oppressive social structures (Harvey, 1990).

In the dissertation, an ideological critique is required to understand hospital culture: the customs, traditions, and relationships between and among older adult factors and hospital environment factors. This critique can expose ideological influences that dominate hospital care and enable older adults “to recognize the reality of their situations and thereby giving them more control over their own lives” (Hammersley, 201, p. 100). The following section illustrates the researcher’s interpretation and potential application of critical theory to the dissertation’s examination of older adults in hospital.

*Interpretation of critical theory to being old in hospital.*

The dissertation seeks to understand how problems arise for older adults in hospital. It also aims to serve as a catalyst for the transformation of the social experience of hospitalization. Applying critical theory to this study helps realize these goals by highlighting the interactions between older people and the hospital environment.

In Western society, power tends to mean control and influence over others (Cusack & Thompson, 1999). Drawing from Max Weber, Vincent (1999) argues that power exercised between people in a relationship involves enforcing one’s will over another, often making the other do something he or she would not otherwise do. If one accepts that all social relationships involve a balance between those who have power and those who want power, domination of one group over another makes for unequal power. The dominance of professionals in the hospital setting is an example. As noted earlier, the status quo in hospitals is exemplified by hierarchical and rigid process and system designs that are oppressive and controlling by nature. Knowledge of how the system operates is held by a select few. Stereotypical attitudes about old people also prevail. In this environment, older adults are dependent on their professional caregivers.

Critical theory applied in the dissertation aims to disrupt the status quo by uncovering contradictions and ideological distortions. Critiquing ideology exposes social structures maintained through political and economic power. The process reveals deeply rooted and legitimized traditions of power-over, as well as barriers to re-orienting the system to encourage power-with relationships (Kincheloe & McLaren, 2003; Lather, 1994). Power-with relationships are “required for people to become active participants in shaping the social ... structures that affect their lives” (Cusack & Thompson, 1999, p. 133). This orientation can empower older adults, transforming their silence into an effective voice (Freire, 1993).

### **Summary**

The dissertation assumes that powerful social and political forces are at play in the hospital environment that perpetuate support for the acute care model. These forces produce reinforcing consequences that continuously promote faith in the acute care model and entrench the existing biomedical powerbase, allowing it formidable influence in the acute care hospital system.

The literature review has covered four major topics to provide contextual understanding to the lack of fit created when older adults are admitted to hospital. Research has demonstrated that divergent needs and expectations exist and that the way hospital care is organized and delivered impinges on the provision of services to older people with chronic health care needs. Furthermore, the literature has exemplified the disempowering nature of hospitals, and identified the consequences produced by bureaucratic forces that culminate in power differentials and control of older people. This disempowering context is reflected in the customs and traditions of hospital operations.

Hospital care is comprised of technology-dependent acute care interventions that can often overlook the special features of older adults' chronic health needs. However, since the hospital is a major site for health care interventions and medical practice, it is important to explore how hospitals may unintentionally create new problems for older people, as well as worsen existing ones. Little is known about the how the underlying dynamics of their interactions together evolve into conflict transactions; this perspective has not been located in the literature.

Conflict and critical theory underpin the dissertation study to support a critical analysis of multiple factors that contribute to both positive and negative transactions. The critical analysis draws on the ideas presented in this literature review, and although some of the evidence on bureaucracies and technology is known to relate to all people rather than only older adults, it gives guidance and direction when combined with clinical practice experience to focus the researcher's attention to relevant areas to explore with each group of participants in this study. Chapter three outlines the research design implemented to answer the question posed in the dissertation.

## CHAPTER THREE: RESEARCH DESIGN AND IMPLEMENTATION

The preceding chapters explained the study's background, problem, and purpose. They also introduced its conceptual framework, summarized relevant research on the topic of older adults and the hospital environment, and provided the theoretical foundation for the study. The researcher has argued that current hospital structures and processes promote a lack of fit, and incompatibilities exist between what older adults want, need, and expect. This chapter outlines the qualitative research design<sup>9</sup> and implementation process used to achieve the aims of the study. These include the paradigm, methodological approach, method, data analysis, strategies for rigor, and ethical considerations employed in the dissertation.

### Clarifying the Language

The terms qualitative and quantitative denote broad categories of methodological approaches. Paradigm, methodology, and method are represented in the literature in different and sometimes contradictory ways. To illustrate, Neuman (1997) refers to

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<sup>9</sup> A research design in the qualitative realm refers to the study layout or loosely constructed phases that to varying degrees:

- take a holistic approach (e.g., it searches for understanding of the whole picture in a naturally occurring hospital setting);
- look at relationships within a system or culture (e.g., relationships within the hospital system);
- focus on understanding a given social setting (e.g., older people in hospital);
- require the researcher to spend time in the setting (e.g., hospital observations and the researcher's clinical experience);
- incorporate purposeful sampling and multiple data sources (e.g., face-to-face interviews, observations, document review);
- involve interpretive methods, and permit ongoing analysis of data (e.g., reflexivity, constant comparative analysis) (Carspecken, 1996; Janesick, 1994; Lincoln & Guba, 1985).

This tradition stresses "the socially constructed nature of reality, the intimate relationship between the researcher and what is studied and the situational constraints that shape enquiry" (Denzin & Lincoln, 1994, p. 4). This type of empirical inquiry is also "shaped by paradigm commitments and by the recurring questions that any given paradigm or interpretive perspective asks about human experience" (Denzin & Lincoln, 1994, p. 199).

paradigm as a representation of world views or a philosophical outlook that includes “basic assumptions, the important questions to answer or puzzles to be solved, the research techniques to be used and examples of what good scientific research looks like” (p. 63). Paradigm, according to Neuman (1997), captures the terms qualitative and quantitative. Denzin and Lincoln (2000) speak of “paradigm positions” identified as positivism, postpositivism, critical theory, and constructivism. According to Crotty (1998) paradigm is explained in terms of objectivism, constructionism, and subjectivism, rather than qualitative or quantitative as cited in Neuman (1997). Kuhn’s (1970) classic discussion titled *The Structure of Scientific Revolutions* describes a paradigm as a set of values, beliefs, and principles that reflect a philosophical stance that guides action in a discipline.

Although the language differs between many of the theorists, their aim is similar, to articulate ideological positions in order to guide how knowledge is constructed or discovered and how methodologies ascribe mechanisms for gathering and then analyzing data. The language used in the dissertation is explained to prevent confusion and ensure both reader and researcher are applying similar meaning to the language. As such, the following definitions apply:

1. Paradigm: the values, beliefs, and principles that reflect an ideological or philosophical stance that guides action (Kuhn, 1970).
2. Epistemology: the theory of knowledge embedded in the theoretical perspective and thereby in the methodology (Crotty, 1998).

3. Methodology: the strategy, plan of action, process, or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes (Crotty, 1998; Neuman, 1997).
4. Methods: the techniques or procedures used to gather and analyze data (Crotty, 1998).

### **The Paradigm**

A paradigm is a way of looking at the world. It guides the methodology in the research enquiry and it is an expression of the epistemological and ontological views of the researcher (Guba & Lincoln, 1994). The paradigm determines the boundaries of the study and provides solutions to practical design issues (Carspecken, 1996) by functioning to:

1. Structure the questions to be asked
2. Eliminate questions that are outside the conceptual boundaries of the paradigm
3. Imply a particular frame of reference common to many investigators
4. Provide a linkage to certain types of research methods
5. Suggest criteria by which to judge appropriate research tools
6. Provide criteria for evaluating the quality of the research effort

(Woods & Catanzaro, 1988, p. 22)

Two paradigms guided the dissertation research design and implementation: the paradigm of understanding<sup>10</sup> and the critical<sup>11</sup> paradigm. Blending two paradigms

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<sup>10</sup> The paradigm of understanding (Lather, 1994) is a way of knowing that seeks to understand social behavior from an emic perspective (e.g., ethnography). Contextual relevance plays a key role in knowledge development in this paradigm.

achieves a critical understanding of the contextual meaning of being old in hospital, while simultaneously seeking transformation and emancipatory change. The dissertation draws on elements of both paradigms because neither alone adequately embraces all of the historical factors that shape people's experiences of being old in hospital. Simply to achieve understanding is inadequate because the research is also viewed as a mechanism for change, one that has the potential to support improvements in hospital systems. Blending components from each paradigm will help the researcher understand the conditions and systems of ideology that contribute to problem construction, as well as to advocate for change that may contribute to improvements in hospital services.

### **Methodological Approach**

Methodology is the "point at which method, theory and epistemology coalesce in an overt way in the process of directly investigating specific instances within the social world" (Harvey, 1990, p. 1). The paradigm of critical understanding requires a methodological approach that provides knowledge to engage the prevailing social structures. This study utilizes critical ethnography.

Lather (1994) points out that a critical research design: (a) explores "interactive, dialogic, and reciprocal research methods that work toward transformative action and equalitarian participation;" (b) "connect[s] meaning to broader structures of social power, control and history;" and (c) "work[s] toward open, flexible theory building grounded in both confrontation with and respect for the experiences of people in their daily lives and profound skepticism regarding appearances and 'common sense'" (p. 107). Critical ethnography exhibits these fundamental characteristics by examining cultural knowledge

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<sup>11</sup> See chapter two for a review of the assumptions supporting the critical paradigm. This paradigm seeks emancipation and change (Lather, 1994).

in a historical context; the approach aims to illuminate issues hidden within ideology to bring about societal awareness that triggers action on values and ethical and political issues (Morse & Richards, 2002). This approach also offers an opportunity to consider existing relationships between older people and the overall hospital environment, including relationships with professionals, systems, and processes found within hospitals. The methodology provides a means to uncover acute care practices that inhibit, repress, and constrain older people in hospital.

### *Critical Ethnography*

Critical ethnography adheres to the core rules of traditional ethnographic methods (i.e., qualitative interpretation of data, field observation, and analysis of cultural meaning). Thomas (1993) characterizes critical ethnography by its transformative agenda. According to Thomas, “critical ethnography proceeds from an explicit framework that, by modifying consciousness or involving a call to action, attempts to use knowledge for social change. Conventional ethnographers study culture for the purpose of describing it; critical ethnographers do so to change it” (p. 4).

Critical ethnography has the potential to achieve social change by attempting “to link the detailed analysis of ethnography to wider social structures and systems of power relationships in order to get beneath the surface of oppressive structural relationships” (Harvey, 1990, p. 11). As a methodology, it offers a culturally based mechanism to analyze factors unique to older people and the hospital environment, allowing the researcher to question customs and traditions that are often taken for granted in acute care hospitals. This simultaneously provides a lens for observing the goodness-of-fit between

older people and the hospital environment, and a means to expose the hidden dynamics of discriminatory practices in hospital.

The question posed in the dissertation assumes that an injustice is present and that the research will not only bring to light injustice for the purpose of understanding, but will also set the stage for change that could improve the situation. A critical re-examination of the hospital environment and the transactions that occur within this cultural space will help the researcher understand the conditions operating in and between older people and the hospital environment.

Critical ethnography considers the impact of power, history, economy, and exploitation; it springs from the assumption that our lives are mediated by systems of inequity (Lather, 1994; Thomas, 1993). This methodology provides a mechanism to understand and explain the synergy created when all these factors converge in a single health care setting – the hospital. This makes it possible to uncover their singular and combined influence.

The methodology also allows the researcher to deconstruct these substantive issues to reveal what is happening at a societal level. This is significant to the dissertation because issues such as power, history, economy, and exploitation are culturally relevant factors that contribute to the existing relationship between older adults and hospital environments as they rest within the context of a larger health care system. Exposing injustice to encourage enlightenment<sup>12</sup> is the first step to understanding existing

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<sup>12</sup> The researcher draws on Habermas's view of enlightenment, which requires dialogue and critical discussion between people to reach consensus, a state of greater awareness (Giddens, 1985). For Habermas, enlightenment is related to ideology, which he defines as a false-consciousness widely accepted by the citizenry. Ideology serves "to shore up certain social institutions and the relations of domination they support . . . [to become] socially necessary" (Finlayson, 2005, p. 11). Habermas argues that openness, inclusiveness, and freedom in the public space are a false-consciousness, an illusion. People's ability to participate as equals and experience freedom and equality exists only in principle, not in practice. To

incompatibles, and then correcting them using empowerment strategies to produce change.

Based on these fundamental characteristics, emancipation is often a research goal in critical ethnography. The dissertation, for example, aims to critically understand the social interactive process of older people in relation to hospital systems and processes. Specifically, the research is intended to transform our understanding of the phenomena of being old in hospital and to set the stage for change to the current conditions of hospitalization for older people. To achieve the goal, the research must explain how hospitals can change to meet the needs of older adults seeking acute care.

The complex nature of older people and the hospital environment also demands a methodology that will take account of multiple data sources. Critical ethnography provides the capacity to utilize and analyze hospital observations, interviews, and documentation review<sup>13</sup> set forth in the study.

Critical ethnography is therefore, appropriate for the dissertation because it aims not simply to understand a situation, but to change it (Lather, 1994). It also supports advocacy values within a wider socio-political context (Lather, 1994; Morse & Richards, 2002). The dissertation's methodological approach utilizes the researcher's clinical background and in conjunction with a critical perspective, supports her desire to make improvements by contributing evidenced-based direction for change.

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expose the hidden existence of this falsehood requires structural transformation and communicative action. Through raised consciousness (i.e., enlightenment) Habermas "wants to identify the social and institutional conditions that foster autonomy: emancipation means the creation of truly democratic institutions capable of withstanding the corrosive efforts of capitalism and the state administration" (Finlayson, 2005, p. 15).

<sup>13</sup> The document review originally planned in this study was discontinued because the information provided was limited. Full explanation of what was learned and why it was discontinued can be found in Appendix A – Document Review Data.

*Attending to relations of power: A methodological issue.*

The theorization of power takes numerous perspectives. For example, early contributors such as French and Raven (1959) characterized social power as referent, expert, and legitimate. This view conceptualizes power as a commodity to attain. In the hospital setting, the role of health care professionals often reflects these notions of power. For example, some people desire the respect, admiration, and honor that health care professionals often enjoy. Health care professionals also hold specialized knowledge as experts in their field, and physicians, in particular, have a legislated mandate to prescribe interventions that influence how people are to behave. Hindess (1996) supplements the conceptualization articulated by French and Raven by incorporating the attributes of capacity (the ability to act) and conformity (the “consent of those over whom [power] is exercised”) (p. 11). He suggests, “the interests of certain individuals or groups may well be excluded from political debate.... There may also be instances of the exercise of power in which its victims fail even to recognize that their real interests are at risk, and consequently make no attempt to defend those interests. On this view, there is a third, particularly insidious, form of power which is able to influence the thoughts and desires of its victims without their being aware of its effect” (Hindess, 1996, p. 5).

This study, situated within a critical paradigm, must examine power dynamics, including the influence of the hospital context, the special features older people bring to the research encounter, and the researcher-participant relationship (Berkman, Leipzig, Greenberg, & Inouye, 2001). Earlier chapters outlined the powerful socio-political forces at play in the hospital environment that perpetuate support for an acute care ideology that is professionally based and bureaucratically supported. The current generation of older

people were socialized in this professionally dominated system to respect authority, not to question or complain, and to defer important decision-making to professional expertise.

Wolf (1996) maintains that power and control is often “maintained, perpetuated, created and recreated during and after field research” (p. 2). Therefore, issues of power are relevant throughout implementation of the research design, from beginning to end. One way to discern the presence of power is to examine the relationship between the researcher and the participants (i.e., older adults and hospital employees), and the research process itself (i.e., the researcher’s academic preparation, who asks the questions, and who makes decisions while implementing the research design, interpreting the findings, and disseminating results).

A hospital’s culture (as noted above) can influence an older person’s ability to freely (i.e., without coercion or subordination) contribute information in the research interview. As a result, the researcher paid particular attention to the power dynamics within her relationships with older study participants. For example, interviews were conducted at a site chosen by the older person, which, in most cases, was his or her home. Only one participant requested the interview take place in the hospital. The researcher also took account of older adult participants’ potential to experience weakness and limited stamina because of physical frailty, sensory and cognitive impairments, and the effect of acute illness following early discharge from hospital.

Similarly, with hospital employees the researcher took initiative to minimize the effects of power relationship dynamics. The researcher attended to hospital employees’ needs and schedules by making efforts to shift, where possible, decision-making

authority to the participants. Interviews were also conducted at a site chosen by the hospital employees, which varied from locations in the community to the hospital cafeteria.

### **Method**

Having considered the paradigm and methodology, this section describes in more detail, the data and data collection methods employed, and the approach taken to gain entry into the research setting.

#### *Data and Data Collection*

Consistent with critical ethnography, the study used a combination of data collection methods; this included hospital observations (with corresponding field notes) and interviews. The dissertation triangulated data sources to understand the dynamics of problem construction in older people's experiences in hospital. The researcher employed these data collection methods in a particular sequence; for example, hospital observations of in-patient areas began after the start of older adult interviews. A concerted effort was made to observe in areas that interviewees discussed. Methodologically this was necessary to maintain internal consistency within the research design. Therefore, observations began in the emergency department and occurred only in other areas of the hospital that older interviewees indicated they attended as in-patients.<sup>14</sup> This was deemed necessary to collect data relevant to the research question and to elicit information that linked the context (i.e., specific area of the hospital) to the interaction between older

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<sup>14</sup> The researcher acknowledges that, methodologically, observations of hospitalized older people actively engaged with hospital systems and processes constitute a stronger research design. However, the researcher was unable to reconcile the power differential between her and older hospitalized participants, despite procedures to minimize its effects. The researcher felt older patients would not be able to exercise a free and unencumbered willingness to participate (an ethical requirement fundamental to the critical paradigm), given the vulnerability that accompanies illness, the crisis of hospitalization, and the older patients' dependency when in hospital.

people and hospital customs and traditions that produce problems potentially harmful to the people.

*Access to the setting.*

Initial interactions with people in the research setting are critical for establishing trust and rapport (Janesick, 1994). When initiating fieldwork, Wolcott (1999) recommends the researcher “seek out informed people to help orientate you, [and] seek out information already available in archival sources” (p. 214). This approach serves two purposes: it helps establish relationships and dialogue; it can also identify key stakeholder groups who can influence the success of the study. These purposes serve the study’s critical agenda for future change. After receiving ethics approval from the hospital and university for Human Subjects Research, the researcher approached the administrative leader of the hospital site to get permission to conduct the study, identify key stakeholders, learn about the hospital, and establish the best process for getting started. The researcher then met with various groups in the hospital.

Initial discussions with the administrative leader not only explained the purpose of the study, but also how findings from the study could assist the leadership team improve services to older people. The administrator wanted to ensure the study would not create additional work and concern for hospital staff already burdened by service demands. The researcher provided an information sheet summarizing the study parameters that could be shared with other members of the hospital administration team and medical community (See Appendix B: Information Sheet).

### *Hospital Observations*

Observations of the hospital environment are considered a data source separate from the interview data; they are not tied to a particular individual. Therefore, older adult interview participants were not observed while in hospital; likewise, hospital employee participants were not observed while performing their duties at work.

Although the research question targets problems older people experience in transactions with the hospital, the researcher also observed and noted positive interactions when they occurred. This was necessary because, although a critical paradigm assumes an inequity exists, this investigation aims to improve the situation for older people in hospital. Solutions may be found in examples of good fit that exist but until now have gone unrecognized. Solutions, therefore, may emerge as positive interactions that could inform recommendations for change at the end of the investigation.

The researcher also used ethnographic mapping (Oliver-Velez et al., 2002; Schensul, LeCompte, Trotter, Cromley, & Singer, 1999) to obtain contextual data on the following:

- Events, movements, and activities that occur when older people interact with hospital systems and processes;
- Interactions between older people and hospital employees working in the hospital; and
- Sources of power, influence, and communication between all people in the observed areas of the hospital.

Conceptually mapping the transactions of older people provided data on hospital infrastructure and internal service networks to determine how hospital customs and traditions become problematic for older people. As an investigative procedure, mapping helped clarify, highlight, and analyze incompatibilities during the process of coming to, being in, and leaving hospital. This process contributed to the identification of differences in the goodness-of-fit between older people and the hospital environment.

The researcher used a field-mapping guide (Oliver-Velez et al., 2002) to capture field note observations. The guide developed for this project was constructed from two areas of research: older adults' experience of being in hospital, and tools used to measure congruence in person-environment dimensions that have been applied to residential and sheltered care facilities for the elderly (Moos & Lemke, 1994).<sup>15</sup> See Appendix C: Hospital Field Observational Mapping Guide for details.

*The observation process.*

There is debate in the literature over the use of pure (or strict) observation versus participant observation; a wide range of definitions and perspectives exist. Wolcott's (1999) theory of observation helped guide the design of the dissertation study. He argues participant observation is distinguished by the involvement and/or detachment of the researcher in the context of the research, not simply by the presence of conversation or dialogue. According to Wolcott, when the researcher "asks," he or she is enquiring, and therefore interviewing; to watch and talk in conversation is not the same as enquiring.

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<sup>15</sup> It is acknowledged that by adapting the person-environment dimensions the reliability and validity of the original tool may be compromised. However, given that the dimensions from the original tool are being used as an observation guide and not for the purposes of measurement, the implications are minimal. The methodological integrity of the dissertation research is maintained because the changes made to create the observation guide have clinical utility and are not used to measure validity in an acute care hospital.

Talking with people while conducting observations is considered part of the contextual nature of field studies (Emerson, Fretz, & Shaw, 1995; Wolcott, 1999). They represent data and are noted as researcher impressions contained in the field notes for the study.

The dissertation study placed the researcher outside her role as a caregiver in the hospital care delivery system; she did not participate as a registered nurse while observing. The researcher anticipated talking in conversation with people while in observation areas. If an individual wished to contribute information beyond an informal conversation, then the researcher sought his or her informed consent before proceeding with a formal interview. This occurred in one case.

The researcher chose to observe in three areas of the hospital: common areas (i.e., patient lounges, main entrance atrium), in-patient units (i.e., emergency department, a medical unit, and a surgical unit) and diagnostic areas (i.e., laboratory, radiology). Patient rooms were excluded from observation. Observation areas were determined by: (1) areas of the hospital where older people were likely to congregate, and (2) areas of the hospital where interviewed older participants indicated they had a positive or negative encounter.

Observations occurred over a twelve-week period between September and December 2004, totaling 36.5 hours. Observations occurred on all days of the week at one to two hour intervals between 0600 and 0100 hours. The richness of the data and the emergence of consistent patterns of compatibility (i.e., fit, or lack of fit) determined the duration of the observation period. The researcher returned to the hospital to conduct additional observation periods to confirm the emerging themes and codes near the end of

the analysis period. Three return visits, totaling seven hours, brought the total observation hours for the study to 43.5 hours.

*Observation procedures.*

The following observational procedures were necessary to ensure people in the area were informed of the researcher's presence, and to inform those present during the observation period about the researcher's duty to report individuals exhibiting harmful behavior during the performance of their duties.

*Reporting problematic staff conduct or care issues.*

As a registered nurse, the Canadian Nurses Association Code of Ethics and the British Columbia Registered Nurses Association Standards of Nursing Practice direct the researcher to advocate on behalf of patients. Based on these standards, the researcher is duty-bound to report conduct that may be harmful to patients. Should the researcher witness care and conduct issues while conducting hospital observations she would report them to the Chief Nursing Officer. The researcher notified hospital staff of this reporting requirement on poster boards and observation information sheets (See Appendix D: Hospital Poster Board, and Appendix E: Observation Information Sheet). The researcher made no reports of conduct violations.

*Notifying in-patient units.*

Any person on an in-patient unit could be observed during an observation period. To alert patients, visitors, and staff that observations were underway, a large poster board was placed at each entrance and exit (See Appendix D: Hospital Poster Board). The posters explained the purpose of the observations and assured people in the observation area they would remain anonymous in the research. No personal identifying information

was used in field notes. Take away information sheets also provided background to the study (See Appendix E: Observation Information Sheet). The researcher attached the sheets to the poster board and distributed them to individuals who questioned her presence. The researcher also identified herself to the hospital staff in charge each time she arrived on the unit, who then helped decide how best to inform others that research activity was occurring in the area.

### *Field Notes*

Field note construction guided by Wolcott (2001) and Emerson et al. (1995) provided the researcher an outsider-insider<sup>16</sup> grasp of routines and meanings constructed by hospital systems. The use of detailed field notes helped strengthen conclusions and validate or refute interpretations drawn by the researcher since she compared data as it was gathered and again during analysis. The researcher recorded her decisions, hunches, and other evolving issues that emerged during the data collection phase, noting positive and negative social and system interactions. Field notes consist of relatively concrete descriptions of social processes and their contexts; they capture observations, hunches, and analytic assumptions while noticing and then noting various contextual features and properties, including relations between the researcher and participants (Hammersley & Atkinson, 1983).

Field notes for the dissertation included observation, methodological, theoretical, and reflexive notes. Drawing on the work of Wolcott (1999; 2001), Emerson et al. (1995), and personal conversations with others (M.E. Purkis, Spring, 2004; K. Stajduhar, Spring, 2004) the researcher constructed field record definitions for each type of field

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<sup>16</sup> The term outsider-insider locates the researcher in the study; it acknowledges her clinical background knowledge as well as the distance enforced between the researcher and participants by the research design.

note (See Appendix F: Field Record Definitions). The definitions compliment the Hospital Field Observational Mapping Guide located in Appendix C, and the principles of reflexivity<sup>17</sup> adopted by the researcher. Together, these elements provided internal consistency within the research design.

Field notes document the researcher's observations, personal reflections, and thoughts. Because the researcher holds previous experience in the hospital field, her past personal experience and understandings of hospital culture were made explicit and monitored in two ways: through the construction of the field note definitions (See Appendix F), and the use of contact summary sheets (See Appendix G: Contact Summary Sheet). The contact summary sheet, a tool adapted from Miles and Huberman (1994) aided reflexivity from the start of data collection to the conclusion of analysis.

The combined use of observation and reflective notes, which recorded the researcher's reactions to specific observations and the data generally, were particularly important for gaining depth and breadth of understanding. They enabled the researcher to record information, build insights, and learn as the study progressed. Field notes also served as devices for later analyzing researcher reactions. For example, the following observation juxtaposed with field note devices helped the researcher learn about objectifying an older patient:

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<sup>17</sup>Depending on an author's conceptualization, reflexivity can seek to promote theoretical and/or methodological advantage in a study. Finlay (2002) conceptualizes reflexivity as methodological accounting, introspection, hermeneutic reflection, intersubjective exploration, mutual collaborations, or social critique. Similarly, Lynch (2000) offers six versions of reflexivity: mechanical, substantive, methodological, meta-theoretical, interpretive, and ethnomethodological. As noted in chapter one, a reflective practitioner also practices reflexivity (Schon, 1983). In this inventory, a central theme is recursive action; a turning back on itself in circular motions to learn, gain insight or awareness in an area of concern is characteristic to all forms of reflexivity. The researcher believes the paradigm and methodological underpinning of the study should govern the form of reflexivity adopted by a study. For this dissertation, reflexivity represents critical reflection, a methodological means to achieve critical understanding, a self-critical evaluation of a researcher's actions (Lynch, 2000).

Observation #7: Everyone seems busy. There are ambulance attendants talking to nurses, housekeeping staff washing a section of the floor, people in lab coats coming and going out of the automatic doors – when I look around everybody is engaged in some type of activity – there is a hum about the place.

A nurse is caring for the patient behind a closed curtain; she flings the curtain back as she leaves the bedside and I see a very elderly man lying on his back with his neck hyper extended. An ambulance attendant is at the head of the stretcher, adjusting the pillow. The older man is silent – neither is speaking to each other. The nurse moves to the desk, pulls out a clipboard, and begins writing. A doctor walks to the desk, the nurse starts to talk about a patient – I assume the person is a doctor but the nurse does not lift her eyes from the clipboard until she has finished writing. She proceeds to give the doctor information about the elderly man. The information is about why he is in the ER, where he came from. The doctor moves to the patient and pulls the curtain closed. After several minutes the doctor returns and gives the nurse several orders. In the meantime, the older man starts moaning and calling out. No one seems to notice – they must hear it, but no one acknowledges the sounds coming from behind the curtain. The doctor goes back behind the curtain. At the same time, two women (mother, daughter as it turns out) come to the desk looking for a patient. The patient they are looking for is the older man being seen by the doctor. The daughter asks about her father and speaks to the nurse. The nurse explains that the doctor is seeing her father and that she will be giving him something for pain. The daughter seems grateful, and says, “He is different, he doesn’t usually complain so something must really be wrong.”

The wife does not speak and the nurse does not explore with either woman “how he is different,” or what that might mean. They are both directed by the nurse to the waiting room.

The doctor comes out from behind the curtain and asks the nurse a question about what the older man “has on.” The nurse laughingly replies: it’s a special kind of diaper. From what I can hear, still no one has spoken to the older man.

The researcher felt great discomfort observing this scene. Later, upon rereading the observation and completing the contact summary sheet, the researcher realized she was distressed both by the hospital staff’s treatment of the older man, and of his family. The older man was virtually ignored, and made almost irrelevant to the care process. Likewise, although the nurse spoke to his daughter and wife, she appeared to ignore the information they provided. Here the researcher’s clinical expertise came into play. Her expectations for standards of care would normally require an attempt to converse with the older man while assessing his injury, and consider the specialized knowledge held by the daughter and wife that could affect the outcome of care.

Field note devices later helped the researcher collect her thoughts and reflect on the actions of all the actors (i.e., nurse, doctor, family members together, daughter, and mother separately) in the fast paced context of the emergency room. The contact summary sheet, observation guide, and the field note definitions all supported the work of the researcher during the implementation phase of the study.

*Interviews: Older Adults, Family Members, and Hospital Employees*

To examine phenomena in cultural context from an emic perspective required that the researcher explore events that represent goodness-of-fit from the perspective of the members of the cultural groups involved (Morse & Richards, 2002). Consequently, semi-structured interviews were conducted with:

- Older adults and their families (e.g., friends, formal, or informal caregivers when needed) after they were discharged from hospital;
- Front-line hospital employees (e.g., professional practitioners); and
- Non-direct care hospital employees (e.g., accreditation surveyors and patient complaint personnel).

*Older Adults and Family Member Participants*

The researcher conducted semi-structured in-depth interviews with eight older adults and, when present, their family members. The interviews aimed to identify events that went well or were problematic during their hospitalization.

The researcher used a two-part semi-structured questionnaire (See Appendix H: Interview Guide: Older Adult and Family). The first part of the questionnaire requested specific information, including age, functional capacity (measured by FMMSE<sup>18</sup> and RRIT<sup>19</sup> scores), gender, living arrangements, marital status, discharge diagnosis, presenting complaint or reason for admission, and use of existing community services. This information provided the researcher a characteristic profile for the older adult, proxy-screening indicators for physical and cognitive functional ability, and the context of how the hospital journey began and ended.

<sup>18</sup> FMMSE = Folstein Mini Mental Status Examination (Folstein, Folstein, & McHugh, 1975).

<sup>19</sup> RRIT = Regina Risk Index Tool (Neville, personal communication, April 2004).

The Folstein Mini Mental Status (FMMSE) exam and the Regina Risk Index Tool (RRIT) were used in the study because of their clinical utility and credibility in clinical practice with older populations (See Appendix I: A – Folstein Mini Mental Examination and B – Regina Risk Index Tool). The information drawn from these tools served two purposes. First, they offered greater descriptive detail about the characteristics of the older adult participants and, secondly, as proxy indicators of frailty, they helped the researcher determine participants' risk for cognitive impairments and post-discharge functional decline. These data, compiled for descriptive purposes, are summarized and reported later in this chapter.

The second part of the questionnaire was structured around the older participants' arrival in the emergency department, experience as an in-patient, and discharge from hospital. During the interview, four areas of the hospital environment were probed to explore participants' experiences: the physical features of the hospital, policy and procedures, social climate, and service and care processes.

#### *Recruitment of older adult participants.*

Personnel in the hospital's health records department initiated recruitment procedures within two weeks of a potential older participant's discharge from hospital. They identified all adults aged 75 and older who had been discharged from hospital the previous week, excluding those with a diagnosis of dementia. The researcher then screened the records<sup>20</sup> to identify individuals who would receive a letter inviting them to participate in the study. Inclusion screening criteria used by the researcher included:

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<sup>20</sup> In recognition that health care records often do not contain a full listing of diagnoses, the researcher elected to screen the records identified by health care records personnel for other indicators of dementia. The researcher's clinical knowledge and experience supported the selection process. This is reflected in the second bullet of the inclusion criteria, which requires clinical judgment.

- Age (75 and older);
- No diagnosis of dementia; five areas of a patient's chart were reviewed for collateral information to determine a diagnosis of dementia: discharge summary, consultation reports, nursing admission history, ER assessment form, and medication profile for dementia drugs (i.e., Aricept or neuroleptics);
- Length of in-patient stay greater than 24 hours determined by admission date compared with discharge date, doctor's progress notes, and nurses notes; and
- The discharge date not greater than one month from the screening date.

Age 75 was chosen based on two criteria: frailty increases with age (Bortz, 2002; Brody, Johnson, & Ried, 1997), as does risk and vulnerability during hospitalization (Inouye & Charpentier, 1996).

The researcher screened records on two occasions. On October 29, 2004, 30 potential older adult participants were identified from 40 records screened; on November 18, 2004, another 32 were identified from 35 records screened. In total, 62 letters were sent to prospective older adult participants; 10 people replied to the letter by return telephone call. One person could not be reached, and another was excluded because of failure to recall on the FMMS examination. Eight of the ten older adults consented to participate in the study.

The introductory letter (See Appendix J: Older Adult Introductory Letter) sent by the Health Records Supervisor to selected older adults introduced the study and invited individuals to participate. The letter included an information sheet and the semi-structured interview guide. Those willing to participate were instructed to telephone the administrative assistant identified by name in the letter to leave their contact information.

The letter also explained the purpose of the study, and participants were provided a copy of the consent form to review (See Appendix K: Older Adult Consent). Informed consent was obtained at the time of the interview, prior to commencing.

*Procedures to ensure reliability of participants.*

Since hospitalization increases the risk of cognitive problems (Inouye & Charpentier, 1996), older adult participants were screened for impairment prior to commencing each interview. The researcher did so to ensure that the older participant had memory capacity, the interview data were reliable, and the older adult could give informed consent. Although the study design purposely excluded discharged older adults with a diagnosis of dementia, it is possible an individual could leave hospital with undetected dementia or some other acute state of confusion such as delirium.

Even where an individual has dementia, he or she may still have capacity to understand and the capability to make certain decisions (Silberfeld & Fish, 1994). Therefore, the design also allowed for the possible inclusion of participants who may leave hospital without a diagnosis of dementia, receive an invitation to participate, but, in fact, have some degree of dementia. Since the degree of dementia is the critical factor, the prevailing assumption in gerontology – that one is considered competent until there is evidence to the contrary – would apply. The research design was built on this premise; therefore, although measures were taken to minimize the likelihood that someone with dementia (mild or severe) could be invited to participate in the study, the FMMSE prior to initiating the interview served as a second level screen for any significant cognitive impairment. In addition, the informed consent process helped to minimize the likelihood

that an older individual may participate with significant cognitive impairment that may or may not be associated with dementia.

Obtaining informed consent involved asking older participants before the interview to explain their understanding of the study and the consequences of their decision to participate. This approach is consistent with clinical gerontological best practice evidence for determining one's degree of competence and decision-making capability (Ebersole, Hess, & Luggen, 2004). Individuals with significant cognitive impairment would likely be unable to stay focused to perform this explanatory task.

The interview required the participant to recall events and describe a recent lived hospital experience. If an older person's short-term memory is impaired, he or she may not recall accurate information and the data could be flawed. The research design guards against this possibility in two ways: by conducting the interviews as soon after discharge as possible, and by screening participants for memory or recall deficits using the FMMS examination before each interview. The FMMS examination helped assess the reliability of the older participant. For example, if a participant does well on questions of recall or orientation, they are less likely to have memory problems and their stories of recent hospitalizations are more likely to be reliable. However, when a participant lost points for recall, the interview did not proceed, and the participant was dropped from the study. This occurred on one occasion; an older participant could not accurately describe the research and as required in the research design, the interview was discontinued, and the participant excluded from the study.

The RRIT tool also provided valuable information on post-discharge functional ability (See Appendix I: B – Regina Risk Index Tool). Since no before and after measures

were taken, however, no correlations could be made about pre- and post-functional ability and the impact of hospitalization. Instead, the RRIT simply helped gauge the degree of functional frailty the older participant was experiencing following hospitalization. This information formed part of the post-discharge profiles of participants.

Though family members were not the target sample, they were included in the study when present at interviews for two reasons. First, family members can play a significant role in the hospitalization of older adults; second, they may provide important information about problems created by the customs and traditions found in hospitals. Three family members participated in the dissertation study. The total older adult sample included eight recently discharged older adults, and three spouses.

#### *Front-line Hospital Employees and Non-Direct Care Hospital Employees*

The researcher conducted semi-structured interviews with front-line hospital employees and non-direct care hospital employees because they hold expert knowledge about the customs and traditions that operate in hospitals (See Appendix L: Hospital Employee Interview Guide). They also offer a different perspective, and serve as proxy informants for the hospital environment. Their perspectives can help explain how customs and traditions create contextual and intervening conditions within the hospital (not easily observed by others) that affect older people. As insiders, they can provide information about various aspects of hospital operations. For example, accreditation surveyors have access to many different hospital environments. Personnel who handle patient complaints are another source of important information because they represent the organizational mechanism for reporting problems associated with hospitalization. They

may also receive letters from older patients and families acknowledging positive transactions.

Once the researcher received ethical approval and administrative permission (See Appendix M: Hospital Administrative Approval Form), she held a series of ten information sessions at different times during the day and evening with various groups (i.e., medical advisory committee, clinical meetings, staff meetings, management meeting, and union-management meeting). The sessions were used to explain the study's purpose, methodology, and observation and consent procedures. Consent forms and information sheets were available during the meetings. Recruitment information sheets were also posted on various hospital units, inviting employees to attend an information session or contact the researcher directly.

Sixty people attended the sessions to learn about the study. Those with two years or more of full-time experience were invited to participate in the study. Twenty hospital employees expressed interest in participating and signed a contact sheet giving the researcher permission to contact them at a specified time and location; fifteen were contacted and five couldn't be reached. Of those contacted, one was excluded because they had less than two years experience.

Fourteen interviews were conducted and written consent was obtained prior to commencing the interview (See Appendix N: Hospital Employee Consent Form). With participant consent, the researcher tape-recorded and transcribed verbatim all interviews (i.e., older adults and hospital employees). The researcher also made hand written notes during all interviews.

### Data Analysis

“In [critical] ethnography the analysis of data is not a distinct stage of the research (Carspecken, 1996; Thomas, 1993). It begins in the pre-fieldwork phase, in the formulation and clarification of research problems, and continues into the process of writing up” (Hammersley & Atkinson, 1983, p. 174). Researchers are participants in the process of collecting and analyzing their data; they are “active creators rather than passive recorders of narratives or events” (Thomas, 1993, p. 47). Data analysis is also circular<sup>21</sup> and reflective in nature (Carspecken, 1996; Hammersley & Atkinson, 1983; Thomas, 1993). In this study, the researcher engaged in an inductive reflective analytic exercise, pondering the impressions gained from three data sources (i.e., interviews with older adults and hospital employees, and observation field notes).

#### *Analytic Induction*

Analytic induction assumes there are regularities to social interaction and that data, when put through a cycle of questioning and answering, achieves meaning and understanding, which constitutes new learning (Carspecken, 1996). In this study, data analysis began during data collection and continued throughout the study using a process of constant comparative analysis (Goetz & LeCompte, 1984; Guba & Lincoln, 1994) in conjunction with a system of coding (Miles & Huberman, 1994).

Constant comparative analysis and coding suited the methodological needs of the study because it juxtaposes incoming data with previously collected data and known knowledge. This approach also allowed the researcher to first focus on each data set

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<sup>21</sup> The researcher has adopted elements of what Carspecken (1996) refers to as the “hermeneutic circle.” For a full description of its features, the reader is directed to Carspecken, P. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. New York: Routledge (pp. 99-102).

separately and then each in conjunction with the others (see Figures 1 and 2). The researcher continuously synthesized transcripts and field notes into meaningful thematic categories and codes<sup>22</sup> until relationships emerged.

Figure 1: Data management: Phase one

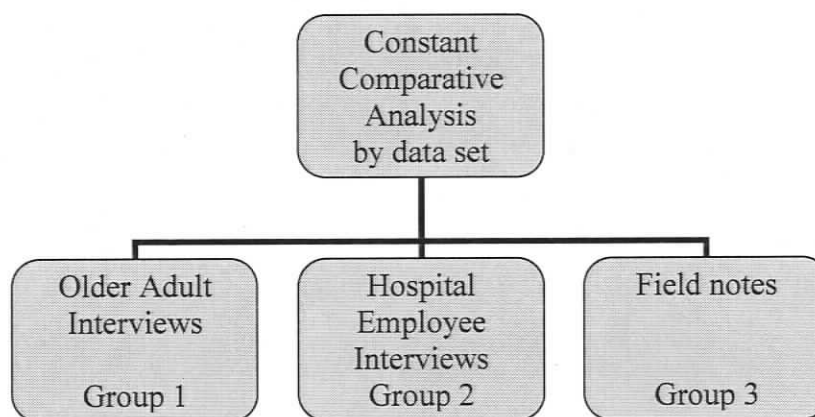
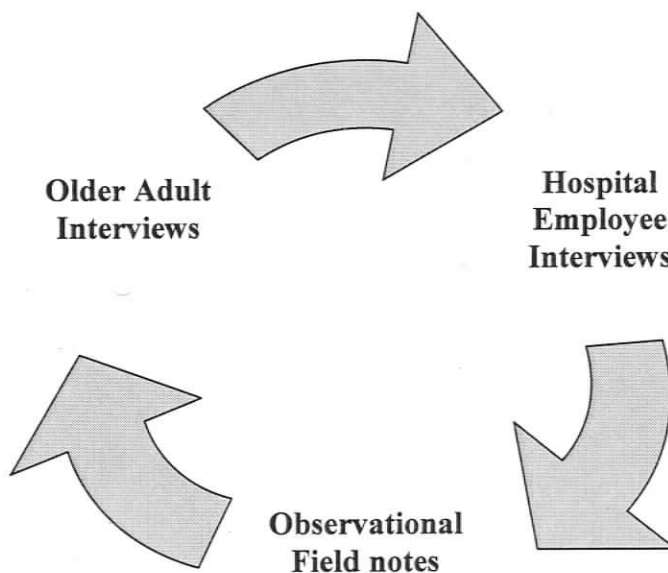


Figure 2: Data management: Phase two



<sup>22</sup> According to Miles and Huberman (1994), coding is an independent form of analysis. Constant comparative analysis is also accepted as an independent form of analysis. The researcher used both in this study. Coding and constant comparative analysis are introduced as separate approaches to highlight the contribution each made to the analysis. A decision to incorporate both permitted each of three data sets to be managed separately, which helped the researcher gain depth and breadth from each source before it was combined with the others in phases two and three of the analysis.

Using a comparative approach to identify codes and repeatable regularities served two important functions. First, it reduced large amounts of data (i.e., older adult interviews, hospital employee interviews, and observational field notes) into a smaller number of analytic units. It also narrowed the fieldwork creating specificity to observations as the study progressed.

The researcher continued to engage in critical reflexivity during the analysis phase of the research process (Finlay, 2002; Lynch, 2000; Schon, 1983). Critical reflexivity, as noted earlier, is reflection-in-action; it involves a systematic recursive turning over and exploring, testing, and retesting experiences to gain knowledge. This approach helped the researcher consider how she was thinking about the data, essentially becoming aware that one is aware, and of what one is aware of in the data (Lynch, 2000). This is complementary to constant comparative analysis, which is a type of inductive analysis. In this analytic approach, data management moves from the specific to the general and involved three phases: organizing and preparing the data, conducting a thematic analysis, and explaining and theorizing the relationship between older adults and the hospital environment (Miles & Huberman, 1994). These phases represent three levels of analysis. Each level has a corresponding methodological purpose (see Table 4: Data analysis framework).

Table 4: Data Analysis Framework

Circular Analytic Process	Level of Analysis	Methodological Purpose
<p><b>A. Organizing and preparing the data</b></p> <p>Listen to the tapes to get a sense of the whole. To understand key elements in older adults' interactions with the hospital environment, data is viewed through a four-dimension lens (i.e., physical design, social climate, policy and procedure, care systems and processes).</p> <p>This is done by grouping data by subject matter.</p> <p>Older adult (OA) = Group #1  Hospital employee (HE) = Group #2  Observation data (OD) = Group #3</p> <p>Review data from groups 1, 2, and 3 to construct journey maps for each older adult participant.</p>	<p><b>Phase 1: First level analysis</b></p> <p>What is the aim? To describe the data and begin to generate provisional codes.</p> <p>Ongoing reflexivity by researcher.</p>	<p><b>Data management</b> (How the researcher handled the data to answer the question).  Task is to become familiar with each data grouping:</p> <ul style="list-style-type: none"> <li>- Determine accuracy of transcriptions</li> <li>- Appropriate emphasis in words</li> <li>- Listen for emotions</li> <li>- Recollect hand gestures</li> <li>- Listen for mood tone of interview participant</li> <li>- What general ideas are participants expressing as potential key elements of hospital-environment fit in problem construction?</li> </ul>

<p><b>B. Conducting thematic and code analysis</b></p> <p>Break down the data: word-by-word, sentence-by-sentence, and paragraph-by-paragraph to identify elements of problem construction: first by data grouping, then all together.</p> <p>Explore and consider how the codes interconnect. Cluster together similar topics, form general codes building greater detail and depth to the codes.</p> <p>Reconfigure data, make linkages, connect categories, compare/contrast from the particular to the general, and vice versa.</p>	<p><b>Phase 2: Second level analysis</b></p> <p>What is the aim? To discover relationships between groups of data.</p> <p>What is involved? Interpretive phase will give depth and breadth to the analysis, juxtaposing three data sources to create one set of antecedent circumstances to problem construction.</p> <p>Ongoing reflexivity by researcher.</p>	<p><b>Data reduction</b> (How the researcher weeded the significant from the insignificant).</p> <ul style="list-style-type: none"> <li>- Develop thematic categories</li> <li>- Determine linkages between data groups</li> <li>- Explore meaning</li> <li>- Identify common patterns and relationships between themes – cluster like codes</li> <li>- Gather and compare similar passages, significant portions of text from all data sources</li> </ul>
<p><b>C. Explaining and theorizing relationships</b></p> <p>Compare what the data reveals in light of the social ecological perspective.</p> <p>Develop new understanding about the research question.</p>	<p><b>Phase 3: Third level analysis</b></p> <p>What is the aim? Explain and theorize to understand the themes, codes, and their relationships.</p>	<p>Look for common circumstances, contextual factors, and the relationship among and between thematic categories in relation to problem construction.</p> <p>Back to data for confirmation Back to participants Expert panel to review</p>

*Getting started with interview data.*

According to Sandelowski (1995), data preparation and analysis may be viewed as “operations that (re)present and (re)organize the data into forms that will permit interpretation” (p. 372). Getting started with interview data in this study involved three concurrent activities: transcribing, establishing logical groupings, listening and then creating older adult journey maps.

A transcriptionist transcribed all audio taped interviews. Transcripts were double-spaced with a two-inch margin on the right side. Each transcript and line in the transcript was numbered for easy identification. As data collection progressed, the researcher separated the data into three groups: older adult interviews, hospital employee interviews, and field note observations. The researcher gained depth and breath of understanding from each source before merging the contributions into one set of codes.

The researcher then listened to the audio taped interviews while reading each set of transcribed notes to double check their accuracy. This activity captured emphases made by all participants, including pauses, silence, laughter, sighs, and hand gestures. Comparative analysis during re-reading and listening sessions produced impressions and new hunches that were recorded as methodological, theoretical, and reflective notes (See Appendix F: Field Record Definitions).

Journey maps constructed for each older adult participant highlighted key events in coming to, being in, and leaving hospital. This permitted comparisons among participants and the clustering of key events under the categories of: coming to hospital, being in hospital, and leaving hospital. By examining the journey to hospital and the corresponding events surrounding participant admissions, the researcher learns about

existing patterns of hospital system and process activity. These patterns of activity – the way things are done – represent customs and traditions as earlier defined in this study.

*Getting started with field note data.*

Field note data was handled differently than interview data. The field notes reflected impressions and decisions about what to notice and observe, and how to record<sup>23</sup> those impressions that emerged from the field experience. Analyzing and comparing what participants had reported earlier influenced subsequent reporting of field observations.

In the field, the researcher used jottings<sup>24</sup> to help recall key observational moments in four areas of interest (i.e., social climate, policy and procedures, physical design, and care systems and processes). Field jottings were important to the dissertation study because they evoked “recall not only of the details about what happened but also of the specific circumstances or context involved: who was present, what they said or did, what occurred immediately before and after, etc.” (Emerson, Fretz, & Shaw, 1995, p. 33). In this way, jottings helped reconstruct the order and sequence of conversations or actions that revolved around a particular hospital process or system.

The complexity of the hospital made observation activity challenging. There was so much activity occurring at one time that it was difficult to find and focus on critical

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<sup>23</sup> While recording observations in the field, I struggled with how to write and convey interpretations of what I had seen. I took guidance from Emerson, Fretz, and Shaw (1995), who suggest that writing arises from a particular stance reflected throughout the research project, from the jottings that occur in the field to the actual write-up. The observations I drew on to illustrate how I made my conclusions are informed by my orientation toward and attitude regarding the topic, what I know about the participants, and my theoretical position and discipline. My political commitments and my prior clinical experience, training, and philosophical worldview have affected what I have written and what I decided not to write about.

<sup>24</sup> Jottings (Emerson, Fretz, & Shaw, 1995) represent simple phrases or words that serve as triggers for remembering events and details later (i.e., when I actually wrote the accounts). I used jottings in two forms: pencil and paper notation, and a mini cassette recorder. The mini cassette recorder captured more complex observations when several features of the environment were happening simultaneously and I did not want to risk forgetting important details.

features because of the distraction of multiple events occurring at one time. For guidance, the researcher relied heavily on information obtained from interviews, the research question, and the conceptual framework supporting the study.

To ensure accuracy, the researcher wrote field notes the same day or evening of the observation period. Analysis occurred during the writing process, often posed as questions that came to mind. During the writing process, the researcher could look back and reconsider initial assumptions, make connections to the conceptual framework, but also look forward to direct the next series of data collection activities.

Dramatic events were easier to identify because they were extraordinary. However, the researcher also made an effort to note everyday or routine elements of the hospital environment because of their potential value in exposing customs and traditions that are often taken for granted, but nonetheless may create problems for older adults. For example, registering upon arrival to hospital is an ordinary and common event that occurs in the emergency department, in the pre-operative admission procedure, and in any out-patient department to obtain diagnostic procedures such as x-rays or out-patient blood work. The researcher examined this ordinary event first by observing the activity, and then by capturing the process in field note writing.

Later thoughts and reflections captured in the contact summary sheet (see Appendix G) provide more detailed and penetrating evaluation of the field notes. This type of mindfulness involved, for example, second thoughts on the meaning of conversations with participants, new ideas that might explain the observations, analytic hunches to pursue later, personal reactions or doubts about the encounter, and insights arrived at when thinking about already collected data (Miles & Huberman, 1994).

The analysis aimed to integrate observation field notes with the perceptions of older adults and hospital employees. The researcher identified patterns, relationships, and central themes to understand how a system of culturally relevant customs and traditions in hospital operate to produce problems for older people.

By continually engaging in a process of reflexivity (Finlay, 2002) and using reflection-in-action (Schon, 1983), the researcher attempted to incorporate new and existing data over time to characterize the fit between hospital customs and traditions and the problems older people experience in hospital. This involved synthesizing insights formed while observing, interviewing, and reflecting on the researcher's field notes to draw out needed change that could improve hospital care for older people.

For this study, four dimensions of fit – social climate, policy and procedures, physical design, and care systems and process – provide a lens to understand transactions between older people and the hospital environment. These dimensions, abstracted from residential care literature and then combined with information from research on older adults' experiences in hospital (see chapter two) and the researcher's clinical experience provided contextual detail to the four dimensions noted above. They also focused the investigation by pointing to what were likely important data to collect and they offered a way to organize data collected throughout the study.

*Description of the framework dimensions.*

The first dimension, social climate, is the atmosphere created by interpersonal relationships and organizational influences; it is experienced as milieu. This dimension, expressed as observable behavior, reflects the treatment of older people in hospital. Communication between staff, older patients, and family members is indicative of the

social climate; cohesive teamwork and the degree of conflict and stress experienced in the environment are also included (Delbanco et al., 1995; McKnight, 1987; Moos & Lemke, 1994; Shumaker & Pequegnat, 1989; Yen et al., 2002).

The second dimension, policy and procedures, encompasses the bureaucratic rules and regulations that affect autonomy – the ability of older people and their families to act on their wishes and desires (Germaine, 1979; Latimer, 1999; Lyytinen et al., 2002; Moos & Lemke, 1994; Wells, 1997). This dimension also governs how employees conduct themselves in their work while fulfilling the mandate of the facility. These bureaucratic influences may be explicit or implicit; they may be enforced through cultural pressure that encourages conformity. Policies and procedures reflect a culture, attitude, and atmosphere that may or may not value older adults, and staff may or may not obtain support to achieve gerontological excellence.

The third dimension is the facility's physical design. This dimension relates to the observable built environment and all its architectural features. This includes the physical configuration, equipment, furnishings, and décor that together enable or disable an older person's independent functioning. Elements of physical design are reflected, for example, in the degree of stress experienced when determining the location and route to a treatment setting; the amount of privacy offered to patients and families; and the ease at which communication is achieved through inanimate objects such as signage, way finding, and physical amenities (Kemp, 2001; Moos & Lemke, 1994; Parker et al., 2004; Ulrich et al., 2004).

The fourth and final dimension, care systems and processes, involves the organization of care and the provision of services that occur to enable the facility to meet

its goals and objectives. Formal and informal bureaucratic conditions and political and economic forces converge to influence how work is completed, and how the mission of the hospital is fulfilled (Germaine, 1979; Goffman, 1961; Moos & Lemke, 1994; Tsilimingras et al., 2003; Weitz, 2004).

Constantly comparing data helped the researcher consider all data sources, simultaneously and over time, from the perspective of these four dimensions to achieve greater insight and understanding. This was one of several strategies employed by the researcher to ensure rigor in the study. The next section presents other strategies used to minimize bias and ensure the quality of the research findings.

### **Ensuring Quality: Strategies to Achieve Rigor**

Procedures to ensure rigor aim to minimize errors in all phases of the study. These procedures differ between the paradigm of understanding (i.e., conventional ethnography) and the critical paradigm (Guba & Lincoln, 1994). For example, the critical paradigm is concerned with historical context, diminishing power differentials, and the degree of change or transformative emancipation achieved (Guba & Lincoln, 1994). The paradigm of understanding is more concerned with trustworthiness and authenticity.<sup>25</sup> The dissertation drew strategies from both paradigms to achieve rigor.

The procedures employed in the study to ensure trustworthiness and authenticity included: continuous reflexivity, participant selection, triangulating data sources, peer

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<sup>25</sup> The researcher drew on the work of Guba and Lincoln (1994), who argue trustworthiness consists of four components: credibility, transferability, dependability, and confirmability. Authenticity is based on "criteria of fairness, ontological authenticity (enlarges personal constructions), educative authenticity (leads to improved understanding of constructions of others), catalytic authenticity (stimulates to action), and tactical authenticity (empowers)" (Guba & Lincoln, 1994, p. 114). Catalytic authenticity and tactical authenticity overlap with the critical paradigm.

debriefing,<sup>26</sup> multiple checks (e.g., expert panel, second older participant interview, meetings with key hospital stakeholders), and the establishment of an audit trail. From a critical perspective, the researcher took action to minimize the effect of power issues in the research design by, where possible, shifting decision-making to participants. The researcher then adjusted the study implementation based on what was learned.

Throughout the dissertation study, the researcher exercised continuous reflexivity (Davies & Dodd, 2002; Finlay, 2002; Lather, 1986) by keeping journals, and recorded observational, methodological, theoretical, and reflexive notes to support the implementation of the research design and the circular inductive process of analysis during all phases of the study.

As a self-corrective technique, reflexivity served as a check on the data's credibility, helping the researcher ensure internal consistency with the philosophical underpinning of critical ethnography. This process revealed potential weaknesses in the research design (Thomas, 1993), as well as subsequent problems in analyzing the data generated in the study. For example, reflexivity assisted the researcher to be constantly alert to power differentials between her and participants, or assisted to identify times when personal views affected the interpretation of data during analysis.

The research design also provided credibility to the data (Sandelowski, 1986) thanks to its approach to participant selection, procedures for data collection, multiple interviews, and the use of triangulating data sources (Thomas, 1993). For example, selection criteria were established and steps taken to ensure hospital employee participants had knowledge and current experience in hospital service. Before

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<sup>26</sup> Peer debriefing (Carspecken, 1996) recommends the use of peer-debriefers; these are colleagues who read interpretations and reconstructions. They play the devil's advocate, checking the researcher's work for signs of bias and partiality.

commencing interviews, the researcher collected demographic information from participants about their years of hospital experience and educational background. Similarly, older adult participants were screened for dementia, memory and recall ability. Triangulating data sources also helped the researcher gain greater representation of the customs and traditions operating in the four selected dimensions of the hospital environment (i.e., physical design, social climate, policy and procedure, care systems and processes). Detailed field notes were maintained throughout the implementation process.

The researcher ensured the trustworthiness and authenticity of data during collection and analysis by recycling data through multiple checks (Lather, 1986; Reason & Rowan, 1981). Recycling data helps achieve “a rigor of clarity, accuracy and precision” (Reason & Rowan, 1981, p. 249). Recycling occurred in two ways. First, the researcher did checks with five different groups: the study hospital’s leadership group (twice), hospital employees for the study hospital, an expert panel with acute care and geriatric specialists from another hospital, as well as return telephone interviews with older adult participants, and an independent group of older adults (N= 15) with similar characteristics as the study participants. Second, four peer-debriefers (Carspecken, 1996) were recruited to check the researcher’s interpretations of the data. The researcher juxtaposed the information and feedback from all recycling checks and peer debriefing sessions to her analysis and then incorporated it in the analysis to inform the study findings.

Creating an audit trail, as proposed by Guba and Lincoln (1984), provided evidence of the researcher’s sequence of decisions. The audit trail – also referred to as the decision or confirmability trail – can justify what was done and why (Wolf, 2003). An

audit trail established at the outset of the study documents the implementation process and all research design decisions made by the researcher.

### **Sample and Setting**

The age range of older adult participants (75 to 89 years) indicates a potentially vulnerable sample. As discussed in chapter two, increased age is a risk factor for vulnerability. Of the nine older adults contacted for an interview, one was excluded because his FMMSE screen suggested a cognitive memory deficit (i.e., 18/30). More men (5) than women (3) were interviewed; however, three female spouses were present and offered collateral<sup>27</sup> information during the interview, bringing the total number of older adults interviewed to 11. Most (N=5) participants were married and living with a spouse. Very few (N=7) accessed community resources outside of those provided by assisted living facilities. The RRIT scores (range 5/51 to 18/51) suggest that all older participants functioned with a high degree of independence; these larger scores reflect older participants' ability to manage self care when afflicted with chronic health concerns and functional disabilities, which conversely implies a stable living situation and the absence of acute illness. See Table 5 for descriptive information about the older adult participants.

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<sup>27</sup> The term collateral is customarily used in clinical practice when referring to the contribution of contributory information offered by family and significant others. In some cases the information is corroborative but other times the information, although connected, is aside from the main subject. Nonetheless, the additional information gives context to the main subject and is considered important by the clinician because it offers insight that would otherwise be missed.

Table 5: Older Adult Participants

Descriptor	Data
Age range	75 to 89
Gender	Male = 6 ; Female = 3 (10 recruited; 1 could not be reached; one male excluded, N=8)  Addition of 3 wives (N=11)
Marital status	Married = 5; Widowed = 2; Single = 1
Living arrangements	Lives alone = 1  With spouse = 4  With family member = 0  Assisted living = 3
Use of community services	None = 7  Homemakers = 1  Home nursing care = 0  Community agencies = 0  Recreational facilities = 0
Folstein Mini Mental Status Examination (FMMSE) score <sup>28</sup>	30/30 = 0  29/30 = 0  28/30 = 6  27/30 = 1

<sup>28</sup> The larger the score, the less likely a cognitive impairment exists; therefore, 30/30 is a perfect score.

	<p>26 to 24/30 = 0</p> <p>23/30 = 1</p> <p>22 to 19/30 = 0</p> <p>18/30 = 1 (excluded from study)</p>
Regina Risk Indicator Tool (RRIT) <sup>29</sup>	<p>5/51 = 1</p> <p>6/51 = 1</p> <p>7/51 = 4</p> <p>12/51 = 1</p> <p>16/51 = 1</p> <p>18/51 = 1 (excluded from study)</p>

Twenty hospital employees were recruited for the study, five couldn't be reached (N=15). All had more than two years experience working in hospitals, with the exception of one person who was excluded from the study (N=14). Most participants were women (13); just one man participated. Participants brought a range of work experiences to the discussion, including experience in administrative, quality improvement, and clinical roles. Health care backgrounds included nursing, social work, physiotherapy, and psychology; only one person had specialized training in gerontology. Their educational preparation ranged from diploma to baccalaureate and masters degrees; their years of experience ranged from 2 to 30 years. See Table 6 for descriptive information about hospital employee participants.

<sup>29</sup> The larger the score, the greater the functional impairment, conversely, the lower the score the greater the independent functional ability of the participant.

Table 6: Hospital Employees \*

Descriptor	Data
Gender	Male = 1; Female = 13  (20 recruited; 5 could not be reached; one female excluded, N=14)
Number of years working in health care	< 2 = 1 (excluded from study)  2 to 10 = 3  10 to 20 = 5  21 to 30 = 5  > 30 = 1

### *Hospital Setting*

Criteria for hospital selection included: 24-hour emergency department services, location in a community with a population greater than 100,000, greater than 100 available acute in-patient beds, and greater than 30% in-patients aged 75 and older. These criteria were adopted for the study to ensure that: the facility was large enough to recruit an appropriate number of informed hospital employees, a high proportion of older adults lived in the community, thereby increasing the likelihood of knowledgeable older adult hospital users, and that the hospital site for the research was representative of a mid sized facility with general in-patient and out-patient services. It was important to the study that hospital employee participants be familiar with the study hospital's systems and processes while understanding the operational relationships between their particular unit and the overall hospital.

The hospital where the study occurred is located in British Columbia, Canada. The hospital has 192 beds, and serves a population of 131,000, of which 13% are aged 75 and older. Designated as a community hospital rather than a major referral center, services include:

- 24/7 Emergency Services
- Anesthesia
- Diagnostic Imaging
- General Surgery
- Gynecology
- Internal Medicine
- Laboratory
- Obstetrics
- Orthopedics
- Pathology
- Pediatrics
- Psychiatry
- Radiology

### **Summary**

The dissertation employed critical ethnography as a methodological approach because of its capacity to uncover existing dynamics associated with problem construction that have a corresponding influence on the experience of being old in hospital; these same dynamics inhibit, repress, and constrain older people. An examination of these practices may aid to facilitate a better hospital fit for an aging population.

A holistic analysis that considers the culture of Western views, power relationships, and the features unique to older adults and the hospital environment will illuminate information critical to producing good fit. The research design and implementation aim to deconstruct customs, traditions, and assumptions often taken for granted in hospitals that can create problems for older people. Examining system and ideological distortions through triangulating data sources will show “how systematically distorted ideas and belief systems arise, and the role they play in maintaining a system of social interaction. Moreover, it also provides an analysis of the workings of the social system, showing the ways in which a system crisis could arise, thereby providing for the possibility of critical theory’s becoming itself a material force leading to system change” (Moon, 1983, p. 175).

The dissertation aimed to discover how problems develop in hospital for older adults. The study compiled data from three sources to understand the dynamics at play that produce these problems. This included interviews with older adults and hospital employees, and observation of hospital systems and processes. Using these data sources, the researcher explored how social climate, policy and procedures, physical design, and care systems and process influence the experience of coming to, being in and leaving hospital. The next chapter discusses the data and presents the interpretation of findings from these data sources.

## CHAPTER FOUR: FINDINGS

Interpretation invokes and challenges the researcher's sociological imagination ... by requiring continual reflections of the data and a constant search for images and metaphors that reorient individually familiar objects and frame them in a new social light. In this sense, our results are never final, but only partial and always subject to rethinking. If done well, intellectual reflections create a new way of thinking.

(Thomas, 1993, pp. 44-45)

Chapter three explained how the researcher carried out the study and managed the data while staying true to the methodological purpose and intent of the research project. Guided by the social-ecological perspective, this chapter presents the research findings that resulted from the researcher's interpretation of three data sources: older adult and hospital employee interviews, and field note observations. The analysis demonstrates that certain older people experience conflict between their needs and the demands and expectations placed upon them by the hospital environment. The lack of fit revealed in the analysis occurred by juxtaposing the study data to the four-dimensional hospital environment lens described in chapter three (i.e., social climate, policy and procedures, physical design, and care systems and processes).

Three assumptions provide context to the findings. First, the critical perspective underpinning the study assumes that a lack of good fit exists in older adults' relationship with hospital systems, and that acute care practices inhibit, repress, and constrain older people; the presence of incongruence is assumed in this relationship. Secondly, the nature of problem construction is complex and dynamic, suggesting not a linear process but one influenced by multiple factors that are simultaneously at play, and mutually influencing one another to varying degrees at any given time. Finally, it is assumed that older adults

and hospital employees are separate heterogeneous populations that bring many factors to bear in the context of understanding how problems occur in hospital.<sup>30</sup> The findings are not concerned with interpersonal relationships; instead, they document the transactions that occur between older people and the hospital's cultural space to expose the circumstances behind the incongruence in problem construction.

Emerson, Fretz, and Shaw (1995) suggest that writing ethnographic findings from a thematic analysis is different from writing an analytic argument "in both the process of putting the text together and in the structure of the final text" (p. 170). Where the logical argument begins with an explicitly stated thesis and subsequent points that build the thesis and are confirmed by the data, ethnographic reporting proceeds through an "examination of evidence to eventually reach its contributing central idea" (p. 171) at the end of the presentation of findings. The data in this study serve as "building blocks for constructing and telling the story" (p. 171) of older adults' problematic experiences in coming to, being in, and leaving hospital.

Based on this information, the first section presents themes associated with the hospital environment to show that poor fit exists in architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude. These factors serve as building blocks to the second section of the chapter in which the researcher elaborates on the consequences that arise when older people are admitted to hospital; together this exposes how problems are constructed for older people in hospital.

Findings in the second section distinguish two groups of people: those identified as ideal older patients and those found to be different or non-ideal. These findings

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<sup>30</sup> I acknowledge that external forces such as provincial and federal health policy or health reform initiatives can contribute to the dynamics that produce problems in hospitalization. Only contributing factors found in the data are reported in this chapter. Other potential factors are discussed in chapter five.

challenge the initial assumption that acute care practices inhibit, repress, and constrain *all* older people. Findings show that incongruent relationships emerge only when older people with certain characteristics enter the hospital's cultural space.

The third section reports findings that do not answer the original question but nonetheless are noteworthy because they show there is more to understand about older adult-hospital environment fit than what the study data can fully illuminate. Finally, the chapter concludes by bringing together the central tenets of the analysis to form an explicit statement of findings.

### **Hospital Environment: Underlying Dynamics for a Problematic Experience**

Findings indicate that a lack of fit in the hospital environment originates from a synergistic relationship between the hospital's architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude; each is in constant motion exerting a reciprocal effect on older people and hospital employees in the environment.

The word "montage" (Denzin & Lincoln, 2000) is useful in depicting the idea of constant motion. These authors write: "Montage invites the viewers to construct interpretations that build on one another as a scene unfolds. These interpretations are built on associations based on the contrasting images that blend into one another. The underlying assumption of the montage is that viewers perceive and interpret the ... montage sequence not sequentially or one at a time but simultaneously" (p. 5).

Problem construction represents the combined effect of the hospital's architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude as they play out in practices that impose an organizational duty on the

employee and a required response from older people. Like a montage, the findings that relate to the hospital environment are reported in a sequence, one at a time to disclose their details but the reader is encouraged to move beyond what might appear as a linear representation to appreciate the simultaneity of their existence. Although they work together, the discussion presents them separately to accentuate their incongruence with older adult needs, and the contributions they make to problem construction: first, the hospital's architecture features that older adults are confronted with upon arrival, followed by the bureaucratic conditions, chaotic atmosphere, and hospital employee attitudes they encounter as admitted patients.

#### *Architectural Features*

A hospital's architectural features can create problems for older people and their families before they even enter the building. Just parking the car can be difficult and upsetting. Both groups of participants described the process as "frustrating" and "damned awful." One hospital employee recalled a conversation with the family member of a patient: "They know we want the bed, and she wants to get her mom home ... and she can't find a darned place to park; it's the straw that breaks the camel's back. Parking is a huge issue" (HE#7, 17:501). For others, finding correct change and following instructions posted on the parking ticket machine created stress and anxiety. "Oh, the parking!" bemoaned the spouse of an older participant. "It's a racket.... All the instructions are off the machine; it's hard to read. You put your change in if you can find some. Then it finally said I had to use my credit card. I end up paying double because nothing comes out of the machine.... Now I'm upset and nervous" (OA#5, 11:310). One hospital employee described the parking machines as overwhelming to older patients: "They've

got to find loonies. Of course [the machines] are not right there, they've got to walk, they're stressed before they get in [the building]" (HE#12, 9:277).

Once inside the building, the hospital's interior design contributed further stress, fear, and anxiety. Older participants unfamiliar with the hospital's layout found it to be complicated and overwhelming. Most found it difficult to navigate because of poor cueing and crowding. One employee described the hospital as a maze where older couples wander the halls trying to find their way to appointments. "I go to meetings all the time so I am in the corridors, and I'm forever finding lovely old couples or a lady wandering on her own. They haven't got a clue. They ask me: 'Can you tell me where...?' It's overwhelming for them" (HE#12, 9:277). They often arrive late for appointments, feeling anxious.

Hospital employees described the hospital's many interconnecting corridors and hallways as a "rabbit warren," complaining that the layout does not help people independently find their way around the building. Physical features such as signage, lighting, and glare off the floors combine with normal hospital activities to overwhelm people, particularly those who have sensory deficits and other cognitive issues. A hospital employee explained the difficulty navigating hospital corridors:

I am very comfortable in a hospital, but way finding and signage is poor. There are arrows pointed at the diagonal and you'll think: does that actually mean this hallway, or to the right, or is it the hallway down the middle? You're just not sure. Or it [the sign] will say follow the red line but the red line is half peeled off. And then you see a red line half way down the hall and think that must be where it

starts. Or it is so tiny that I didn't notice it right away. This is a problem; we don't do our way finding keeping in mind the elderly. (HE#1, 10:280)

The same participant also explained how lighting in the environment contributes to difficulty in way finding. "The floors are polished, slippery, and the light reflects off them," she said. "I know because of my eyesight. The last few months I'm noticing all the glare spots and this must be what seniors experience with vision problems. That's not helpful when you're nervous, confused, and not sure about where you're supposed to be" (HE#1, 10:280).

Hospital employee participants also felt crowding hindered recovery by interfering with their ability to mobilize older dependent people. As one hospital employee explained: "Their equipment, like walkers and the side tables, it gets really crowded and it hinders their recovery because they tend not to get up amongst all this stuff ... even IV poles and catheter bags" (HE#2, 5:141). An older participant agreed that crowding makes it difficult to move around: "All that stuff in the hallways, they got all their lifts in the hallway. Two people with a wheelchair make it tough to go by there" (OA#5, 15:438).

Hospital employees also recognized crowding as a challenge to perform their work duties. "The hallway is often filled with supplies and trolleys of one type or another because there is nowhere to put them," explained one nurse. "You've got three people, the individual themselves, perhaps with a walker in front of them, a rehab assistant, and a physiotherapist, plus equipment – and you're trying to navigate" (HE#7, 14:412).

The nurse went on to explain how crowding also contributes to worry and anxiety in patients who are learning to maneuver after surgery in a cluttered area that lacks space for effective mobility:

If you have a walker in front of you, you can't get into the bathroom. You have to stand sideways. Now, if you are learning to use your new artificial knee, or your new hip, and you're trying hard to get it right in your head, thinking about left foot, right foot, the walker moves, the hand next, you don't need to be thinking about: "Am I going to run into something or is someone going to be in such damn fool hurry they are going to run into me, heaven forbid?" So I don't think the physical plant in any way, shape, or form is helpful to these [older] people. In fact, it must be scary and they do worry. (HE#7, 14:412)

Lack of space and overcrowding interfered with older participants' ability to receive private support from visiting family members. "The room was very crowded and there was hardly room for the chair," reported one older participant. "The nurses found a chair for me to sit on and when my daughter came, she sat on the bed" (OA#5, 8:217). Another participant complained there was not even privacy to "[take] your last breath" and die in peace. He explained: "Sometimes there are five or six people standing around the bed, and they are making a hell of a racket and you'd like to get up and say: 'Get out of here!' but then..." Lost for words, he shrugs his shoulders, implying nothing could be done, and then said: "That's the way of hospitals" (OA#5, 20:605).

For others, privacy issues arose when hearing-impaired older patients discussed personal matters loudly or hospital employees raised their voices to be heard. The problem is particularly troublesome in a four-bed room, according to one hospital

employee: "I don't like four-bed rooms because everybody knows everything and then we talk about it at the nurses' stations that is right close by, and then everybody knows everybody's business" (HE#9, 22:651). The researcher observed a similar scenario while sitting in the atrium of the main entrance. Everyone present in the waiting room overheard a pre-operative assessment conducted in another room behind a closed door. In this case, the architectural features of the environment did not adequately protect the privacy of a day surgery patient; everyone present overheard a nurse repeat the person's confidential medical history to confirm its accuracy.

Finally, the noise level within the hospital environment emerged from the data as problematic for older people. Noise emanated from other patients, phones ringing, people talking, call bell systems beeping, intravenous pump alarms, rattling carts of various types, and – on occasion – overhead paging and personal pagers (OB #8). These sources of environmental noise were distracting and added to stress and confusion for older people. Their accumulative effect made it difficult for older adults to rest and recover from their illness. "This man's breathing ... it was something!" reported one older participant. "He snored at night and it was unreal ... so, I really had no sleep for days. When I got home, I fell asleep and, boy, I said, I'm not going back to that kind of setup again. It was a terrible experience" (OA#8, 6:169). Other older participants expressed concern about noise that came from visitors: "There were an awful lot of them. There were kids and adults and everything else. There's no way we were going to go to sleep with that racket" (OA#8, 8:217). Another older participant, irritated by the noise of other visitors, took action: "Her friends came, and then her husband, and all four of them sat

there and practically yelled. So, finally, I asked if they'd mind pulling the curtain so I could hear my radio and they toned it down" (OA#6, 8:215).

### *Bureaucratic Conditions*

Bureaucratic conditions represented what one hospital employee participant described as the "system driver." Schedules enable in-patient units to run efficiently. However, hospital employees reported that the bureaucratic conditions within the hospital did not acknowledge the needs of older adults. According to one hospital employee, routines are rigid and lack the flexibility that older adults benefit from:

In the hospital system, I think they are very driven by the schedules that have been established to make the unit run. There is not accountability or acknowledgment of the needs of the older population.... You know, everything's pretty standard. It's set. There is a routine and the units work around that....

Routines you have to have, your 6:00 in the morning vital signs – stuff along that line. It's all very acute care medical orientated. (HE#6, 14:427)

All participants agreed that hospital routines are necessary because there are "things that need to be done; tests have to be done. There's a lot of regimentation just to get the services and the care that they require" (HE#6, 14:452). However, activity tends to revolve around the regimentation of acute care needs. There is an inherent assumption that, if the need is not acute, it is of less importance. When the participant speaks of "a lack of acknowledgement for the needs of the older population," she does not refer to all older people, but only those who have different care requirements. Those who need flexibility are unable to conform to bureaucratic conditions and become problematic to

the system. Those who are unable to conform are disadvantaged and the hospital environment “causes them to lose their confidence” (HE#1, 9:260).

Hospital employees noted that regimentation has an inherently disempowering effect on older people that often fosters a learned dependence. For example, routine administration of medications can usurp older adults’ opportunity to learn to safely self-care, which erodes a person’s ability to succeed at home after discharge from hospital. One nurse complained:

This whole thing of walking around and handing out pills just drives me crazy....

They have to do it when they go home; they have to know what those pills are and here’s their chance to ask, “What’s this red one again? Oh yeah. What’s that for?”

And, “How will I know if I forgot to take it?” You need to encourage that dialogue. Handing out the pills does not do any of that. Then we wonder why when people go home with the prescription, they never actually take them properly or they end up coming back into the hospital because they didn’t take them properly. (HE#1, 17:523)

The routine of medication administration becomes problematic because it is applied indiscriminately to all individuals in hospital. While some older adults may lack the cognitive ability to self-manage their medications, bureaucratic conditions usurp hospital employees’ ability to use their discretion. As the case above indicates, in the administration of medications there is no accounting for the older patient’s abilities; routines apply equally to all, irrespective of different wants, needs, and abilities.

When asked to describe their impressions of being old in hospital, older adults chose words such as “dependent,” “under authority,” and “intimidating.” They reported

experiencing little freedom to choose or make decisions; most accepted hospital procedures as non-negotiable. Hospital employees agreed with these sentiments, suggesting that the hospital “certainly is not elder friendly ... it is a system that controls the person who walks in” (HE#8, 11:316). This led to fear, discomfort, fatigue, and distress for some older participants. For example, one participant was encouraged to go to bed at 6:00 p.m. The nurse explained that the staff preferred to get everyone settled early. The older participant replied:

Well, this might be very easy for you, but I said I’m an asthmatic, and I said I take medicine at 10 o’clock at night, and I take it at six o’clock at night, and I take it at 12 noon, and I take it at 7:30 in the morning, and there is no change in that. I said: if you think you’re going to turn out the lights and leave me here in the dark to take my medicine, you’re out of your mind ... because at 10 o’clock tonight I want lights on. I have to see my medicine.... I have to see what I am doing; this is too important. I am a very serious asthmatic. (OA#1, 8:221)

In this case, the older participant was assertive and the lights stayed on until eight o’clock. The participant also reported that at 10:00 p.m. she called the nurse to put on the light to take her medications. Still, she said she felt less like a person, and more like a medical problem. The nurse referred to her as “the asthmatic,” and the older participant felt the staff tried to “get rid of the annoying patients earlier” (OA#1, 8:221). Similarly, another older participant reported wanting to relocate to a different area of the unit to help him sleep:

I’ve always had this terrible problem breathing at night and I asked the nurse if I could go to the TV room or sort of just sit there or lie down on the couch there so

I can get more air because they had the window open there ... seems there was no ventilation in my room. She was very against that. She didn't want me to do that. She just said that's not the rules or something ... so I just said, well, I won't cause any problems. They were pretty firm about it. (OA#2, 16:474)

The participant reported returning to his bed where he spent a sleepless night, uncomfortable, and unable to breathe easily.

Older participants also found the bureaucratic conditions of hospital to be practical and therefore acceptable even when they did not like them. For example, one patient discussed the routine of mealtime in hospital: "It is the only practical way to do it and to do it economically," he said. "They've got to have breakfast at such and such a time, and lunch at such and such a time. It would take tremendous staff to do anything otherwise" (OA#7, 12:339). Another participant echoed the sentiments of others this way:

Where you are looking after a large number of people by a small number of people, there's got to be a regime; there's got to be regulations; there's got to be systems to take care of it. I would have preferred to have my coffee and my breakfast maybe at 8:00, but it was convenient for them to serve it at 7:00. Well, you know ... you can put up with it. (OA#5, 15:430)

Older adults interviewed could not imagine the hospital being any other way. "A hospital is a hospital," (OA#6, 9:249) stated one participant; they were grateful, accepting, and found security and comfort from the service. "You just don't have the freedom," one participant explained. "I can't really say there is anything wrong with hospitals. Thank God they're there" (OA#6, 11:331). Another participant argued,

“Routines are a good thing. You know what to expect. You know your lunch is coming at such a time, and you know that they [hospital staff] come and take your blood pressure every so often. I think it is quite all right. They [the rules] certainly make sense” (OA#7, 13: 374).

In the medically dominated acute intervention model of the hospital, the study found that routines served the bureaucracy. System needs appear to trump competing priorities that hospital employees face in their daily work, leaving older patients with less acute needs feeling isolated and alone. Hospital employees echoed these sentiments, describing their experiences of being subordinate to system demands. One hospital employee, for example, described the operating room as a “surgical machine”:

The operating room is run on a clock. It takes an hour for x procedure. That’s all they’re booked; that’s all they’re given. Today, the classic example: the first O.R. case this morning, I think, was allotted 45 minutes. That’s the standard time for that particular type of surgery. Three and a half hours later that patient is still on the table and, in that period of time, we *should* have done four other cases; we’ve only done one. The clock is 24 hours. We now need 30 hours to get the same job done ... it’s impossible. But somehow *we* – we meaning team – we have to make this happen. Can we catch up time? Can we rearrange? Can we find more staff? What do we have to do to keep the machine moving forward? Because it is all driven by the clock. (HE#7, 1:10)

This game of catch-up contributes to feelings of frustration among hospital employees. Likewise, when older adults require more time and attention due to their slowness, lack of physical agility, and hearing and vision problems, these system

pressures, as noted above, add to their sense of incompetence. At the same time, if older patients are able to keep up with the pressures placed on them by bureaucratic demands, they have less difficulty fitting into the chaotic atmosphere of the hospital environment.

### *Chaotic Atmosphere*

All participants attributed the chaotic atmosphere of the hospital to the “fast and furious” speed at which activities occur. Time and bureaucratic pressures influenced the behavior of both hospital employees and older adults. This often contributed to feelings of frustration, guilt, sadness, and dependence. For example, one hospital employee described the often impersonal, rapid-fire preparations for surgery:

They come in; they have a volunteer getting them ready. They have their IV in, and they sit for a little bit. It is just the whole system; it's just the way we've got to get them in, and then you might unexpectedly have, okay, O.R. #3 is ahead of time. So get them in, get them in, get them in! (Rushes speech and claps hands) So that IV goes in quicker, and then the patients are sat in the hallway, and then they're walked into the O.R., and then they come back out and before you know it they are up to the bathroom and they are out the door. They probably don't even realize it. Is there a better way of doing it? Because I know we have to be cost-effective and we have to meet deadlines and ... the system has to work. But I wonder ... if you don't get the right staff it becomes a conveyor belt, because you have to remember that there's a patient there and there's a patient on that belt. And I think that is awful in acute care everywhere. (HE#12, 9:255)

Hospital employees used an assortment of analogies to describe the pace of the hospital environment, referring to it as a “gatling gun approach” and a “tug-of-war.”

They also described the organizational structures in place to control and facilitate the rapid pace of people moving through the system as a “conveyor belt,” “assembly line,” and a “machine in trouble.” Within this hurried environment, older patients reported feeling lost and forgotten. The “hurry-up syndrome,” as one participant called it, led to diminished choice, contributed to adverse outcomes, and deconditioning. Rushing was consistently blamed on time constraints. One hospital employee described how being rushed led to diminished patient choice, affecting even the simple task of helping an older patient sit up in bed. The participant described how staff rapidly talked the patient through the procedure:

Okay, Mr. Smith, on the count of three, we’re just going to take you ... you don’t move anywhere ... just hold your hands ... and we’re going to count ... and we’re going to move you up in the bed. One, two, three. Okay, done. And I’m not kidding you, it happens just like that. Not once were they looking at the person and getting any kind of nod of approval, does the person understand? ... There was no eliciting co-operation there. [Speaking rapidly] We’re done now, okay? Done. So I think it is always the rushing, and I mean it is back to the whole, the system routine, the clock – the keep it moving. (HE#7, 19:576)

This example also illustrates how routines function to contain the chaotic atmosphere to maintain order and promote efficiencies. Caring is on “the nurse’s terms and in the nurse’s time frame,” according to this nurse. “It is like virtually all the autonomy is gone because everything has to be the way we do business, by and large, to fit in” (HE#7, 19:571). Patients are not in their home; “they’re in *our* [emphasis] place. In

an acute environment, it is kind of our way or the highway. You know what I mean? It's *our* [emphasis] way and I don't think we mean it, but it's the way it is" (HE#7, 19:595).

Hospital employees also noted that older patients with more complicated medical profiles often did not follow a normal trajectory, and, in turn, did not fit in with hospital systems. A normal trajectory involves preparatory work-up, arrival to hospital at the appropriate pre-scheduled time, and moving sequentially through the prescribed process. Factors that contribute to a normal trajectory are stable medical conditions and the absence of any unexpected events during the process of coming to, being in, or leaving hospital. As long as the older patient follows the prescribed process, the "machine runs well" (HE#7, 10:280). When they do not, the study found that system demands took precedence, and older patients and families had to adjust. As one hospital employee explained:

Not only are we dealing with the surgical intervention, but we're very often now playing catch-up with trying to figure out these other medical things that are going on with [older people] them. So they don't follow a prescribed pattern. And in our business, we're set up to follow a trajectory of days in hospital. And, by gosh, if you don't fit in that trajectory so that the hip is repaired, poof you're out the door, it is six days later, man are we in trouble. So everybody's stress level rises because we are so worried about ourselves and trying to put through more people in this system. (HE#7, 1:10)

Caring for older adults takes more time when they are slower to recover, have heavier care needs, and are less agile and more fearful. When older adults with these attributes require more time, whether it is preparing them for surgery or assisting them

with everyday tasks, they do not fit well in the fast-paced hospital environment.

However, the notion of taking time to address these different needs conflicts with the culture of efficiency that operates in hospitals. Hospital employees have little time, and must work within scheduled blocks to meet hospital system demands. The result: hospital employees rush to meet the demands of the system, while older adults rush to wait. For example, older patients wait to register, and to be seen and assessed. They wait their turn; they wait for interventions, and then they wait to go home. Only after the decision to discharge has occurred does the waiting turn to rushing for older adults.

The experience of leaving hospital is affected by the rush to vacate acute care beds. At the time of discharge, linkages to other health system resources affect continuity and can ease transitions. These linkages include timely access to community-based programs such as home care or home support and family support. However, hospital employee participants reported that resource availability alone is not enough. One participant described the story of an independent 93-year-old man discharged home with a colostomy for the first time in his life, the result of major abdominal surgery. "We're going to be sending him home today at 2:00? Well, the family doesn't come to visit until the evening. I doubt that they're going to think this is a great idea, sending him home at 7:00 p.m." (HE#7, 9:251). The nurse reported that numerous factors influenced her ability to discharge the older man home safely. They included: the timing of the physician's rounds, the time the discharge order was received, and coordination with the family. The nurse also explained that the needs of the patient and family were not her only concern; she also had to consider system demands. She anticipated pressure from the emergency department to vacate beds:

What if I've got to get that [his] bed tonight? Like I know emerg is going to be on my case – [they'll say] he could have gone home but you kept him. So what do you do with this? If we could have sent him home today at 2:00 and had someone that could come and maybe stayed with him, that would have been okay, but just home tonight, maybe home tomorrow morning when the family has had a night to sleep on it, and time maybe to make some arrangements themselves. I knew that I had a couple of empty beds that I could offer the emergency room. If that wasn't the scenario today, if there were five cases in the emergency room that had to get to the O.R. tonight and we needed every bed, the 93-year-old man would have gone home. (HE#7, 9:245)

Leaving hospital when you are old is not a simple matter. Other hospital employees reported encountering similar conflicts as they tried to balance what was best for patients with what the system required. They had to negotiate with other elements of the system, synchronize activities, and coordinate actions to realize continuity and ease transitions in the chaotic atmosphere of the hospital.

In contrast, older adult participants failed to recognize the negotiated approach described by hospital employees. All older participants left hospital for home at different times of the day, either by taxi or in a family member's vehicle. They reported leaving very quickly, often before they could organize themselves for a smooth transition back home. Some could not get rides; others had no clothes to wear. "They let me go very, very suddenly – almost without warning," complained one older participant. He reported leaving hospital by taxi in "little more than a dressing gown and overcoat.... Usually

when I've been in the hospital I know often a day in advance before I am discharged. At the least I would expect a good number of hours, but there I had minutes" (OA#7, 5:125).

Some older adults leave quickly only to return because "a lot of times we discharge them too early," according to one hospital employee. She recalled discharging an older patient who later returned:

I can't believe they sent her home. She was very dizzy, she could hardly walk and she was just totally unable to care for herself and she lived alone. Elderly people are assessed by social work before they go home but I am wondering if this one slipped through the cracks or something, I'm not sure. Maybe she did fit the criteria and they sent her home anyway but she was back within half a day.

(HE#15, 7:190)

Another older participant explained his view of leaving hospital this way: "Right now it is more about get them in and out as fast as you flippin' can" (OA#4, 2:46).

### *Hospital Employee Attitude*

Older adults had mixed feelings about hospitals and hospital employee attitude. While all older participants reported a desire to receive treatment from staff who exhibit an attitude of dignity and respect, they often felt cold indifference. As one older participant's spouse explained, "Attitude they give me is like, well, you're just an old person, you're really just dying anyway, we'll put up with you, that's the problem; that is the attitude they gave me at the emergency" (OA#2, 8:216). All older participants used negative words and phrases such as "invisible," "a burden," "baggage," and "uninterested in me" to describe their experience of being old in hospital. As one participant put it, "I

would expect that they would treat me like a human being not just another workload. That is very evident, you're just another workload" (OA#2, 17:500).

However, older adults also expressed gratitude. As one older participant put it, "There is nothing wrong with hospitals, thank God they're there" (OA#6, 11:331). Older adults were also self-effacing when explaining the attitude of hospital employees. They offered reasons to explain the poor treatment they receive and excused the negative attitudes of staff. For example, one older participant put the onus on others his age: "Lots of people my age and older are a bloody pain in the ass; they are miserable. They can't come to grips with the fact that these people [hospital employees] are doing their best to help you, so co-operate and be good about it" (OA#5, 13:396). Co-operating and "being good" are ways older participants coped with the negative attitudes of hospital employees. "Nobody with a good nature should have a problem in hospital," another older participant explained (OA#1, 6:156). Another said: "I'm happy-go-lucky and I jolly along with everybody but I think they are just glad to get rid of me (shrugs shoulders and smiles) (OA#5, 13:418).

The study found that ageist attitudes emerged as a bi-product of pressure on hospital employees to keep the system moving when older patients could not conform to the demands of the environment. Hospital employees reported incidents of stereotyping and discrimination. They stated: "judgments go on," and reported disparaging remarks such as: "Why is granny ringing again?" (HE#5, 16:477). One hospital employee said stereotyping occurred regularly and that the mindset of some "health care professionals [is] ageist" (HE#6, 2:52). She described a daily bed-meeting that she attended in her role

to facilitate hospital discharges. She reported feeling pressure from other hospital employees who urged her to discharge patients to free up acute care beds:

... they needed more beds and people were saying, "Well, you need to have the flu to kill off more of your population." Now, sorry if that's black humor or not, this is supposed to be a professional saying this. I just thought, no, we have so much ageism in our population. (HE#6, 2:52)

Another hospital employee participant described how emergency department staff, distracted by the hectic atmosphere often make assumptions about people that interfere with providing individualized care: "We assume that older people are comfortable in hospitals," she said, "because they've all been in and out and in and out" (HE#15, 10:303). However, she said those assumptions can be misleading:

In the busyness of the shift, you just assume when an older person comes in that they have been in hospital before and that they have a ream of medications. I had this 97-year-old lady; she had never been in the hospital before. She had no medications that she was on and was totally scared because she had never been here before. I asked her for a urine sample; well, she didn't know what that was. She just looked at me with this shock on her face because she couldn't believe that I wanted her pee. She had never ever done that before and she was in her 90s. (HE#15, 10:303)

This hospital employee overlooked the older woman's need for health care education and, consequently, did not provide appropriate information about diagnostic assessment and treatment strategies. The nurse assumed that, at age 97, the woman would have had previous hospitalization experience, and at least some medical knowledge and

understanding of the expectations that accompany a health assessment. Had the woman been younger, the nurse might have employed a different approach. She explained the difference this way: “With little kids, of course, you take more time to explain things and even with younger adults,” she said. “But the older people, you just kind of think they’ve been here, done it before ... but some of them haven’t” (HE#15, 10:303).

In this case, the chaotic atmosphere had a cascade effect. In her rush to complete work and meet the demands of the system, the nurse overlooked the unique individual needs of the older patient; the nurse assumed, based on the older woman’s age, that her level of knowledge and understanding would be adequate to meet her needs. As a result, the nurse failed to provide education on diagnostic procedures. This, in turn, contributed to the older woman’s anxiety and fear. “In the rush to get things done,” explained the nurse, “you [still] have to remember not to see all old people just the same because they are old; [for] some their hospital experience is very new to them” (HE#15, 10:303).

Other hospital employees also reported making judgments about what patients could or could not do based on their age. For example, one participant explained that younger people “go with the flow more and take the experience and make it work for them.... The elder population can’t do that in this fast place [the hospital]” (HE #7, 18:545).

The attitude of hospital employees was also influenced by the challenges of providing care within workload pressures and tight timelines to “dementing” older adults with diminished functional ability and increasing dependence. This led to frustration among hospital employees. As one nurse explained:

... with dementing patients I would come home with a bruise or something, you know, a lot of abuse to me. That is very frustrating. I know there were times I almost lost it because it was hard to take. I know they didn't know what I was trying to do [for them]. It was very hard to explain to them; you know, just trying to do their personal care without getting mauled in the mean time. (HE#15, 1:8)

Hospital employees talked about workload in the context of system pressures to "move people along." This pressure triggered frustration and a moral conflict for hospital employees. When asked to talk about the day-to-day challenges of working with older people, one emergency nurse lamented not "having the time to give them the care that they deserve and that they need, and not feeling good at the end of the day because I know I haven't been able to do that" (HE#15, 3:82). Another nurse described "feeling like a loser" when she was unable to balance competing demands for her time. "You feel that maybe you aren't meeting the patients' needs and it is extremely frustrating," she said. "We've had occasions where you go, 'Did you feed Mr. A?' 'No, I thought you did!' And it turns out Mr. A's tray has come and gone and he hasn't even been fed, which is really, really discouraging" (HE#3, 14:416).

Older participants expressed concern for professionals working in the hospital setting, often noting their heavy workloads. When comparing his last hospitalization to previous admissions, one older adult noted a decline in attitude, which he described as a widespread "unhappiness" among hospital employees. For this participant the unhappy attitude he observed in hospital employees "has built up" over time.

### *Summary of Poor Fit in the Hospital Environment*

The study found a lack of fit in four aspects of the hospital environment: architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude; they represent the underlying dynamics of what is occurring within the hospital's cultural space. Together they represent the incongruence that exists between what older adults need and what the hospital provides; they promote conflict transactions by contributing in the following ways:

- Architectural features: contribute to older participants' stress, fear, anxiety, and worry; they interfere with independent way finding, promote deconditioning that limits recovery, and interfere with family support by making visiting difficult.
- Bureaucratic conditions: contribute to efficiency, create order and pressure to conform, but limit choice and flexibility; they place demands on hospital employees and older people, and enhance their disabilities when functional impairments exist.
- Chaotic atmosphere: contributes to hospital employee frustration; creates fast-paced pressures and demand for corresponding quick solutions; erodes older adult independence and confidence; workload pressures promote discriminatory practices; and further enhance disabilities in older people.
- Hospital employee attitude: contributes to older participants' feelings of cold indifference, and their perception of being a workload.

Although these conditions exist in a synergistic relationship, they account for only half of the dynamics at play in the construction of problems; the other half involves older

adults themselves who are engaged in transactions with the four hospital-based environmental conditions. The social ecological perspective now requires that attention turn to older people in the hospital environment.

### **Older People: Underlying Dynamics for a Problematic Experience in Hospital**

Data indicate that two groups of older adults enter hospital: those identified as *ideal* older patients, and those with characteristics that hold them apart as *being different* from the ideal older patient. Findings indicate that the latter group has problematic encounters when they interact with the hospital's architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitudes. Interaction with these aspects of the hospital environment sets in motion processes that produce reinforcing consequences for older adults, hospital employees, and the system. The distinguishing characteristics of each group are described below to illuminate their fit or lack of fit within the hospital environment.

#### *Being an Ideal Older Patient*

Hospital employees in the study did not recognize age in people who met the attributes of the ideal older patient. Their characteristics include being acutely ill, physically agile, functionally independent, able to solve problems, and having access to social supports. They have "more strength to get up and move around and to follow through" (HE#7, 5:149). The ideal older patient demands little from hospital employees, has a predictable illness course, and leaves hospital when expected. As one participant explained, "they've been worked up ahead of time and they just follow the prescribed pathway and we don't really see too many issues" (HE#7, 1:16). This type of older

patient “can go with the flow more and can take the experience and make it work for them” (HE#7, 18:545).

Ideal older patients are also “able adults”; they “speak English, are involved in home and community events, and drive a car” (HE#7, 22:657). In addition, they are “healthy and have few co-morbid problems” (HE#12, 1:8) that complicate their care. They are “prepared enough to know what to expect, can tolerate being out of their familiar environment, and [they] have support systems” (HE#11, 1:12). It also helps “if they behave and go along” (HE#9, 12: 353) with expectations set out by hospital-employees.

Interviews with all participants indicate that fewer problems exist with this group of older patients because they can keep pace, follow the prescribed path, and obey instructions. These older patients also have the ability to ask for what they want, and wait patiently until staff can comply. They fit within the system because they have the necessary abilities to match the demands placed on them and, in turn, this places less demand on the system to adjust and accommodate their needs.

The impact of this sort of patient on the system is negligible because hospitals are organized, equipped, and resourced to respond to their needs, thus achieving older adult-hospital environment fit for both older ideal patients and the hospital employees who care for them.

#### *Being a Different Older Patient*

Being different as an older patient in hospital is distinguished by two types of intertwined characteristics: being different (and difficult) and being different (and inappropriate). The first, being different (and difficult) involves an older patient’s

personal functional attributes.<sup>31</sup> These older adults may function well, with or without support, when they are outside the context of the hospital environment. But when they enter the hospital's cultural space they do not fit in because the environment demands more from them than they can independently tolerate. Limited functional abilities increase their sensitivity to the hospital environment and make them difficult to care for. These individuals may, in fact, be acutely ill, but take longer to recover and require a different approach to care.

The second, being different (and inappropriate) involves older patients whom hospital employees deem non-acute or no longer requiring acute care intervention. Hospital employees view these older people as needing something else; they do not belong on "our" particular acute care unit or service. In this situation, when classified as different, these people receive the label ALC – alternate level of care. Consequently, their non-acute status changes the type of care and attention they receive by hospital staff who perceive them as a burden in an already overtaxed care delivery system. These older patients also often have significant functional disabilities, which prevent their discharge home causing longer stays in hospital that are judged by hospital employees as inappropriate. The next section discusses evidence that both groups of participants offered to illuminate how the features of being different work together in problem construction.

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<sup>31</sup> Guided by Ebersole, Hess, and Luggen (2004), functional attributes in the context of the dissertation comprise an older person's performance of survival skills needed to negotiate everyday life. From a gerontological perspective, the focus is on those skills related to basic physical and cognitive function to perform self-care (i.e., activities of daily living, instrumental activities of daily living), mobility and balance, and comprehension and communication. Together these categories of skills facilitate a person's ability to function safely within their home or community setting – including the hospital as a health care treatment setting.

*Features of being old and different in hospital.*

Hospitals operate on the assumption that all patients, including older adults, are able to comply with the demands and expectations of the hospital environment. Most patients are able to do so; they form the norm within the hospital setting and are referred to in the dissertation as the ideal patient.

Being old and different in hospital relates to personal characteristics that are distinct and unlike the norm found in a hospital's population of ideal older patients. Older adults who are deemed different, and difficult or inappropriate exhibit any combination of the following: disruptive behavior, an unpredictable clinical course, difficulty expressing their needs, wants, and desires in ways that hospital employees understand; difficulty following directions, and less physical ability to perform independent self-care.

Hospital employees describe these older patients as hard to care for and socially isolated. They consider these traits problematic because these older patients do not have family or others looking out for their interests; they become a burden to acute care staff. It is not clear from the findings whether lack of family support is a defining characteristic of being old and different (i.e., difficult or inappropriate). Nor is it clear how family support helps or does not help to mediate expectations in the context of care delivery in hospital. It may be that family support or other forms of advocacy ease the pressure hospital employees experience in doing their work. Conversely, a lack of support or advocacy could aggravate the situation because hospital employees may knowingly or unknowingly depend on family support, which shifts the burden of care to family or other advocates. Support and advocacy may also potentiate problematic situations by family

adding pressure on hospital employees to be increasingly more responsive to their older family member.

In addition, those who lack short-term memory have difficulty following directions; they do not do as they are told, and they require more attention, which takes time away from acute patients. These older patients are also less physically able and require more equipment or aids. As one hospital employee described, personal characteristics can make all the difference between positive or negative admission experiences. She contrasted being older-different to the ideal older patient this way:

You have a relatively healthy 76-year-old – has good family support, has a terrible knee. Coming into hospital goes into preadmission clinic, has a husband that can drive them; they come in, the appointment's fine. They get a nurse that is really encouraging and talks to them and does all of the preadmission clinic procedures fine. Comes in on the day of surgery, there's no problems; they knew which of their pills to take. They go in, have their surgery; they come back. They have a spinal; the anesthetic is great; they have no pain. They get up; there's no problems. They have their physio; they go home. Great. And we have lots of that, but we also have the little lady living on the edge at home. She is not really ready to go into [pause – seems lost for words] ah, not ready to give up, has a fall, fractures a hip, sits at home, incontinent, eventually found by somebody, goes into emerg. There are no beds in the hospital, sits on a stretcher in emergency for 36 hours. Has no family, eventually gets to the operating room. By now is so confused, doesn't know where she is. She's sitting there; we're giving her something for pain. We're turning her. We're watching her. We don't have time

to get to know who she is ... we try but ... still confused. Now she has to be placed [throws hands up in the air, rolls eyes]. Oh no, now how are we going to get her off the surgical floor? (HE#12, 14:397)

These contrasting cases also reveal how patient suitability is determined by the specialty of the hospital service or department. The question, "How are we going to get her off the surgical floor?" suggests that only certain types of patients belong in certain areas. The patient's needs must conform to the expectations set out by the service. "We do surgery on my unit," said one participant. "So once the surgery is over, they need something else" (HE#7, 5:128 and 183). Once a patient has recovered from surgery, they are transferred off the service or onto another unit because they no longer fit with the expected operations of the original service. On the surface, this may appear appropriate. After all, matching expertise to patient need surely must contribute to quality care; however, not so for older adults with different needs or abilities. When a mismatch occurs, these older adults are labeled as inappropriate for the specialty service where they are being treated, and are cared for differently. One participant explained what often results from this mismatch: "When they no longer require acute care, they become ALC – alternate level of care," she said. "Then a big shift happens; they get less attention. We keep them safe and make sure that their basic needs are met, but they're no longer a priority for us" (HE#2, 2:60).

Trouble emerges in hospital for older people particularly when, as one nurse noted, "these folks come to us on the ward from the emergency room" (HE#7, 1:10). These older adults have co-existing medical problems that may or may not be in control or well managed. "They are on the teetering point, planning to see their doctor, but before

they get the medical assistance they require, they have a fall after tripping on a carpet. They've broken their hip; they're in the hospital and it seems to then start a cascade of events down a bit of a slippery slope" (HE#7, 10:280). In these unpredictable situations, the unanticipated event requires acute intervention; however, these needs run concurrent with other problems, often complicating the admission and contributing to unpredicted longer lengths of stay. Hospital employees reported that these older people often fall off the expected path.

On the surgical unit, being different often related to the speed at which a patient could recover; older adults take longer to recover. When it takes longer than the system can accommodate, the patient is deemed unfit for the service and has to go some place else. For example, one hospital employee explained the added challenges of seeing an older patient through a rehab program.

That person at 85 needs more time. They need to move to the next phase of this where we can work with that person to give them upper body strength to be able to work the walker so that they can then get up and move around. And it is frustrating when that isn't the expertise that our group of nurses [in surgery] has. Yet this person is in our bed, in our care, but our expertise part of it is done. So I don't know that there is resentment, but there is a whole other cascade of things going on inside the nurse that says, "This patient doesn't belong here; get her out of here." Okay, where is the place? (HE#7, 5:140)

When deemed inappropriate for a unit or service, staff expressed frustration while waiting for an older adult's transfer off the unit. They expressed frustration at "not being able to look after them properly because you [the practitioner] are busy with acute

people, and people who are alternate level of care don't really have any acute issues and you tend not to spend that much time with them" (HE#2, 2:60). These older adults may find themselves unintentionally ignored and isolated. During an observational visit to the hospital, the researcher witnessed an older woman subjected to this isolation:

Restrained in a broda chair, she was nestled against the back of the chair in a slouched position. She appeared frail and lightweight; her white hair was shoulder-length and thinning. She did not appear to have her teeth in; she was rhythmically mumbling and chewing on her gums. Numerous people passed by; other patients – young and old, visitors, lab technologists, patient care porters, physicians, nurses, dietary, housekeeping, and security personnel – all walked by this woman seated in the broda chair, and all looked away. Some took a quick second look; others just looked at the floor as they passed by. For two hours no one spoke to or acknowledged her presence. Essentially ignored, it was as if she did not exist. (Observation 21-04-18-05)

This older woman was different from other patients because of her physical characteristics and appearance; she portrayed a lack of interest in her surroundings and vocalized incoherent noises. She was dependent on staff for all activities of daily living. Set aside in the hallway, she is an example of the type of person that hospital staff described as "not doing well in hospital" because "she is dependent," "can't follow directions," and "is unable to do for herself." Her behaviors represent the observable consequences of diminished physical and cognitive function, and other probable sensory impairments.

The older woman's behavior was difficult for some to observe; she did not appear to be a socially able older person. She communicated and behaved in ways that made determining her needs difficult, which produced a corresponding challenge to staff; her cognitive impairment isolated her from others. On the surface, the tasks related to her care were custodial, not of the acute medical intervention type. This made her different from the ideal older acute care patient who, as noted earlier, hospital employees described as acutely ill, physically agile, functionally independent, able to solve problems, and as having accessible social supports. In the view of hospital employees, this older woman was inappropriate for the setting.

The above case also highlights that being different relates to changes associated with the physiological consequences of aging to produce frailty, functional impairments, and diminished coping ability (See Appendix O – Potential Age-related Physiological Alterations). The manifestation of these physiological alterations in conjunction with disease and illness contribute to an inability to communicate in ways that hospital employees can understand, an inability to follow directions and perform self-care, and an unpredictable clinical course, which are all associated with being different.

The degree to which these changes are present in any individual is highly irregular and so too is their impact on an individual's ability to function, cope with stress, and conform to pressures in the hospital environment. As a heterogeneous group, older adults will present with varying degrees of age-related physiological change, disease and illness, and corresponding functional ability and/or decline. Although older participants reported experiencing cold indifference, and impersonal and non-individualized care unrelated to specific physiological changes, hospital employee participants indicated that

only older patients who experienced pronounced visual, hearing, physical, skeletal/muscle, or cognitive changes had greater risk of problematic experiences and were themselves problematic to the system. A hospital employee explained it this way:

Old doesn't mean they are incapacitated, but some are more incapacitated ... they aren't able to jump out of bed and go to the bathroom and they aren't able to eat properly. They aren't able to even ask for help sometimes. They're either demented or just physically unable to get up. So, it is getting them in and out, like getting them on the commode, getting a walker for them, that kind of stuff makes it hard [to care for them]. (HE#15, 2:46)

Of these changes, findings suggest that cognitive impairment in an older patient is a significant alteration that contributes to problem construction in the fast-paced hospital environment. As one hospital employee participant explained:

I think it's our fast pace, our quick solutions, we got to do something, so we treat all the [people] the same. We don't know what to do about the dementias and the mental issues with old people. We're pretty good with the physical things, but we don't know what to do, so ah, we kind of brush it off. (HE#14, 14:21)

Cognitive impairment is critical because it represents brain function; it enables the person to remember, follow directions, problem-solve, perform independent self-care, and communicate. Older people with cognitive impairments and other physiological alterations, as noted in Appendix O, are individuals who often also have difficulty with the hospital's architectural features and bureaucratic conditions. These individuals run the risk of being labeled as inappropriate if their acute care medical problem resolves and

they stay longer than expected because there is no discharge disposition available to them.

In the chaotic atmosphere of acute care, being different is not tolerated well by hospital employees working in the system. Some older patients are different, as one nurse put it, because in many cases they are not “sick anymore.” “They are stable,” she said. “They’ve gone back to living their life as they are able, but there is no life in a hospital, of course. You have no activities; you have nobody to interact with in a significant way. I have acute care pulling me away with ... all kinds of stuff so I cannot be back there with the long-term care people” (HE#9, 1:24).

When non-acute older people are on hospital units, people with more acute needs become the priority. This disadvantages some older people because their needs are less urgent. The psychosocial needs of older non-acute patients come second to the needs of the acutely ill. As one participant explained, mixing two populations creates problems:

You are looking at value of life and keeping them warm, clothed, fed, and healthy, and the other side is all about fixing, and it is chaotic. The two don’t mesh very well. You always go to where the most crisis is, and always in the back of your mind is this little old lady sitting in a chair needing interaction that you can’t give her, and that is there all the time. I know she is back there waiting for me and when you look at life’s crisis she can always wait for interaction; a GI bleed can’t wait. If I wait, they die, right? So I have to be there, I know that. But I know she is sitting back there in that chair staring at the walls. (HE#9, 1:24)

Under these conditions older patients become labeled as *the problem*, are no longer a priority, and then ignored and isolated, when the issue is actually a combination

of three factors interacting simultaneously – frailty, a high demand environment, and an inflexible system of care delivery. The lack of fit rests in the relationship between being an old and different patient in the context of a fast-paced acute intervention setting.

The next section looks at related, but unexpected findings that suggest there is more to know about older people in hospital. Although the study data are limited and unable to provide a full and detailed analysis of these findings, the researcher chose to introduce the reader to them and include their relevance in discussions in chapter five.

### **There is More to Know: Glimpses Into Being Old in Hospital -**

Although not the focus of the dissertation study, two related serendipitous findings emerged from the data that provide direction for future research. The first finding sheds light on the benefits and limitations of applying the four-dimensional lens constructed from residential and sheltered care facility literature (Moos & Lemke, 1994; Moos & Smail, 1974) to assess older adult-acute care environment fit. Drawing on older adults' lived experiences and clinical practice to enrich the lens may contribute early groundwork for the development of an older person-environment fit assessment tool for acute care.

The second serendipitous finding stemmed from comparing the journey maps of older participants (noted in chapter three). A comparison of these maps highlighted key events in the process of coming to hospital, which suggest hospitalization from the older participant's perspective begins before arrival at the hospital and includes how decisions are made to come to hospital. While there is more to know about these two areas, they offer other investigative avenues to further our understanding of being old in hospital. Although incomplete, these unexpected findings are presented below.

*Application of a Four-Dimensional Lens to the Hospital's Cultural Space*

The study found that hospital customs and traditions reside within the dimensions of social climate, physical design, policy and procedures, and care systems and processes; they place boundaries on assessing the experience of being old in hospital. Overall, when juxtaposed to interview and field note data, these four dimensions worked well as global concepts to expose the complex nature of the hospital environment. They helped focus the investigation by pointing to areas within the hospital to conduct field observations, and throughout the study, they offered a way to organize the data. This helped to uncover dynamics related to poor fit that were at work beneath the surface of transactions.

The defining attributes of person-environment fit from the residential and sheltered care facility literature (Moos & Lemke, 1994; Moos & Smail, 1974), however, lacked contextual specificity. Though both settings share bureaucratic conditions, acute care hospitals are qualitatively different from residential and sheltered care settings. The differences rest in their mandate: one provides short-term acute intervention; the other provides long-term supportive housing and quality of life interventions. Transposing the attributes of residential and sheltered care facilities directly to the hospital setting was, therefore, methodologically undesirable because the work that occurs in each practice setting is different and thus places different expectations and demands on hospital employees and older adults. It was for this reason that existing research on older adults' lived experience of hospitalization and the researcher's clinical practice informed development and application of the lens described in chapter three. Two examples follow that illustrate these points and the benefits to combining researcher clinical experience

with older adults' hospitalization experience to develop the four-dimensional lens adapted for this study.

*Example 1: Policy and procedure dimension.*

The policy and procedure dimension encompasses rules and regulations that control individuals in both hospitals and residential and sheltered care settings. Though the extent of control exerted in each environment may be similar, what is being controlled differs greatly. Issues of control in hospital focus on patient activities and their ability to make decisions; these pertain to bed rest, parking, visiting, admission processes, and rules about access to services at discharge. In contrast, attributes associated with control in the policy and procedures dimension of residential and sheltered care environments pertain to curfews, having coffee makers in rooms, and the presence of a residential council (Moos & Lemke, 1994; Moos & Smail, 1974). What is controlled in the practice setting has implications for the work hospital employees perform and the care older people receive; this affects the experience of being old in hospital, the contextual factors surrounding the problems people encounter in the environment, and consequently the evaluation of person-environmental fit.

The study also found that, when asked directly, older participants were unable to specifically identify or discuss policies and procedures.<sup>32</sup> They were, however, able to tell stories about problematic situations that, in fact, arose from policy decisions. When asked

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<sup>32</sup> I acknowledge that older individuals living in residential and sheltered care facilities may also have difficulty discussing specifics related to policies and procedures. The point is not to compare whether either sample (i.e., residential or hospital samples) were able to or not able to speak about policies and procedures but rather to highlight the methodological issue of how the researcher frames the interview questions to expose knowledge hidden within experience but not consciously known by the participant, as with policy language. The methodological point relates to the need for attention and application of sensitized interview techniques in order to extract information from older people's experiences of being old in hospital. Future research on this dimension of the older adult-hospital environment fit lens requires an accounting of this issue.

if they “came across any policy or procedure while they were in hospital that created difficulty for them,” they paused, thought carefully for a moment, and then replied that there was nothing to report. Each older participant then proceeded to tell a story about a difficult situation that in retrospect, the researcher was able to determine emanated from a policy. For example, one participant, while discussing his discharge from hospital, stated, “No, I can’t honestly think of any policy.... With the new hospital they will probably have more rooms, so they wouldn’t have to rush you out to get a bed free” (OA#7, 9:250). This man, rushed to vacate his bed, did not realize policies on access to acute care beds had influenced his experience. Others had similar stories, each illuminating different consequences of the policy and procedures dimension that affected the quality of their hospital experiences.

Conversely, hospital employees not only discussed specific policies and procedures, but also commented on their often-negative impact on older patients. One hospital employee assessed the impact of hospital policies on meeting individual patient needs this way:

Our system is there to ensure trends and accountability, and our policies really reflect that. Choice or awareness of an older individual’s understanding is not ever really considered in a policy or in how our system moves [people] from admission through treatment to discharge. Discharges that happen rarely, if ever, consider if it’s a good time for *them* [older people] to be discharged. (HE#8, 11:316)

Noting that older adults are the primary users of hospital services, this same participant went on to provide another example of the lack of fit between policies and

procedures and the needs of older people. The story exemplifies the detail with which hospital employees discussed this dimension of older adult-hospital environment fit. The participant pointed out financial imperatives and population comparisons, suggesting that policies pertaining to food and nutrition do not respond to the needs of older people, the primary users of the hospital service:

Food and nutrition policies are very much around budget constraints more than it meets the needs of the population that it is serving. We predict our elderly population is mostly in our hospital, but food textures, size, quality, and the types of food are reasonable for the 30 to 50-year-olds. So, when we look at our policies and procedures, it's really around the economics for how we manage the meal service and not old people. (HE#8, 11:316)

*Example 2: Care systems and process dimension.*

Each care setting (i.e., hospital or residential and sheltered care facilities), is driven by their respective treatment focus, exhibits qualitatively different attributes within care systems and processes. Residential and sheltered care settings respond to functional needs, while hospitals respond to acute medical needs requiring biomedical intervention. Consequently, their respective internal systems and processes support opposing missions and organizational goals. While residential and sheltered care facilities aim to support quality of life issues in a long-term care setting, all study participants in the hospital setting emphasized its fast pace and the pressure to shorten patient stays.

These differences are important to the study because, although each setting is bureaucratic, their cultural space is different. The culture directly affects what happens to people in these settings, their interactions, and the problems they experience.

Corresponding customs and traditions will influence the circumstances that surround interactions that affect not only the type of problems encountered but also how the special features of care systems and processes contribute to problem construction.

Though the four dimensions (i.e., social climate, physical design, policy and procedures, and care systems and processes) were useful as global concepts in understanding events, activities, and processes associated with being in hospital, they offered limited assistance, however, in understanding events that occurred prior to arriving at hospital. This was problematic because the study found that the experience of *coming to* hospital influenced the experience of *being in* hospital, suggesting the hospitalization experience begins before arrival and admission to hospital. All older participants described the events that triggered the decision to come to hospital; from their perspectives, events prior to arrival shaped their hospitalization experience, and potentially contributed to problem construction.

#### *Deciding to Come to Hospital*

The study found that the decision to come to hospital was not easily made by older participants. All sought other forms of help before coming to hospital; it was not a first choice for any older participant. All reported attempting to deal with their medical problem on their own or with the help of a family member. When attempts failed, older participants sought help from other sources by calling their doctor's office, visiting a doctor's office or attending a walk-in clinic, or calling a family member. More than half of those interviewed tried more than one source for help. One participant explained her experience of coming to hospital this way:

I wasn't feeling well for a few days. I tried to see my doctor, but I couldn't get an appointment so I went to a walk-in clinic. The good thing is I'd seen that doctor before. It took about a week to get into the hospital. My friend helped me. You end up putting people out, asking people to help. I finally had to come to emergency. (OA#4, 14-11)

Six of the eight older participants traveled to hospital by ambulance from their homes. Two others arrived at hospital driven by a friend, and the other by a daughter. All remember arriving at the hospital and being in the emergency department; however, their recollections were vague and non-specific. They blame their vague recollections on being ill, stressed, confused, and in an unfamiliar environment. As the hospital stay lengthened and their condition improved, their recollections became clearer prior to discharge.

### **Conclusion of Findings**

This study has focused on understanding problem construction in hospital from a social ecological perspective utilizing the concept of person-environment fit. The study found poor fit to exist in the hospital's architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude. These environmental features act in independent and cumulative ways to produce a disempowering synergy that erodes independence and confidence; produces stress, worry, and anxiety; and enhances disabilities when functional impairments exist. Each feature constantly exerts a reciprocal effect on older people and hospital employees. Cumulatively, they represent the underlying dynamics of problematic experiences. For example, the architectural features create confusion; signage and lighting provide inadequate aid to older adults attempting to locate specific areas of the hospital, particularly those afflicted with sensory

and cognitive deficits. Coupled with noise, over crowding, and a chaotic environmental atmosphere, a visit to hospital becomes an overwhelming experience. While bureaucratic conditions provide order in a hospital, choice and independence are also curtailed; the study found older participants accepting of these conditions. Although a nuisance, these conditions are source of security and comfort that all participants viewed as practical and necessary to keep the system moving. In this context, hospital employee attitude projected frustration and a sense of indifference toward older adult participants. This attitude emerged as a consequence to the demanding, inflexible, and chaotic atmosphere of the hospital environment.

The study also found that not all encounters in hospital are problematic for older people, nor did practitioners working in hospital find all older adults difficult to care for. For many older people, hospitalization results in positive clinical outcomes and few individual problems. The study affirms that older adults in hospital are a heterogeneous group.

Findings indicate that a lack of fit exists for only non-ideal older patients, those considered different either because of their personal functional attributes or because hospital employees judge them to be unsuitable or inappropriate for the unit or service. These people have characteristics that either impede the mission of the hospital to provide acute care interventions, or hinder the ability of hospital employees to do their work. Being different is key to lack of fit in the hospital environment and the construction of problems.

In such situations, the environmental conditions noted above converge to exacerbate disabilities in non-ideal older patients. Problem construction in hospital is,

therefore, more a matter of being different than it is about being old. Positive experiences are more likely to occur for ideal patients, irrespective of age.

Being different in hospital equates to being hard to care for, staying too long, requiring more time, and needing diverse equipment and aids. In these situations, older patients are labeled inappropriate and designated a different care status that reduces their priority in the minds of hospital employees. They become isolated and, in extreme cases, ignored as attention shifts to those with acute care needs. Although not totally forgotten – meals are delivered, their positions adjusted, and their physical needs met – these individuals are considered less a priority and a burden when they overstay their welcome, particularly when there is a need for the beds they occupy. Attention then shifts toward their departure from the unit.

A reciprocal relationship develops between frustrated staff and those older patients deemed inappropriate and difficult to care for. When these patients are deemed inappropriate and there is no place for them to go, the situation triggers a cascade of events that leaves hospital employees feeling frustrated and older people unwanted.

The unique needs of older patients and the needs of the hospital system exert reciprocal pressure on the other to conform. Hospital systems and processes appear to take a one-size-fits-all approach, which hampers responsiveness to individual needs. Hospital employees respond with frustration to this approach as they deal with the hospital's chaotic atmosphere and the pressure of demanding workloads. While the study does not deny ageist organizational practices may exist, ageism emerges in this study as a bi-product of the pressure on hospital employees to keep the system moving. This conflict exaggerates inflexibility and disabilities, and reinforces the incorrect notion that

all old people in hospital are problematic. The study found that facets of being different are less a consequence of chronological age and more about personal characteristics and discharge options. Consequently, other populations that share similar characteristics to those reported in this study may also experience problematic encounters.

Finally, the findings indicate the utility and limitations that the residential and sheltered care literature offer to understanding older adult-hospital environment fit. In addition, related findings suggest that older adults make efforts to gain help before coming to hospital. This is important to know because it suggests that the process of hospitalization begins before older people arrive at the hospital. The next chapter discusses the implications of these study findings for current and future hospital practice. It also examines the limitations of the study and offers suggestions for future research.

## CHAPTER FIVE

### DISCUSSION OF FINDINGS

Throughout the study, the researcher held the position that the experience of being old in hospital, a fast-paced intervention-oriented environment, is problematic for older people, and that reciprocally, older people pose problems for employees working in hospital systems. In light of this conviction, however, the preceding chapter presented findings that indicate a reciprocal lack of fit exists for those deemed old and different, but not for those considered ideal older patients. This lack of fit relates to four areas of the hospital environment: its architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude.

This chapter returns to the literature presented in chapter two to illustrate how the present study contributes to understanding older adult-hospital environment fit. The critical paradigm (Habermas, 1973) and the social ecological perspective (Stokols, 1992; Stott, 2000) provide a lens for achieving this understanding. Ethnographies informed by the critical perspective taken in this study reveal how larger social structures and systems influence and shape people's experiences (Reed & Clarke, 1999; Thomas, 1993) and, in so doing, offer a fresh way to think about older people in hospital.

The concluding discussion places the study in a socio-political context by first drawing on hospital employees' and older adults' opinions and personal experiences of hospitalization to illustrate how the gap between needs and expectations produce conflict as a reinforcing consequence. Study findings are juxtaposed against the hospitalization experience in which all patients exist in a self-contained and disempowering sequestered environment that is influenced by a larger health reform agenda. Together these topics set

the stage for changes in hospital practice and, within that context, applying conflict resolution at both the local and system level. The chapter concludes by exploring the limitations of the study and offers suggestions for future research.

### **Conflict: A Consequence of Poor Fit**

Conflict is not simply a matter of misunderstandings, but rather a phenomenon grounded in the belief that incompatibilities exist that expose actual differences between people and disempowering social systems (Fisher, 2000; Mayer, 2000; Parker-Follett, 1973). This study affirms that conflict exists in hospitals between older people who are deemed different because their goals, needs, and expectations are incompatible with the mandate of the acute care hospital. In so doing, the study provides a definition of conflict that has utility for future hospital-based research; thus, conflict is said to exist where relationships between patients and hospital systems reciprocally impede their respective goals, needs, and expectations.

The concept of person-environment fit is well suited to discuss conflict that occurs when older adults' changing acute and chronic health care needs require different environmental resources in hospital. The study confirms what others (Higgins et al., 1997; Malcolm, 2005; Mistiaen et al., 1997; Van der Smagt-Duijnste, Hamers, & Abu-Saad, 2000; Watson, Marshall, & Fosbinder, 1999; Yen, Chen, & Chou, 2002) have found when studying the types of problems older adults encounter in hospital: problems related to communication, privacy, approaches to care, and the physical environment. The study also extends our understanding of the sentiments of discontent by shifting attention away from the type of problems older individuals' experience to system factors underlying the construction of problems.

Ecological thinking provides a wider view of hospitalization. Rather than focusing exclusively on older individuals in their immediate social and physical environment, this perspective permits an exploration of relationships beyond the micro level into larger health care systems, and more complex phenomena, such as evolving economic and political change, and social arrangements.

This study moves the analysis beyond the individual level to emphasize the interplay between older people and the environment. Concepts derived from systems theory (e.g., interdependence, adaptation) are incorporated in this analysis (Germain & Gitterman, 1996; Stokols, 1996). For instance, when an older person is admitted to hospital, they may experience problems as noted above in previous research. The hospital can be conceptualized as an independent system but also as interdependent within the larger health care system, which includes regional authorities, and provincial and federal governments.

Unlike previous studies (Dady & Rugg, 2000; Forbes et al., 1997; Latimer, 1998; Mistiaen et al., 1997; Shih & Shih, 1999; van der Smagt-Duijnsteet et al., 2000) where older adults were considered one population, the present study demonstrates that hospital systems serve some older people well and others poorly (i.e., those deemed different). The study directs attention away from chronological age and toward relationships between vulnerable people, functional abilities, and the demands of environmental systems.

The study identifies two separate groups of older people that use hospital services. Members of the first group, ideal older patients, are capable of self-determination and having a say in their care. As Thursz (1995) points out, they "are like everybody else.

They seek autonomy and participation in decision-making. They do not perceive themselves as clients or patients, they are not willing to abandon their judgment for the judgment of others and [they] want to maintain control of their own destiny” (p. iv). In this study, ideal older patients were those who were able to function independently, were cognitively aware, and could make conscious decisions to fit into the hospital environment. If they decided to conform, they did not pose a problem to the system. If however, they were a nonconformist, as English and Morse (1988) suggest, they ran the risk of being considered a problem-patient by hospital employees.

Conversely, the study also demonstrates that members of the second group challenge existing hospital systems. Supported by existing literature (Longino & Murphy, 1995; Martel, Belanger, & Berthelot, 2003; National Council on Aging, 1997; Segall & Chappell, 2000; Tsilimingras et al., 2003), the study affirms that some older patients have needs that do not fit well within acute intervention criteria symbolized by bed designation and availability. This group consists of frail and cognitively impaired older people who are unable to make decisions for themselves or function independently while in hospital; they fall into the category of patients deemed older and different.

Older-different patients are unpopular; hospital employees report feeling like losers in their attempts to provide care to this group, which contributes to negative attitudes toward older patients generally. Similar to other studies (English & Morse, 1988; Juliana, Orehowsky, Smith-Regoko, Sikora, Smith, & Stein, 1997), older-different patients have health care needs that consume more time than is considered reasonable for their condition while they are in hospital; they are more helpless, demand special attention, and fail to co-operate with requests and comply with regimes.

The study indicates that caring for older-different patients is a complicated and demanding proposition for hospital employees. The difficulty emanates from at least four areas of poor fit: the hospital's architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude. These issues of poor fit emerged when hospital employees could not satisfy the needs of older-different patients. This often occurred because they felt bureaucratic pressure to achieve greater efficiency, making the older-different patient unpopular. The incongruence between these patients' needs and the demands of the acute care environment made performing work duties troublesome for hospital employees. However, instead of seeing patient care as difficult, they saw older people as difficult. As Neuwirth (1999) argues, "there is a profound difference between saying that a patient is difficult and realizing that patient care is difficult" (p. 49). Acknowledging this shifts responsibility for the problem away from the person and onto the environment. This places the burden to change on the system. The study, therefore, shifts attention away from the *problem of old people* and toward the consequences of converging hospital environment factors and their effect on one group of older people – the older-different patient group. This exposes the gap between their particular needs and those of a highly bureaucratic hospital system that privileges activities that gain efficiencies.

By focusing on the difficulty of providing care in a hospital setting that employs a one-size-fits-all approach, the study exposes how existing hospital responses fall short of the needs of older-different patients. Re-directing attention to the difficulty of caring for *any* vulnerable group shifts culpability away from people in systems receiving care, to the systems of care themselves. This type of conflict invites system assessment to determine

how to increase the repertoire of appropriate responses beyond the classic approach used by hospital employees in this study, that being to move older-different patients some place else because their acute care work is complete.

*Conflict: A Struggle Between Divergent Needs*

As noted in chapter two, conflict is accepted as a contextually based relationship of incompatibilities that manifest as a reinforcing consequence at an individual level, but also at a system level. Findings from this study draw attention to incompatibilities in the hospital's response to the needs of older-different patients, and the struggle experienced by hospital employees trying to deliver acute care to those with divergent needs. To understand these struggles this discussion distinguishes between the manifestations of needs and satisfiers, suggesting that satisfiers are "need-filling devices" (Gillwald, 1990).

This study suggests that first, satisfiers for the chronic health needs of older patients are different from satisfiers that are acceptable for patients with acute care needs, and the competition for satisfiers between these groups of needs generates conflict. Second, architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitudes are a way to classify needs and their corresponding satisfiers – those required for improving the fit between older-different patients and the hospital environment.

In the context of biological crises, existing hospital bureaucracies serve the system well. One could argue the hospital must continue to do so to fulfill its mandate to save lives, particularly when situations require the use of high-tech equipment. After all, when an individual – young or old – requires surgery or is having a heart attack or stroke, it is critical to quickly and effectively interrupt the course of the illness. When the crisis

is over, however, a different approach is required that considers the elements of poor fit (i.e., architectural features, bureaucratic conditions, chaotic atmosphere and hospital employee attitude). This is so because findings from this study indicate that poor fit contributes to older adult: (a) stress, fear, anxiety, and worry; (b) loss of independent function, and confidence; (c) deconditioning, which interferes with recovery and enhances disabilities; and (d) feelings of indifference and discriminatory practices.

The idea of an *adjusted acute care*<sup>33</sup> approach acknowledges that older-different patients require acute intervention when they experience a biological crisis, but not to the exclusion of their other health care needs. Adjustment is required to accommodate the chronic health needs that accompany them into the hospital. The adjusted approach to hospital care addresses the patient's acute needs as well as the impact of the illness on functional abilities. This approach extends the repertoire of acceptable hospital interventions to include the preservation of functional ability and psychosocial approaches. Expectations about the duration of an illness moves from primarily temporary and episodic to temporary and/or progressive and/or permanent for individuals who are frail and have chronic health concerns with episodes of acute illness. The professional approach moves from diagnostic physician-nurse dominance to one that is interdisciplinary and family centered.

Table 7 illustrates the relationship between needs and need-filling devices by listing the dimensions of hospital environment fit described in chapter three and the elements of poor fit described in chapter four. The table's third column lists needs adjusted for acute care of older-different patients that emerged from participant

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<sup>33</sup> Personal conversations with Jessie Mantle on the topic of modifications for the long-term care client in acute care.

interviews.<sup>34</sup> Examples of corresponding satisfiers that could meet the needs identified in column three are noted in column four. Items listed in column four correspond to dimensions of hospital environment fit (column one) and elements of poor fit (column two), and represent ways to meet needs. They are examples of how current acute care clinical interventions and systems might adjust to improve fit at the local hospital and health care system level (i.e., fiscal resources, acute care beds, time resources).

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<sup>34</sup> In this discussion, the dissertation focuses on the older-different patient. Ideal older patients may also benefit from an adjusted acute care approach, one that could protect their existing functional ability.

Table 7: Meeting Needs for Hospital Fit

<b>Dimensions of Hospital Environment Fit</b>	<b>Elements of Poor Fit (Present study findings)</b>	<b>Need (Adjusted acute care)</b>	<b>Satisfiers for Meeting the Need (Need-filling devices at hospital and system level)</b>
Physical Design	Architectural Features	<ul style="list-style-type: none"> <li>Built environment that supports functional ability</li> </ul>	<ul style="list-style-type: none"> <li>Proper equipment</li> <li>Appropriate cueing</li> <li>Noise control</li> <li>Ease of parking</li> </ul>
Policies and Procedures	Bureaucratic Conditions	<ul style="list-style-type: none"> <li>Flexible admission and discharge processes</li> <li>Opportunities to prepare for returning home</li> <li>Opportunities for family to become involved in transition planning</li> </ul>	<ul style="list-style-type: none"> <li>Timely transition planning with the community care team involved in hospital care</li> <li>Increased repertoire of flexible community based service options (implies funding)</li> </ul>
Care Systems and Processes	Chaotic Atmosphere	<ul style="list-style-type: none"> <li>Access to appropriate acute intervention</li> <li>Slower pace</li> <li>Longer recovery time</li> </ul>	<ul style="list-style-type: none"> <li>Trained advocates</li> <li>Safe and supported place to recover</li> <li>Age sensitive clinical and social interventions</li> <li>Increased hospital employee time and attention to non-medical issues</li> </ul>
Social Climate	Hospital Employee Attitude	<ul style="list-style-type: none"> <li>Respect and patience</li> <li>Education</li> <li>Tolerance</li> </ul>	<ul style="list-style-type: none"> <li>Gerontologically trained employees</li> <li>Improved workplace to enable best practice</li> <li>Access to interdisciplinary resources</li> </ul>

To follow is a case illustration that contrasts features of the current acute care system to an adjusted acute care approach providing examples of needs (column three) and satisfiers (column four). This case is drawn from study data:

Mr. T is 91 and lives with his wife Eunice aged 87. They have a son who lives locally. Mr. T is having some difficulty getting around, remembering names, dressing, and voiding. He saw his doctor and was told his prostate was enlarged. His Doctor arranged for him to see a specialist (urologist). The urologist gave him a new prescription and booked him for surgery.

*How does the current acute care system respond?*

Mr. T waits at home for the hospital surgical booking clerk to call to inform him of his surgery date and time. On admission, Mr. T's chronic health concerns (medically defined as shortness of breath, atrial fibrillations, congestive heart failure and memory loss) and his social circumstances (age 91, lives with wife and needs assistance with activities of daily living) are noted on admission assessment. He is asked to arrive at the hospital at 0545 hours for a surgery time of 0700 hours. His son is away that week, Eunice does not drive and Mr. T doesn't want to bother his neighbors or church friends so he comes to hospital by taxi.

His surgery is successful (the enlarged prostate is treated) and because he is on the short stay surgery program he is discharged home in 72 hours with an indwelling catheter but given instructions on how to care for the catheter. At the time of discharge, 0700 hours, Mr. T is a little vague about everything but wanting to go home.

The current hospital system fails to provide a slower pace, longer recovery time, flexible admission and discharge processes, and opportunities to prepare for returning

home (column three). It fails because it does not recognize that some older adults are different – in Mr. T's case, difficulty getting around, remembering names, dressing and voiding. The hospital's current one-size-fits-all approach does not meet their needs because satisfiers for those needs are either absent, inaccessible or applied inconsistently (column four). Furthermore, these individuals are not able to take action to improve their situations in bureaucratic environments organized for efficiency and, therefore, hospital administrators must pursue a different approach to service, one that will ensure the needs of older-different patients are met and their rights protected.

*How would an adjusted acute care approach respond?*

Study findings suggest that hospitalization for older people begins prior to arrival to hospital. As identified in Table 7, an adjusted acute care approach enacted with need-filling devices would begin when the doctor makes the decision to refer Mr. T for urological consultation. At that time the doctor would have accessed interdisciplinary resources – a geriatric preoperative assessment, a pre-anesthetic evaluation, and a Community Support Team to establish a network of activity prior to hospital admission to shore up tenuous coping situations – this represents an increased repertoire of accessible and flexible community based service options for the family. While Mr. T is waiting for his urologist appointment, the Community Support Team would organize a family conference in the home to discuss Mr. T's, Eunice's and their son's needs. Others helpful in Mr. T's recovery and Eunice's ability to assist Mr. T at home would also be included – this represents opportunities to prepare for returning home and allows family to become involved in transition planning. An anticipatory plan developed with the

family and orchestrated by the Community Support Team, would also include potential need-filling devices such as:

1. A built environment that supports functional ability

The acute care surgical unit has available the following: proper equipment (i.e., stretchers of appropriate height, walkers, amplifiers for the hearing impaired, blanket warmers); appropriate environmental cueing (i.e., night lights, toilets with raised toilet seats); noise control (i.e., maintenance plan for wheeled carts, pocket pagers verses overhead paging), and appropriate wayfinding directions to and from the hospital unit (i.e., large non-glare signage).

Proper equipment is made available in the hospital to aid Mr. T's independence and the same equipment is also made available in the home pre admission, and post discharge. He is provided with an opportunity to practice with the equipment before being required to use it.

Arrangement of the surgical admission date takes account of pre operative assessments, post operative follow-up, the son's availability, and other ways of providing relief for Eunice. Admission is eased by clear instructions on how to locate the pre operative area. The OR slate indicates that Mr. T's condition places him at risk for post operative confusion and a longer length of stay related to adverse clinical outcomes such as pain and constipation.

2. Flexible admission and discharge process, opportunities for family to become involved in transition planning

Arrival to hospital is adjusted for later in the morning to accommodate Mr. T's arrival by taxi. A contingency plan is put in place in case the son has to unexpectedly

leave town on a business trip. The contingency plan includes support from church members and the other seniors' volunteer organizations. A referral to Home Nursing Care when the surgical date is determined and the Home Care Nurse visits discharge day and assesses to determine when other visits will be made. Home maker support is arranged once the surgical date is determined.

### 3. Information and education are provided

A tour of the hospital is offered. All are invited to an educational session to support and enhance their autonomy in decision making. Opportunities are available for the family to meet and talk with other seniors with similar problems to learn self-management strategies. They receive a workbook that guides them in preparing for coming to the hospital. The workbook outlines questions that are important to ask family physicians and specialists; space is available to record answers for later reference.

Educational materials are provided about what the surgery entails but are prepared in a fashion that will enable everyone to understand what the procedure is about and its effect on functional ability and recovery. Eunice is also provided an opportunity to practice handling and deflating a catheter before Mr. T is discharged.

The care processes reflected in the acute care adjusted approach (column four) consider chronic health concerns, functional ability, and gerontological clinical knowledge. Hospital employees on the in-patient short-stay surgical unit are trained in gerontological best practice approaches, the normal consequences of aging, and understand the social implications of disease and illness on recovery; they ensure appropriate clinical care is provided in pain management, prevention of deconditioning, falls prevention, continence care, and delirium and dementia care. The acute care team

has access to specialized geriatric services if needed but are skilled in the provision of basic gerontologically sensitive care.

The pre-admission clinic hospital employees, in-patient surgical unit, and the Community Support Team coordinate efforts for a successful transition between hospital and home; they take account of family involvement, access to ongoing interdisciplinary resources, recognition of life long patterns, and respect for the older adult and family to make choices. Appropriate transition planning in an adjusted acute care response takes account of existing and/or predictable tenuous coping. This case example exemplifies the potential benefits of forging a blend of acute care intervention with chronic care needs. These examples incorporate study findings by noting that the physical design features of the build environment must help support functional ability on arrival to hospital; bureaucratic conditions need to permit flexible admission and discharge processes, and an increase repertoire of flexible community funded service options; and care systems and processes need interdisciplinary gerontologically trained hospital employees that exemplify respectful attitudes.

Study findings suggest that the type and scope of need-filling satisfiers required by older-different patients are beyond what the hospital environment is set up to handle. Struggles arise because the hospital is ill equipped to respond to problems outside the scope of narrowly based biomedical problems. On many occasions, hospital employee participants reported frustration at not being able to move older people off their units who did not belong. The lack of system satisfiers available to hospital employees (i.e., other types of treatment settings such as sub-acute or transitional care units) led to unfulfilled needs among older-different patients.

Conflict over satisfiers in the current hospital system is influenced by a wider set of factors that includes older adults' values and historically based societal interests (Gillwald, 1990), which often remain hidden from view. Gallagher and Hodge (1999) found older adults valued health care services, attributes of service providers, and the health care system overall when it was responsive to their expressed needs. They valued services that provided what was needed, when it was needed, and in an affordable, efficient, and consistent manner; flexibility in service delivery was seen as an asset.

Older adults also valued service providers (e.g., hospital employees) who were respectful, caring, trustworthy, effective communicators, anticipated their needs, and would go the extra mile (Gallagher & Hodge, 1999). Similarly, other studies indicate that older adults value clear communication, caring and supportive attitudes, and knowledgeable, well-trained caregivers (Attree, 2001; Mistiaen et al., 1997; Watson et al., 1999). Plausible satisfiers for an adjusted acute care approach would incorporate these expressed values.

Historically based societal interests (i.e., social, economic, and political forces) influence the direction of change efforts and the corresponding availability of satisfiers. When satisfiers are in abundance, the likelihood of conflict diminishes; however, when there are limits to satisfiers, competition emerges, heightening sensitivity to differences. Conflict then manifests as a reinforcing consequence. The next section discusses the disempowering context of hospital care and illustrates the influence of historical factors on present issues of incongruence between needs, expectations, and access to satisfiers that could meet needs. The reciprocally reinforcing relationship between these factors potentiates the labeling and discrimination of older people found in this study.

### **Hospital: The Disempowering Context of Care**

Similar to Goffman (1961), Moloney and Paul (1993) describe the disempowering nature of hospitalization as a form of incarceration, which contrasts sharply with the notion of a hospital as a place of help, where one receives care, understanding, and ready access to technologies that can help interrupt acute illness. They describe an oppressive environment, where patients surrender control over their privacy and comfort to “uniformed strangers.... Patients get interviewed, wheeled, scoped, poked, and processed on whatever shifting schedules they can be slotted into ... life itself becomes unfamiliar and beyond control” (p. 293). In this bureaucracy patients are also classified for example, as medical, surgical, cardiac, or alternate level of care.

Bureaucratic conditions<sup>35</sup> within hospitals act on both employees and older patients. Each group must follow strict unit routines; activities are tightly scheduled, regulated, and controlled. These regular patterns of activity exist to organize groups of people and keep the system operational (i.e., the operating room slate manages the flow of people through the system). Although this study affirms the disempowering nature of hospital bureaucracy (Tolley, 1997; Whitler, 1996), older participants not only accepted these conditions, but also viewed them as necessary, expressing gratitude for the existence of hospitals.

This study confirms the idea that bureaucratic power is acceptable to older participants because: (1) the hierarchy found in a bureaucracy is thought to be reasonable;

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<sup>35</sup> I draw on Ferguson (1984) for the defining characteristics of contemporary bureaucracy. This involves a rational division of labor, with fixed duties; rule-governed authority that is universally applied; supervision from above; predictable procedures, standardize communications; and management practices that follow general rules. This combination of characteristics results in the arrangement “of individuals and tasks so as to secure continuity and stability and to remove ambiguity in relations among participants, but are nonetheless usually beset by a variety of internal conflicts” (p. 7).

(2) the chain of command is deemed necessary to avoid confusion; (3) having a system of rules is desirable; and (4) fairness is promoted by formalized and objective logic found in bureaucracy (Longino & Murray, 1995). Activities imposed from a hierarchy of hospital administrators and professionals demonstrate power-over authority. While the use of formal rules made sense to older participants to achieve collective order and ensure hospital operations remained efficient, they objected to the lack of choice in discharge processes, and found it difficult to keep pace in the persistently chaotic atmosphere of the hospital.

As noted in chapter two, empowerment involves aspects of participation, collaboration, power, and ownership (Anderson et al., 2000; Davis et al., 1999; Fetterman, 1996; Gibson, 1999; Labonte, 1990; Israel et al., 1994). This study affirms Gibson's (1993) conceptualization of empowerment as participatory competence characterized as self-determination, capacity, and competence for decision making, and self efficacy. Ideal older patients exhibited more characteristics of empowerment than older-different patients. In fact, organizational structures, systems, and processes served many hospitalized older people without stripping away their autonomy any more than they would younger patients. Older ideal patients have the cognitive and functional ability to compromise; they can negotiate for their needs, navigate the system to gain access to services of their choosing, and accommodate the demands set forth by the system. Non-ideal, older-different patients lack these abilities.

Although bureaucratic systems achieve efficiencies, older adults who are different do not conform to the demands of the system; they do not have the functional capacity to keep up with the expectations the systems set forth. The disempowering nature of

hospitals is a constant feature not subject to the will of individual patients; they must compromise to fit in with the demands of the system.

The fast-paced chaotic atmosphere in hospitals emanates from a drive to achieve efficiencies, which – in this study – is central to understanding the dynamics of poor fit. The concept of efficiency was embedded in older participants' discussion of leaving hospital quickly or before they were ready, and in hospital employees' perceptions of working in a hospital environment that pressures them to move people along.

#### *The Ideology of Efficiency: A Social Political Issue*

The key tenets of bureaucracy are rationality, efficiency, productivity and control (Armstrong & Armstrong, 1996). Each tenet is incorporated into the bureaucratic environment of hospitals as normative expectations. In this study, the concepts of time and efficiency emerged most prevalently in problem construction with older-different patients – hospital employees' lack time and older-different patients take more time – the bureaucratic nature of hospitals raises the issue of efficiency.

Efficiency is the primary means to offsetting scarcity (Clark, 1990). It is “always part of the conversation when resources are not infinite and citizens and governments have important choices to make among competing public goods” (Stein Gross, 2001, p. 6). In health care, Armstrong and Armstrong (1996) suggest, “Efficiency is equated with the number of procedures done and parts fixed or at least treated. Outcomes are recorded by length of stay, not state of health when the patient leaves. Success is to a large extent reported in terms of doing more operations and other procedures, rather than in terms of reducing the need for such services or in terms of making people well” (p. 66).

Bureaucratic efficiencies operationalized at the local hospital are influenced by

wider health reform activities that target system efficiencies (Chappell et al, 2003). It is not within the scope of this discussion to debate the accuracy of this underlying premise, it is however, acknowledged that efficiency is an instrument used in health reform to achieve cost savings goals (Stein Gross, 2001). Historically, these hospital based efficiencies included: reducing the number of hospitals, closing acute care beds, shortening lengths of hospital stay, creating same-day surgical admission programs, performing more day surgery and out patient services, contracting out services, and development of off-site services (Armstrong & Armstrong, 1996; Tully, 1997). These types of strategies may gain system efficiencies resulting in cost savings but they also have consequences for relationships between older patients and hospital employees.

Doctors and nurses spend less time with patients because efficiency dictates how time is spent. In this study, hospital employees indicated that personal contact with older-different patients was minimal and was further minimized by competing acute care demands. Both hospital employees and older adult participants repeatedly discussed time as a factor in their experiences. Hospital employees described their frustration with the “surgical machine” and the “gatling gun” approach to moving people along. At the same time, older adults reported feeling rushed and treated as a “workload.” Clearly, efficiency pressures have a detrimental effect on people considered old and different because they require more time from hospital employees; efficiencies lose effectiveness with older-different patients. The study suggests that, in practice, the need for more time stems from disruptive behavior, having unpredictable clinical outcomes, an inability to communicate in ways understood by hospital employees, having difficulty following directions, and

being physically less able to perform self-care. A person with these attributes may or may not be old.

To fit in, an older person must be functionally able and – as an ideal patient – willing to follow the plan set forth by hospital employees to meet the demands of the system. The older-different patient puts stress on bureaucratic hospital systems. Achieving equilibrium between needs and satisfiers is a dynamic endeavor that is made difficult because of competing demands between acute care needs verses chronic care needs. Conflict is a reinforcing consequence of the competitive tension between needs, expectations, and available need-filling satisfiers. The pressure to be efficient in the hospital (i.e., access to surgical services and moving people through the system) contributes to a chaotic atmosphere. These time pressures have a cost to hospital employees (i.e., frustration and demanding workloads), and a cost for older people (i.e., feeling burdensome and rushed to leave hospital when not ready). A one-size-fits-all approach aids efficiency endeavors in a technologically dependent hospital setting.

Interrupting this pattern of hospitalization however, is difficult. The difficulty relates to larger health care system issues that from the critical perspective of Habermas (1971; 1973), are influenced by external capitalistic forces operating to support the status quo. In his view, tensions and conflicts involved in capitalistic society stem from political power vested in constraints that protect the status quo. More importantly, it is the *acceptability* of efficiency and the unabated support efficiency endeavors have from the populous that act as constraints. The acceptability of efficiency, the mantra of expensive health care and the logical corresponding response – cut back – unknowingly contribute a

negative effect on older-different patients in hospital, and this effect remains hidden from consciousness.

*Support for efficiency: The ethos of capitalism.*

Hospitals are an integral part of a health care system. They are technologically dependent, which requires tightly controlled mechanistic systems (Franklin, 1999). In this study, such dependency contributes to poor fit by exacerbating disabilities in older different patients because they are unable to keep-up with the demands set forth in this type of environment. Hospital employees motivated to keep “the surgical machine” going, worked at a pace defined by pre-operative preparation; the operating room slate, coordinated to facilitate ongoing access to diagnostic and treatment equipment, dictates hospital systems and processes; this forces all patients to comply but older different patients are unable to meet the demand.

While technology enables hospitals to fulfill their mandate, it influences and is influenced by, a larger capitalist socio-economic system<sup>36</sup>. This larger economic system is hidden from obvious view, making it difficult to oppose.

A capitalistic philosophy gives priority to the profit-making capabilities of corporations to maintain self-sustaining profits (Armstrong & Armstrong, 1996; Rachlis & Kushner, 1989). To sustain profits, “capitalism needs bureaucratic administrative structures to impose predictability and stability on the economic realm” (Ferguson, 1984, p. 38). Fixing the fit between older-different patients and hospital systems must take account of capitalistic endeavors and historical “inequalities in power and economic resources . . . dominated by the search for profit” (Armstrong & Armstrong, 1996, p. 5).

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<sup>36</sup> I draw on the principles of political economy (Armstrong & Armstrong, 1996; Drache & Clement, 1985) to understand the complex relationships between political and economic systems, and their influence on social relationships, which encompasses the experience of being old in hospital.

This dynamic relationship is also characterized by competition over power and resources within and among different aspects of the system itself (Cox, 1991).

The natural competitiveness that exists in a capitalistic philosophy facilitates conflict between the proponents of the chronic health model and the acute care model. Hidden competition (i.e., funding for chronic health initiatives) has consequences overtly expressed in the frustration of hospital employees, the discontent of older adults, and the hospital system's inability to respond appropriately to the needs of older-different patients. In this study, the lack of fit is exemplified, particularly with older-different patients, in at least four areas: architectural features, bureaucratic conditions, chaotic atmosphere and hospital employee attitude. These elements of poor fit are symptoms of larger social-political forces that are related to professional dominance, technological dependence, and capitalistic ideology. Hospital systems reliance on professional dominance and technological dependence supports capitalistic endeavors. The hospital's focus on acute intervention for illness treatment exists in a codependent relationship with vested interest groups who represent capital investors.

Corporations that support illness care have vested economical interests in maintaining the status quo because illness care enables them to keep their profit margin up. Through their business investments these investors support economic renewal and growth in Canada (Mishra, 1990). It is in the best interest of the business community to oppose social reform efforts that might divert economic efforts to chronic health initiatives that could support the needs of older hospitalized people (Rachlis & Kushner, 1989).

The capitalistic nature of hospitals in Western developed countries promotes an ideology of competition based in a doctrine of efficiency that is tied to the allocation of resources. Need-filling satisfiers appropriate for older-different patients are therefore, less likely to be viewed as a funding priority and consequently, less likely to be available and easily accessible. Regulatory control and codependency with vested interest groups continues to potentiate dominance of the illness model with its technologically dependent acute care interventions (Rachlis & Kushner, 1989; Segal & Chappell, 2000). The next section addresses the implications of this conflict, focusing on hospital practice and conflict resolution practices that have the potential to improve hospital environment fit.

### **Implications for Hospital Practice**

#### *Transactional Conflict: Improving Hospital Environment Fit*

Fisher (2000) contends that conflict resolution is a collaborative process where differences are handled and all parties jointly agree to the outcomes. Reaching consensus in such situations is a difficult task given the complex nature of hospital services in the current health care system. From Fisher's perspective, individuals engaged in conflict must resolve, manage, or mitigate situations where the needs of individual older adults are not met, thus fixing the fit for older individuals troubled by their experiences. This type of resolution, however, does not help change the larger system.

The study findings suggest that reduction of incompatibilities needs to be targeted at the hospital level to four areas of poor fit (i.e., architectural design, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude). To interrupt self-perpetuating social-political patterns that inherently favor biomedical approaches over chronic health approaches requires a multiple interventions strategy. Two levels of

activity are needed to address the social-political issues that affect older individuals' day-to-day interactions with the hospital system that produce conflict. This includes efforts directed toward changing the one-size-fits-all pattern of hospital service at the local individual level while at the same time, advocating for change at the health system level so that need-filling satisfiers for chronic health needs are funded, making them attainable at the hospital level.

*Reducing incompatibilities at the local level.*

The social ecological perspective does not offer solutions or suggest how or when to intervene to reduce incompatibilities that disadvantage older-different patients in hospital. It does, however, direct attention to interventions that promote adaptation. Adaptation in this case is not equated with passive adjustment to the status quo, but refers to the active effort by individuals to reach a goodness-of-fit with their environment (Germain & Gitterman, 1996; Stokols, 1992; Stott, 2000). Adaptation is a reciprocal process where interdependence exists between older people and the hospital environment.

In this study, hospital employees engaged in conflict-based transactions with two groups of older people: older ideal patients, and older-different patients. Older ideal patients have the cognitive ability to engage in conflict resolution processes; they are functionally able, if they choose, to advocate for having their needs satisfied. However, before engaging in conflict resolution processes with older ideal patients, hospital employees must evaluate the situation to better prepare themselves to anticipate, predict, prevent, and reverse remediable problems that may arise to produce the stress and anxiety reported by older participants in the study. To do so, hospital employees must take into account: the normal physiological consequences of aging, chronic illness, social factors,

and the physical environment. Considering these issues will help ensure older adults who choose to engage in conflict resolution have equal, fair, and accessible opportunities and choice (Schmitz, 1998).

Conversely, older-different patients are unable to function independently in the hospital's environment and they lack the functional ability to engage in conflict resolution processes that are suitable for older ideal patients. An adjusted approach is needed for this group that incorporates the use of gerontologically trained advocates (See Table 7, column 4) when family members are not available.

System adjustments are also needed because the solutions used to address singular episodic events in both groups of older patients, do not achieve system change. Case-by-case strategies, although important to ensure fair and equitable treatment and to protect their rights, are ineffective in dealing with ideological conflict at the system level.

Previous research indicates that: (a) older adults rely on advocates to report their health care complaints (Anderson et al., 2000); and (b) they wish to remain independent and avoid burdening their families (McDaniel, 2005; McDaniel & Tepperman, 2004). It is not known, however, if older adults would utilize conflict resolution mechanisms if they were available. Nonetheless, mechanisms must be in place to support, encourage, and enable those who wish to challenge the status quo, whether they are older ideal patients or older-different patients. Even with support, some patients may still chose not to access these mechanisms and, instead, rely on advocates such as family members. The dissertation study adds to existing research by suggesting that advocacy is an appropriate strategy to employ during hospitalization to monitor and ensure that the needs of older-

different patients are met. For some older people it is not only necessary, but in their best interest to appoint an advocate, such as a family member or close friend.

Educating hospital employees about the normal consequences of aging and the effects of hospitalization would make an important contribution to improving conditions in hospital for all older adults. Kus (1990) suggests that "sometimes patients are unpopular with nurses simply because the nurses do not feel competent to care for them" (p. 64). Education alone, however, will not achieve long-term improvements unless the systems and processes that organize hospital care are adjusted to meet the special features that older people bring to the treatment setting. It would be ineffective to educate hospital employees and then return them to a practice environment that makes it easier to provide the wrong care approach than the right one. Even the most knowledgeable, educated, and informed hospital employee can succumb to the pressure exerted by bureaucratic forces within the hospital setting. As a result, system incompatibilities must be examined. This next section discusses why local hospital efforts (i.e., hospital employee education) are at best diluted, or worse ineffective, without larger system adjustments.

*Reducing incompatibilities at the system level.*

Guided by the values of older adults, the research reported in chapter two, and this study's findings, changes to hospital systems are required to accomplish a more appropriate response to the needs of older-different patients. Sensitization training for acute care medical and surgical hospital employees through educational programming or the transfer of older adults off medical and surgical units is not enough. The challenge is to reconcile competing ideologies and priorities in a period of fiscal restraint. Currently, there are no mechanisms available to work with competing interests and, therefore, we

are unable to facilitate a move to a holistic, more inclusive model of hospital care that would give attention and resources to issues that emerge from frailty and chronicity.

The traditional biomedical model of acute intervention is necessary and most often achieves what it is supposed to for most people – young and old. The acute intervention curative model, however, does not serve all people well, particularly the older-different patient. To reduce the likelihood of conflict between older-different patients and the hospital system where they intersect – at the bedside – requires a philosophical shift, not away from the curative bias of traditional biomedical science, but to one that embraces the whole person by taking account of progressive and/or permanent illnesses and interventions to preserve functional abilities.

Recognizing the heterogeneity of older patients is essential to reducing incompatibilities and re-establishing equilibrium in a system that responds with a one-size-fits-all approach. As noted in chapter two, some older adults suffer from chronic conditions that affect their ability to function. By taking account of chronicity and the nature of older adults' health concerns, serious attention can be given to prevention, maintenance, and management of care requirements related to declining functional abilities (Longino & Murphy, 1995; Tsilimingras et al., 2003; Wolinsky & Johnson, 1991).

Older different patients require a hospital that is supportive, practical, and accepting of low-tech interventions. In periods of fiscal restraint resources that must be protected include: support services for assistance with retaining strength and aiding recovery (e.g., access and assistance to appropriate food and fluids, pain management); rehabilitative services (e.g., equipment to aid mobility, professional time to reverse

deconditioning, transition planning for home support – meal preparation, bathroom aids, or physical therapy, occupational therapy treatment, education); and acute geriatric specialty services (e.g., interdisciplinary treatment measures designed to cure or alleviate the impact of illness and disease on independent function, appropriate medication, caregiver support).

Balancing the effect of the biomedical model is critical because the health care system as it is currently organized and politically supported cannot be divorced from the medical paradigm. It is this model that values effectiveness and efficiency in “terms of money spent and people processed” (Armstrong & Armstrong, 1996, p. 9).

Currently, hospital systems and processes lack fit in architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude. Therefore incompatibilities remain despite sound research that continues to advocate for health system change (Chappell, 1995; Evans & Stoddart, 1990; Longino & Murphy, 1995; Tsilimingras et al., 2003; Wolinsky & Johnson, 1991). “Reforms are still based mainly on the medical model and [they are] chiefly designed to change who pays” (Armstrong & Armstrong, 1996, p.10). What is required is a new approach based on different assumptions that lead to more alternatives for helping the older-different patient. Creation of new structures and processes may interrupt the disempowering cycle that exists for older-different patients. To achieve system adaptation, redefining the hospital’s role for people who are old, frail, and vulnerable is a required first step.

At present models of specialized geriatric services exist in hospitals. For example, Geriatric Evaluation and Management (GEM) teams (Reuben et al., 1995); Acute Care for the Elderly (ACE) units (Counsell et al., 2000; Covinsky et al., 1998); In-

patient geriatric consultation services (Hogan & Fox, 1990); Hospital Elder Life Programs (Inouye et al., 2000); Family-centered geriatric resource nurse (Fitzpatrick, Salinas, O'Connor, Callaban & White, 2003); The OASIS Program (Tucker, Quartana, Werner & Connelly, 2006); and Care Transition Programs for persons with continuous complex care needs (Colman, 2003; 2004). These approaches hold promise but they rely on specialty funding and are not available in all hospitals. For older adults to access these programs they must meet access criteria that vary between programs.

Other in-patient hospital approaches like transitional care units, and convalescent and sub acute units also exist. Although they offer interdisciplinary care and service, which is more responsive to frailty and the chronic health needs of older people, these units are structured and resourced in the biomedical paradigm.

Specialized geriatric services and the other approaches are also limited in their influence on acute medical and surgical, emergency department and diagnostic areas – older adults in these areas do not have access to the specialty resources and the benefits that they offer. In all, both geriatric specialty services and other approaches serve the status quo because the underlying philosophy does not change – the danger to being old in hospital is unchallenged because the responsibility rests with specialized geriatric services when instead, it is other acute care specialties (i.e., orthopedics, cardiology, and cardiovascular surgery), and the infrastructure systems and processes of the other services that must embrace gerontological principles.

In this study, hospital employee participants recommended that older patients leave hospital earlier. This would support the flow through of patients and diminish the effect of system pressures created by older patients who stay too long. However, a

broader range of innovations are required to shift the emphasis towards supportive transitions<sup>37</sup> in acute care services, and away from the current model of discharge planning, which simply emphasizes getting older-different patients out of hospital. The difference in these approaches rests with the underlying motivation. Discharge planning is rooted in an efficiency mandate that serves the system and places the burden of success on another agency, or in some cases on the family. Supportive transitional care processes in the adjusted hospital focus on older patient needs; here, the hospital system carries some responsibility for success in the community.

Older adult-hospital environment fit could improve with adequate funding directed towards need-filling satisfiers that respond to a broader range of innovations between hospital and community. These could include non-medical home-making, personal support, environmental aids and modifications for the home, development of supportive housing options, functional maintenance services, access to nutritional support, podiatry services, counseling and other alternative healing methods, wellness clinics, expanded access to day care programs, respite and family care giving support, and opportunities for meaningful community contributions. This broad range of innovations would increase the repertoire of community options and services available to older-different patients, and to hospital employees who facilitate the process of leaving hospital.

Providing gerontological sensitive acute care is the aim of an adjusted acute care system but it requires less reliance on specialty practice, and more on the integration of

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<sup>37</sup> Transitional care in this discussion refers to a set of practitioner and hospital system actions designed to ensure continuity of needs for vulnerable individuals orbiting through a system of health care services. For full details, the reader is directed to Coleman, E. (2003). Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of American Geriatrics Society*, 51, 549-555.

gerontological principles across acute care services. Specialized geriatric services, a subspecialty of medicine, is one way to improve conditions for older people generally but one strategy is not enough because those who are under the supervision, care, and treatment of non-geriatric specialist while receiving treatment in medical, surgical, emergency room, and diagnostic areas of the hospital, must also have their needs met with attention to frailty and chronicity.

The health care system and corresponding hospital environment are too complicated to depend on goodwill alone to achieve the depth and breadth of change required. The challenge of reconciling incompatibilities is more difficult than a century ago, in part because the vested interests of professionals and businesses are increasingly associated with the growth of technology and its link to the patient in hospital. In addition, competing priorities exist with diminishing fiscal resources, while the population ages and chronicity rises.

Incremental conflict resolution, a process of managing incompatibilities single issue at a time (e.g., patient complaint registries), is prevalent in hospitals for managing discontent experienced by patients. This approach is fundamentally flawed because it fails to consider the broader context and system issues. "Incrementalism [as a means to dealing with incompatibilities that create conflict] generally accepts the legitimacy of existing structures and service mandates, including the existing power structure within service organizations" (Wharf & McKenzie, 1998, p. 88).

Legislative action is needed to address incompatibles as they exist in the health care system because the power tied to economic gains is strong, the philosophical differences between stakeholder groups is wide, and the structures and processes

necessary to build agreement is missing in the health care system generally. When significant change is needed, those with power will not allow their interests to be thwarted (Wharf & McKenzie, 1998); serious redistribution of power and resources does not take place. Without a larger vision for change opportunity for substantive adjustment in health care delivery is lost. Without system change, local hospital change is unlikely.

Without an orchestrated effort by key stakeholder groups (i.e., local and provincial government, medical associations, other health care professionals, not-for-profit organizations, and the citizenry) to resolve the ideological conflict that exists, unabated support for the existing biomedical model in hospital will continue to disadvantage older-different patients with chronic health concerns who are not considered the ideal patient. With no consensus on how health conflicts should be managed, incremental conflict resolution continues by default. Incremental adjustments, with their 'muddling through' approach, are not a preferred strategy when dealing with the entrenched biomedical paradigm that operates today. Thorne (1993) states,

... the health care system lumbers along, recreating the same flawed structures and perfecting the same errors. While there is widespread acknowledgement of problems in health care, one finds little agreement on what ought to be changed. Typically, Band-Aid solutions such as more money, more beds and more doctors are proposed. What these would do to solve the problems of chronic illness is rarely considered. (p. 207)

In a climate of fiscal restraint, competing priorities, and public pressure, the challenges are even greater in hospital when older adults have the characteristics of the non-ideal patient, producing reinforcing consequences such as conflict at local treatment

settings. The incompatibility that produces conflict will continue until an adjusted acute care approach is able to adopt a broader range of chronic health interventions.

Table 7, column four, provides examples of a broader range of appropriate need filling devices that have the potential to address hospital incompatibilities in architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude. Implementing these need filling devices improves functional ability when hospital architectural features include appropriate environmental cueing and noise control. Options that support timely transition planning between hospital and community care teams require flexible admission and discharge process, which is hindered by existing bureaucratic conditions. In addition, acute medical, surgical, and emergency departments staffed with gerontologically trained interdisciplinary teams knowledgeable in the normal consequences of aging, and the social implications of disease and illness are positioned to support recovery in frail older different patients. Reducing incompatibilities improves older adult-hospital environment fit.

### **Limitations**

The study findings reveal the breadth and complexity of older adult-hospital environment fit. Application of the findings is restricted to the populations studied. The sample represents people 75 years of age and older who were acutely ill and hospitalized at the study site. Those admitted to the study hospital from long-term care facilities, those under age 75, and those who did not speak English were excluded and, therefore, limit the study's application to English speaking, male or female individuals 75 years or age and older who live in the community. Likewise, not all areas of the hospital are represented in the study. However, given the strength of standardization in hospitals, the

findings, although limited by the particular study sample, are relevant to any hospital-based biomedical service operating in a Western developed country.

Findings may differ for teaching and rural or remote hospitals, as well as within different areas of the same hospital. This study concentrated on the emergency department, medical and surgical units, and diagnostic areas; other areas of the hospital may yield different results. In addition, interviews occurred with older participants after their discharge from hospital. Although the timing of the interview was scheduled as close as possible to the discharge date, recollection of events may have improved if interviews had occurred prior to and immediately after discharge from hospital.

#### **A Way Forward: Insights for Future Research**

The dissertation study opens a number of avenues for future research. For example, coming to hospital was not the first choice of older participants in the study. Future research could examine how older adults make the decision to come to hospital. A better understanding of what influences this choice could help hospital services focus activity and program development. As noted earlier, administrators might find benefit in increasing the repertoire of community options available to meet the requirements of older-different adults, offering them options more tailored to their unique needs.

Second, the study provides a starting point for comparisons with other vulnerable populations in hospital. For example, is being different a phenomena experienced by other groups? Do others feel invisible in the hospital environment? Do younger patients feel the same way? If other groups have similar experiences in hospital, correlations between groups could help refine and clarify how hospitals might avoid adverse outcomes in all vulnerable populations.

Third, what role should hospitals play in a society with an aging population? Should they respond to biological crises, functional crises, or both? As increasing numbers of older adults enter hospital and staff work to reduce recovery time and speed discharge, it becomes critical to learn how the hospital can better serve the vulnerable, and tailor its systems and processes to prevent disadvantaging older people. The goal is to determine the operational patterns in hospital that deny rather than satisfy needs. As a future direction, research in this area may uncover how existing hospital systems and processes unknowingly create harm to older people. For example, how does an ideal older patient on admission become an older-different patient during their hospital stay? Determining if this situation occurs and how it occurs would uncover unsafe hospital practices; customs and traditions could be interrupted and then corrected.

Fourth, reducing acute care beds has been one method of implementing health reform in Canada (Armstrong & Armstrong, 1996). Future research could examine how health reform initiatives and reductions in acute care beds have contributed to problem construction and promote ageist reactions within the hospital system. How can hospital environments be organized to maximize function and prevent deconditioning? Pringle (2003) urges nurse researchers to investigate cognitively impaired people in residential facilities to understand the quality of their lives. The same urging must be made for these people in hospital. Finding effective ways to retain abilities and prevent excess disabilities arising from hospitalization requires a research focus. Establishing a research agenda in this area will aid in answering questions that develops foundational knowledge for achieving a goodness-of-fit that ultimately aids efforts to improve hospital

responsiveness. This responsiveness must however, stem from understanding the quality of a lived hospital experience by an older adult and their family.

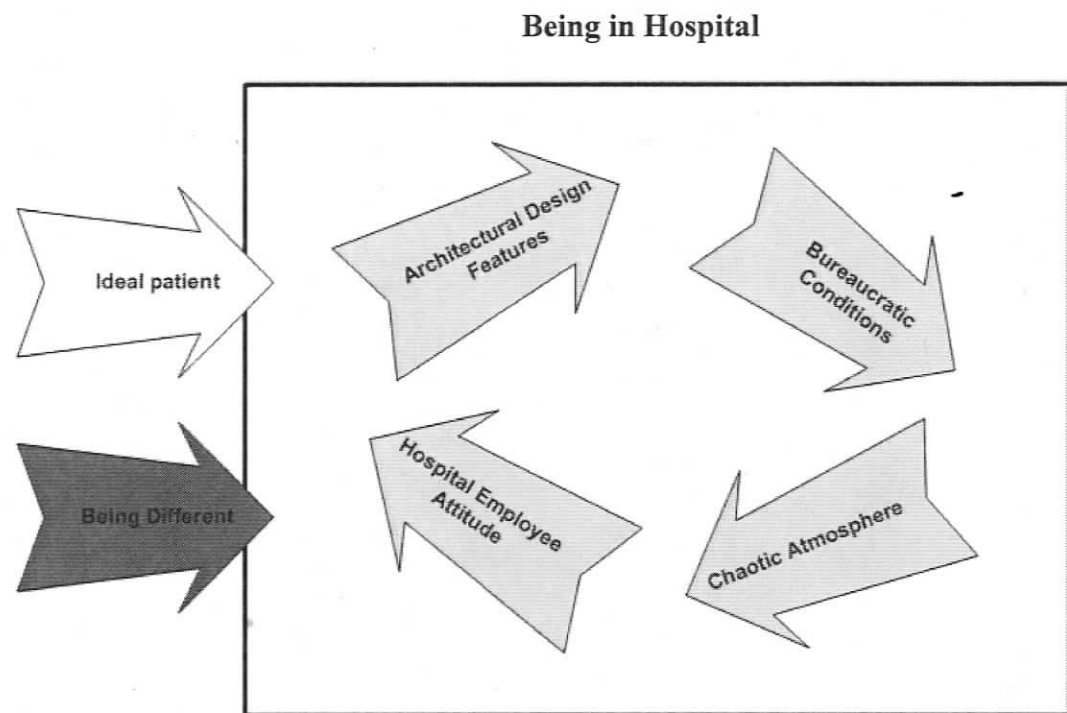
Finally, the study applies a four-dimensional hospital lens (i.e., social climate, policy and procedures, physical design, and care systems and processes) to identify four elements of corresponding poor fit: architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitudes. These elements of poor fit could serve as categories that may help other researchers measure older adult-hospital environment fit. Future research could focus on identifying indicators for each category. This information could be assembled into a unit- or service-based questionnaire that could assist in measuring the impact of strategies aimed at changing the overall culture of the patient care area. Once indicators are identified for each element of poor fit, attention could turn to reliability and validity testing of instruments measuring goodness in older adult-hospital environment fit.

### **Conclusion**

The dissertation study has attempted to understand the dynamics of problem construction through a social ecological perspective that articulates the hidden dynamics between older people and the hospital environment that produce a goodness-of-fit. To achieve this aim, the objective was to: (a) understand problem construction by investigating how a lack of good fit between older people and the hospital environment produces problems for older people, (b) expose hidden ageism that disadvantages hospitalized older people; and (c) illuminate, if and where they exist, positive aspects of existing customs and traditions. In doing so, this study shows that being old in a system of care is a complicated matter. It is complicated because findings reveal that two groups

of older people enter hospital but only some have problematic experiences in hospitals because of their sensitivity to four areas of poor fit: architectural features, bureaucratic conditions, chaotic atmosphere, and hospital employee attitude (see Figure 3: Summary of findings).

Figure 3: Summary of findings



Positive aspects of being old in hospital are associated with a match between the mandate of the hospital to deliver acute intervention and the characteristics of being an ideal patient. Conversely, poor fit challenges the ability of hospital employees to respond to the needs of older-different patients; these individuals are often deemed the problem and labeled inappropriate by hospital employees. Ageist attitudes emerge from workload pressures experienced by hospital employees in a workplace environment that favors efficiencies. Conflict exists as a reinforcing consequence more because the patient is different than because he or she is old.

This study challenges the current premise that “good hospital care” for older people is only safe biomedical intervention. For older people this study indicates good hospital care is more than acute intervention; it takes account of functional crisis, frailty, and chronic health concerns. This is particularly so for older-different patients.

A multiple intervention approach that will influence the local day-to-day experiences of older people as well as achieve system change is required to improve the fit between older-different people and the hospital environment. To simply abandon the acute intervention approach to gain greater support for chronic health needs of older hospitalized patients would be inappropriate. The system approach must find a balance between providing acute intervention services with gerontological sensitivity without diminishing its aims to intervene when a biological crisis is present.

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## APPENDIX A

### DOCUMENT REVIEW DATA

To give breadth to the investigation, public documents and/or documents that contained aggregate data were of interest to the dissertation study. The document review involved: administrative policy and procedure directives, hospital statistical data, complaint and complement letters, and clinical audit data. These types of documents were of interest because: (a) they represent system infrastructure and activity, and (b) they govern behaviors within the hospital system (i.e., policy statements and strategic plans) and influence front-line practitioners in their duty to serve older people in hospital.

These documents also provide a lens into organizational philosophy and values. In all, they serve to identify how customs and traditions create problems for older people in their journey from admission to discharge from hospital. Documents of a personal nature such as patient records or employee records were not part of the document review; only documents that influence systems and processes were of interest. However, if patient complaint letters were available, the documents were reviewed after personal identifying information was removed.

#### Document Review Process

The researcher generated a list of relevant documents in consultation with the hospital administrator based on criteria of relevancy – whether or not the documents could illuminate customs or traditions. The review included the following documents:

- Community demographics from Health Data Warehouse, British Columbia Ministry of Health and Planning;
- Acute care utilization statistics for 75+ population (fiscal year: 2003/04);

- Case mix groupings for in-patients 75+ population (fiscal year: 2003/04);
- Health care incident reporting system (ENCON<sup>38</sup>);
- Admission and discharge forms (i.e., preoperative checklists, discharge summary, standard physiotherapy assessment);
- Complaint and compliment management form;
- Summary table of complaints by service;
- Process for complaints management;
- Section 51 summary forms and decision process;
- Process details for view of formal investigation for critical incidents or incidents with potential for unfavorable outcomes;
- Patient education tools (i.e., precautions following surgery, postoperative exercises); and
- Operational infrastructure tools (i.e., weekly staffing roster – days, nights, and evenings, Kardex systems).

In all, these documents represent risk management systems, human resource management tools, administrative policy and procedure manuals, and unit-based health care record forms and teaching aids. After critically assessing the quality and appropriateness of the data within the documents to answer the study question, the researcher decided to remove the hospital document review as a data source from the dissertation study. The documents lacked detail and the specificity required to help

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<sup>38</sup> ENCON is the risk management documentation and tracking system employed by the hospital. This system defines what a reportable problem is, involves documentation of an incident, and the long-term tracking of indicators that are reportable quarterly to administration.

understand hospital customs, traditions, and their relationship to problems experienced by older people. Five examples illustrate the point:

1. The last quarterly report on complaint data noted that the hospital's quality improvement department received 23 complaints. Though complaint data was available, it was organized by reason for complaint and hospital department, but not by age group. An age criterion was necessary for the purposes of the study, but was not available.
2. The number of adverse hospital outcomes relevant to older adults, such as falls, disruptive behavior, or medication errors was available in aggregate data. Trends in quarterly reports showed the frequency of each type of adverse outcome, but provided no qualitative information regarding the circumstances surrounding each event, preventing the researcher from determining what factors contributed to the problem. The aggregate data also did not allow the researcher to exclude the younger than 75 population from the total. Although adverse outcomes tracked by the risk management system are of interest to the dissertation study, there is no way to determine how person-environment fit (i.e., physical design, social climate, policies and procedures, and care systems and processes) may or may not have contributed to the problems. The documents did not help answer the research question.
3. Administrative policy and procedure documents focused on operational interests of the hospital. For example, the policy and procedure manual's table of contents lists topics concerned with material management, operating grants to external agencies, human resources (such as conflict of interest, dishonest

acts, and harassment), quality improvement, and information management.

These documents outline the obligations of hospital employees in their relationship to the hospital, not to patients. The study seeks to understand how hospital customs and traditions create problems for older people as they journey through the system from admission to discharge. These documents do not help answer the research question, except to indicate that administrative policies and procedures *are* a custom and tradition and they serve the needs and interests of the organization.

4. As noted in the second example, the hospital's risk management and quality improvement activities do relate to gerontological interests. The researcher found, however, that quality improvement investigative processes do not take account of age-related changes. For example, the Healthcare Incident Reporting System's risk management documentation and tracking process defines an incident as any occurrence that deviates from normal institutional routine. This includes an unplanned event that is inconsistent with the routine and safe operation of the institution; an incident is anything that happens which should not happen. This definition is problematic because it ignores older adult risk factors. If an incident occurs outside of a significant medical event, it is not recognized as a reportable event. For example, being old and confused in hospital can be perceived as normal, but may in fact be an abnormal and preventable clinical event. Though it would not register as an incident, it may be the precursor to a fall, resulting in a fractured hip or subdural hematoma and death. The adverse outcome then becomes the

incident, which triggers the investigation and system response, rather than the episode of confusion that led to the event. In the end, critical analysis of the quality improvement system only raised more questions that are beyond the scope of the study.

5. The health care record forms reviewed clearly reflected the medical model. However, to adequately investigate fit requires reviewing forms and documentation systems related to actual hospitalized individuals with reported corresponding problems. Since the study design does not permit review of personal health care records, simply reviewing health care record documents did not offer enough detailed information about the fit between older people and the hospital environment. Nor did they help explain *how* problems arise from hospital customs and traditions.

After assessing the quality of the documents and their ability to help answer the research question, the researcher decided to exclude them from the study. The supervising committee also advised the researcher to exclude data from the review if the information gleaned did not help answer the research question.<sup>39</sup>

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<sup>39</sup> The lack of specificity found in the document review may, in fact, be an interesting finding in the study. Although aggregate data was recovered during the document review, which highlighted the overrepresentation of older people in hospital (i.e., number of visits or percentage of in-patient days compared to younger age groups), there was a corresponding lack of information specific to older adults in the existing documents. This might suggest that all adults in the hospital system are considered the same, which suggests hospital systems do not recognize (and thus often fail to respond to) the special needs of older adults.

**APPENDIX B**  
**INFORMATION SHEET**

My name is Belinda Parke and I am a registered nurse completing doctoral studies at the University of Victoria's Center on Aging. As part of the requirements for my PhD in aging and health, I am conducting a research study at MSA Hospital. My research is supervised by Dr. Neena Chappell.

The purpose of my study is to investigate how the hospital environment affects older people. The objective is to understand how hospital systems and processes contribute to positive and problematic experiences for older people.

This research is important because older adults are the primary users of hospital services and their use of such services will only increase in the future. The research will look at hospital operations together with the perspectives of hospital employees and older people. Findings from this study may potentially contribute the groundwork needed for defining quality service based on the fit between what older people need and expect, and what the hospital provides. This research has the potential to set the stage for assessing hospital environments and creating policies better suited to older people.

Participating in the study involves an interview. The interview will last one to two hours. We will talk about your experiences working with older people and what that experience has taught you about older people and the hospital environment. If you have two or more years experience working in an acute care hospital environment, please consider volunteering to participate in this study.

If you are interested in volunteering, please sign the sheet provided or contact Ms Peters at 1-604-792-7121. This person will not be participating in the study and will pass your name on to me. If you sign the sheet provided, it means you agree to me contacting you to arrange a mutually convenient time for an interview. The interview will take one to two hours. You may wish to have the interview conducted during your workday or you might choose another time and place. You are free to withdraw from the scheduled interview and/or the study at any time.

Thank you for considering participating in this study.

Sincerely,

Belinda Parke, RN MSN  
Telephone: 1-604-703-2016

## APPENDIX C

### HOSPITAL FIELD OBSERVATIONAL MAPPING GUIDE

The purpose of the observational guide is to focus the researcher's attention to specific aspects of the hospital environment.

The concept of person-environment congruence focuses on four observational dimensions that include:

#### A. Physical Features

How does the physical environment support functional abilities of older adults and older visitors?

For example:

- architectural design - interior and exterior space; furniture; lighting; a barrier free physical layout;
- equipment and design for physical independence and mobility;
- visual aspects – features that help orient the older person;
- safety features and instructions; and
- way finding that promotes problem solving.

#### B. Policy and Procedures

How do policies and procedures enhance or restrict choice and autonomy?

How does the hospital incorporate values, views, and perspectives of older adults and older visitors?

For example, how does the hospital environment affect:

- choice and autonomy;
- individualized routines;
- units or settings resourced to the needs of older people;
- involvement and influence of admission and discharge processes;
- available information;
- administrative directives for defining expected behaviors and communication patterns;
- appropriately resourced (e.g., number and type of staff, available equipment); and
- recruitment, orientation and ongoing education?

### C. Social Climate

How are older people treated?

For example, how does the hospital environment:

- help, support, and encourage older people to express opinions and feelings;
- provide time for professionals to spend time with older people in conversation;
- inform older people of information so they know what to expect (e.g., clarity of rules and procedures to govern activity); and
- listen to the opinions of older people?

For example, can older people:

- influence rules, policies, procedures, and processes of their choosing in any circumstance; and
- influence the rules, policies, procedures, and processes when the consequences knowingly negatively affect them?

For example, how does the social climate affect the unit or department milieu (e.g., cohesiveness of the staff, degree of conflict present, interest in older people)?

### D. Care Systems and Processes

How do services, systems, and care processes reflect gerontological research and evidence?

For example, do hospital routines (e.g., assessment, care planning, acute interventions, discharge planning, hospital orientation, food delivery systems, and housekeeping procedures) reflect normal developmental and age-related changes? Do acute interventions take account of iatrogenic potential? Are interdisciplinary professional resources expected to have knowledge in gerontological care?

**APPENDIX D**  
**HOSPITAL POSTER BOARD**

**UNIT OBSERVATIONS UNDERWAY**

**RESEARCHER ON SITE**

Observations of the hospital environment are under way by a graduate student who is a registered nurse completing a PhD program in health and aging from the University of Victoria's Center on Aging. The purpose for conducting observations in the hospital is to understand how the environment affects older people.

**Observations will begin at \_\_\_\_\_ hours and conclude  
at \_\_\_\_\_ hours.**

This research is important because older adults are the primary users of hospital services. These observations may help provide insight into how to improve hospital services for older people. The study could potentially lay the groundwork for defining quality hospital services based on what older people need, want, and expect.

Confidentiality will be maintained. All information will be coded; NO personal identifying information will be used. All observations will be in common public areas; no observations will be conducted in the private or personal space of patients in this area.

The graduate student conducting the observations is a registered nurse and, therefore, guided by the Canadian Nurses Association Code of Ethics and the Registered Nurses Association of British Columbia Standards of Nursing Practice. These direct the student to advocate on behalf of patients. As such, there is a duty to report any conduct that may be harmful to patients. Such care and conduct issues observed by the student will be reported to the Chief Nursing Officer.

If you have any questions during this time, please ask the individual in charge of this area. Information sheets are available at the nursing station or registration desk.

You can register any concerns with the Chief Nursing Officer at (604) 587-4649.

You may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research, at the University of Victoria (250-472-4362).

## APPENDIX E

### OBSERVATION INFORMATION SHEET

Observations are currently underway in this area of the hospital for a research study entitled:

**Understanding the hospital environment and older people: A social ecological analysis**

My name is Belinda Parke. I am a registered nurse and a graduate student at the University of Victoria's Center on Aging. This study is being conducted as a requirement for an interdisciplinary PhD in health and aging. The study is supervised by Dr. Neena Chappell of the Center on Aging. Dr. Chappell can be contacted at (250) 472-4465 and I can be contacted at (604) 703-2016.

The purpose of my study is to investigate how the hospital environment can affect older people. By observing, I hope to understand how hospital systems and processes contribute to positive and problematic experiences.

This research is important because older adults are the primary users of hospital services and their use of such services will only rise in the future. Findings from this study could potentially contribute to laying the groundwork for determining what quality hospital service can be for older people. This research has the potential to set the stage for assessing hospitals and ensuring policies are better suited to the needs of older people.

Your confidentiality and the confidentiality of the data will be protected. NO personal information or identifying information is recorded or used; information gleaned from the observations are coded with fictitious initials and numbers and organized into themes. Observation notes will be shredded once all scholarly activity is complete.

The results of this study will be shared with others in the following ways: thesis for library usage, presentations at scholarly meetings, and publications. I hope to use the information from this study in my capacity as a registered nurse to improve care and service to hospitalized older people.

As a registered nurse conducting the observations, I am guided by the Canadian Nurses Association Code of Ethics and the Registered Nurses Association of British Columbia Standards of Nursing Practice. These direct me to advocate on behalf of patients. As such, I have a duty to report any conduct that may be harmful to patients. Such care and conduct issues will be reported to the Chief Nursing Officer. Any concerns you have may also be registered with the Chief Nursing Officer at (604) 587-4649. You may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research, at the University of Victoria (250-472-4362).

Thank you

## APPENDIX F

## FIELD RECORD DEFINITIONS

Observational Notes	Methodological Notes	Theoretical Notes	Reflexive Notes
<p>Descriptive accounts of observations as a third-party observer.</p> <ul style="list-style-type: none"> <li>• Describe the general hospital environment and organizational context, considering four dimensions: physical features, social climate, policy and procedures, care systems and processes.</li> <li>• Describe how the four dimensions support functional abilities and empower or disempower older people and older visitors.</li> <li>• Describe encounters between older patients and older visitors with the hospital environment.</li> <li>• Describe how the hospital environment affects choice, autonomy, individualization, and routines.</li> <li>• Describe social and interactional processes that make up hospital activity.</li> <li>• Describe how older people are treated: how does the hospital environment encourage older people to express opinions?</li> <li>• Describe how care systems and processes reflect gerontological best practices.</li> </ul>	<p>“Notes to self” (in-process memos) on the research process, questions to follow-up on, a new focus to pursue, and/or a learning to clarify or pursue in greater detail in subsequent observations and/or interviews.</p> <ul style="list-style-type: none"> <li>• Record questions that should be asked in follow-up observations.</li> <li>• Record questions that should be asked in second round of interviews</li> <li>• Comment on whether interview questions could be better phrased or observations better organized</li> <li>• Make suggestions for returning to or pursuing new observation sites.</li> <li>• Record issues experienced, decisions made, their rationale.</li> <li>• Explain how the design shifted with the constant comparative analysis employed.</li> </ul>	<p>Notes linking observations to literature and theoretical insights through the data analysis process. Juxtapose interviews with observation and field tales to conceptual framework: person-environment fit.</p> <ul style="list-style-type: none"> <li>• Describe any analytical hunches and ideas for theoretical linkages (e.g., conflict, critical, total institution).</li> <li>• Record ideas for coding preliminary categories, initial concepts, and themes arising from the data.</li> <li>• Record questions arising from the literature.</li> <li>• Record concepts that need to be explored through theoretical sampling.</li> </ul>	<p>Reflections on one’s own professional and social positioning. Considered are the researcher’s reactions to the situation, participants’ reactions to the researcher, and the dynamics between the researcher, the setting, and the participants that may have influenced the research process.</p> <ul style="list-style-type: none"> <li>• Record impressions of the observations/interviews and how you may have influenced the encounters.</li> <li>• Record any biases or “blind spots” you may have.</li> <li>• Record reasons for methodological decisions.</li> <li>• Record reasons for including or excluding observational data.</li> <li>• Describe any personal feelings/interpretations that you may have of the data, and distinguish this from interpretations grounded in the data.</li> <li>• Describe how decisions might have been influenced by considering the following: <ul style="list-style-type: none"> <li>(a) The stance taken by the researcher (e.g., theoretical position within the discipline; personal, political, and moral commitments) and what factors influence the stance taken.</li> <li>(b) How prior clinical experience and training influences the research process: what draws the attention of the researcher? Why?</li> <li>(c) If a particular gender, social, cultural, intellectual or clinical position is operating.</li> </ul> </li> </ul>

## APPENDIX G

### CONTACT SUMMARY SHEET

Date: \_\_\_\_\_ Observation/Interview: \_\_\_\_\_

Description of the encounter – what factors influenced the encounter?

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What were the main themes or issues that arose in the contact?

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Summarize the information gained in this contact - How does the information obtained from the contact assist in answering the research question?

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What, if any, reasons might exist that influence the researcher to include or exclude observational data?

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What personal feelings/interpretations do I have that may influence my interpretations of the data?

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Describe: (a) decisions to include or exclude data and (b) how interpretations of the data are influenced by:

1. My theoretical stance as a professional:

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2. My personal beliefs about power and authority:

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3. My prior clinical experience and training as a nurse:

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4. Are there any personal opinions and biases on gender, social conditioning, and cultural dynamics operating?

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5. What new ideas, speculations, analytic hunches, or hypotheses arise from this contact – new questions to be considered, new concerns arising from this experience?

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## APPENDIX H

### INTERVIEW GUIDE: OLDER ADULT AND FAMILY

#### PART ONE - INTRODUCTION

I would like to include some information about who you are. This information will provide background about the older adults who participated in the interviews for this study. The information will not be used to identify you personally. All answers to the questions asked are kept strictly confidential. The only other person who would have access to this information is my supervisor - Dr. Neena Chappell at the University of Victoria. You get to decide which questions you will or will not answer. We can skip any questions that you would rather not answer or we can add anything that you think would be important to include.

AGE \_\_\_\_\_ GENDER: Male \_\_\_\_\_ Female \_\_\_\_\_  
 MARITAL STATUS: \_\_\_\_\_

LIVING ARRANGEMENTS (e.g., living alone, with a spouse, with a family member): \_\_\_\_\_

USE OF EXISTING COMMUNITY SERVICES (e.g., home support, home nursing care, community agencies, recreational facilities):  
 \_\_\_\_\_

#### FUNCTIONAL CAPACITY

FMMSE SCORE (conduct screening test) \_\_\_\_\_  
 RRIT (conduct assessment) \_\_\_\_\_

REASON FOR ADMISSION TO HOSPITAL  
 \_\_\_\_\_

DISCHARGE DATE  
 \_\_\_\_\_

DISCHARGE DIAGNOSES  
 \_\_\_\_\_  
 \_\_\_\_\_

## **PART TWO - JOURNEY OF HOSPITALIZATION**

### **1. What areas of the hospital were you in?**

#### **2. The description of problems – Emergency Department**

2.1 Can you tell me about the circumstances surrounding how you decided to come to the Emergency Department?

2.2 Please describe any problems you or your family experienced while being in the Emergency Department.\*

2.3 What went well for you in the Emergency Department?

2.4 What did you need and expect from your stay in the Emergency Department?

#### **3. The description of problems – In-patient Unit**

3.1 Please describe any problems you or your family experienced while being on the in-patient unit of the hospital.\* This could involve the transfer from the Emergency Department to the in-patient unit or during the time you spent on the unit.

3.2 What went well for you while you were on the unit?

3.3 What did you need and expect when you were on the unit?

#### **4. The description of discharge**

4.1 Can you tell me about the circumstances surrounding your leaving hospital and returning home?

4.2 Please describe any problems you or your family experienced while preparing to return home.

4.3 What went well for you on your return home?

4.4 What might have improved or assisted your return home?

#### **5. The description of problems since being at home following discharge**

5.1 Can you tell me about how it's been for you now that you are back at home from spending time in the hospital? How are you managing?

5.2 How has being in hospital contributed to how you are now?

#### **6. Other information**

6.1 Is there anything about being in hospital that you would like to talk about that we have not covered in our conversation so far?

\* Prompts will be used from observational dimensions when they are relevant to the conversation.

## APPENDIX I

## A - FOLSTEIN MINI MENTAL EXAMINATION

Maximum Correct Score	Client's Score
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## ORIENTATION

1) 5 ( ) What is the - date \_\_\_\_\_, day of week \_\_\_\_\_, month \_\_\_\_\_, season \_\_\_\_\_, year \_\_\_\_\_?

2) 5 ( ) Where are we - name of country \_\_\_\_\_, province \_\_\_\_\_, city \_\_\_\_\_, place \_\_\_\_\_, floor \_\_\_\_\_? -  
(Street) (House # / Apt #)

## REGISTRATION

3) 3 ( ) Name 3 objects (HOUSE, TREE, CAR). Take 1 second to say each. Then ask the client all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record.

TRIALS \_\_\_\_\_

## ATTENTION AND CALCULATION

4) 5 ( ) Serial 7's

$100 - 7 = ( )$ ,  $93 = ( )$ ,  $86 = ( )$ ,  $79 = ( )$ ,  $72 = ( )$ , 65.

One point for each correct answer. (Alternatively spell "WORLD" backwards).

## RECALL

5) 3 ( ) Ask for 3 objects - HOUSE ( ), TREE ( ), CAR ( )

## LANGUAGE

6) 9 ( ) Name a pencil, and watch ( ) 2 points

Repeat the following - "NO IFS, ANDS OR BUTS" ( ) 1 point

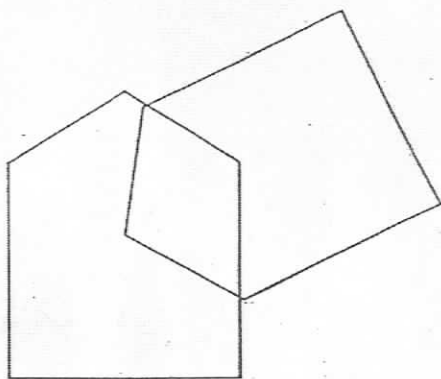
Follow a 3 - stage command:

"Take the paper in your right hand, fold it in half, and put it on the floor."

( ) 3 points

Write a sentence (1 point)

Copy design (1 point)



**B - REGINA RISK INDEX TOOL**

Older Adult Number: \_\_\_\_\_

<p><b>Age</b>      79 yrs and under (0) <input type="checkbox"/></p> <p>                 80-84 yrs (1) <input type="checkbox"/></p> <p>                 85-89 yrs (2) <input type="checkbox"/></p> <p>                 90+ yrs (3) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>Mental Status</b>      no difficulties (0) <input type="checkbox"/></p> <p>                 symptoms of depression (1) <input type="checkbox"/></p> <p>                 Hx major mental illness (3) <input type="checkbox"/></p> <p>                 MMSE 26-30 (0) <input type="checkbox"/></p> <p>                 MMSE 21-25 (1) <input type="checkbox"/></p> <p>                 MMSE 16-20 (2) <input type="checkbox"/></p> <p>                 MMSE 15 or less (4) <input type="checkbox"/></p> <p>                 developmental disability/ABI (4) <input type="checkbox"/></p> <p>                 palliative (4) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>IADL Meals</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>Gender</b>      male (0) <input type="checkbox"/></p> <p>                 female (1) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>Self-Rated Health</b>      good (0) <input type="checkbox"/></p> <p>                 fair (1) <input type="checkbox"/></p> <p>                 poor (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>IADL Medications</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>Marital Status</b>      single (1) <input type="checkbox"/></p> <p>                 married (0) <input type="checkbox"/></p> <p>                 widowed (1) <input type="checkbox"/></p> <p>                 divorced/separated (1) <input type="checkbox"/></p> <p>                 separated beyond control (1) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>Level of Activity</b>      2-3 times/week (0) <input type="checkbox"/></p> <p>                 no regular activity (1) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>ADL Bathing</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>Net Monthly Income</b>      \$1,500 + (0) <input type="checkbox"/></p> <p>                 \$1,200 - 1,499 (1) <input type="checkbox"/></p> <p>                 \$900 - 1,199 (2) <input type="checkbox"/></p> <p>                 &lt; \$899 (3) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>Hospital Within The Last 12 Months</b>      no visits (0) <input type="checkbox"/></p> <p>                 once (1) <input type="checkbox"/></p> <p>                 twice (2) <input type="checkbox"/></p> <p>                 more than twice (3) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>ADL Dressing</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>Living Arrangements</b>      lives alone (1) <input type="checkbox"/></p> <p>                 with spouse only (0) <input type="checkbox"/></p> <p>                 with spouse &amp; others (0) <input type="checkbox"/></p> <p>                 with other family (1) <input type="checkbox"/></p> <p>                 with others (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>Hospital Total Days</b>      no days (0) <input type="checkbox"/></p> <p>                 1-7 days (1) <input type="checkbox"/></p> <p>                 8-14 days (2) <input type="checkbox"/></p> <p>                 15+ days (3) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>ADL Eating</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>Type of Residence</b>      house/apt (0) <input type="checkbox"/></p> <p>                 housing (1) <input type="checkbox"/></p> <p>                 housing with supports (2) <input type="checkbox"/></p> <p>                 assisted living, group (3) <input type="checkbox"/></p> <p>                 no fixed address (4) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>IADL Telephone</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>ADL Transfers</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>Caregiver Support</b>      stable, avail (0) <input type="checkbox"/></p> <p>                 stable, limited (1) <input type="checkbox"/></p> <p>                 unstable, avail (2) <input type="checkbox"/></p> <p>                 unstable, limited (2) <input type="checkbox"/></p> <p>                 short term, occasional (2) <input type="checkbox"/></p> <p>                 no significant (3) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>IADL Transport</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>	<p><b>ADL Urinary Management</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>TOTAL SCORE</b>      = sum of scores for each section</p> <p>    <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/></p>		<p><b>ADL Bowel Management</b>      by self (0) <input type="checkbox"/></p> <p>                 with assist (1) <input type="checkbox"/></p> <p>                 total assist (2) <input type="checkbox"/></p> <p>                 unable to complete <input type="checkbox"/></p>												
<p><b>OUT OF</b>      = 54 minus the sum of the largest score of each incomplete section</p> <p>    <input style="width: 30px; height: 20px;" type="text"/> / <input style="width: 30px; height: 20px;" type="text"/></p>		<p><b>Added Risks</b>      not present (0) <input type="checkbox"/></p> <p>                 present (4) <input type="checkbox"/></p> <p>                 explain      unable to complete <input type="checkbox"/></p>												
		<p><b>Entered by:</b> _____</p> <p><b>Date:</b> _____</p>												
		<table style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center; border-bottom: 1px solid black;">Risk Level</th> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Minimal Risk</td> <td style="padding: 2px;">0 - 7 <input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Low Risk</td> <td style="padding: 2px;">8 - 14 <input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">Some Risk</td> <td style="padding: 2px;">15 - 20 <input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">At Risk</td> <td style="padding: 2px;">21 - 25 <input type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px solid black; padding: 2px;">High Risk</td> <td style="padding: 2px;">26 + <input type="checkbox"/></td> </tr> </table>	Risk Level		Minimal Risk	0 - 7 <input type="checkbox"/>	Low Risk	8 - 14 <input type="checkbox"/>	Some Risk	15 - 20 <input type="checkbox"/>	At Risk	21 - 25 <input type="checkbox"/>	High Risk	26 + <input type="checkbox"/>
Risk Level														
Minimal Risk	0 - 7 <input type="checkbox"/>													
Low Risk	8 - 14 <input type="checkbox"/>													
Some Risk	15 - 20 <input type="checkbox"/>													
At Risk	21 - 25 <input type="checkbox"/>													
High Risk	26 + <input type="checkbox"/>													

## APPENDIX J

### OLDER ADULT INTRODUCTORY LETTER

Date:

Dear Mr. or Mrs. \_\_\_\_\_

This letter is being sent to you by MSA Hospital on behalf of Belinda Parke. Belinda is a registered nurse who is a graduate student at the University of Victoria's Center on Aging. She is completing a PhD in health and aging under the supervision of Dr. Neena Chappell.

Belinda is studying how the hospital environment can affect older people. You are being invited to volunteer to participate in this study because you have recently been discharged from hospital. Your recent discharge may have given you important knowledge about what it is like to be an older person in hospital.

Participating in the study involves an interview with Belinda. The interview will last one to two hours. You will be invited to talk about your experience of being in hospital because Belinda would like to learn about what went well and what problems you might have encountered while in hospital. The knowledge you have can help Belinda understand how hospital environments negatively and positively affect older people.

This research is important because older adults are the primary users of hospital services. Findings from this study may help hospitals become better suited to meeting the needs of older people. In the end, this study could lay the groundwork for defining quality hospital services, which are based on what older people need, want, and expect.

We are sending you this letter on Belinda's behalf to protect your privacy. **You have NO obligation to respond to this invitation because you have been a patient at our hospital.**

If you are interested in volunteering to participate or would like to know more about the study, please call MSA Hospital Health Records department at \_\_\_\_\_ and leave your contact information. When you call this number, it means you agree to be contacted by Belinda. When she contacts you to arrange an interview time she will provide you with the details of the study. You will have an opportunity to ask and have answered any questions before agreeing to proceed. Prior to beginning the interview, Belinda will ask that you sign a consent to participate.

You may change your mind at any time after submitting your name to the Health Records Department and you are free to withdraw from the study at any time before, during, or after the interview. Enclosed with this letter is the interview guide that Belinda will use during the interview to guide your discussions.

Thank you for considering volunteering for this study.

Sincerely,

\_\_\_\_\_

Supervisor, Health Records Department

## APPENDIX K

### OLDER ADULT CONSENT

You are invited to participate in a research study entitled:

#### **Understanding the hospital environment and older people: A social ecological analysis**

My name is Belinda Parke. I am a registered nurse and a graduate student at the University of Victoria's Center on Aging. This study is being conducted as a requirement for an interdisciplinary PhD in health and aging. The study is supervised by Dr. Neena Chappell of the Center on Aging. Dr. Chappell can be contacted at (250) 472-4465 and I can be contacted at (604) 703-2016.

The purpose of my study is to investigate how the hospital environment can affect older people. By conducting interviews with older adults, I hope to understand how hospital systems and processes potentially contribute to positive and problematic experiences.

This research is important because older adults are the primary users of hospital services and their use of such services will only rise in the future. Findings from this study could potentially contribute the groundwork for determining what quality hospital service can be for older people.

You are being invited to volunteer to participate in my study because you have recently been discharged from hospital. Your recent discharge may have given you important knowledge about what it is like to be an older person in hospital. I would like to learn from your experience. I am interested in knowing what went well and what problems you might have encountered while in hospital.

Your participation will involve an interview to talk about your experiences of coming to hospital and being in hospital. Before the interview begins, I will explain the study in detail and answer any questions you might have. Before obtaining your consent to proceed, I will ask you to explain your understanding of the study.

The interview will begin with questions about personal information including living arrangements and personal care needs. This information will provide background about the older adults who participated in my study. You will be asked to complete two questionnaires to evaluate your cognitive and physical abilities. You get to decide which questions you will or will not answer. You can skip any questions that you would rather not answer or you can add anything that you think would be important to include.

With your permission, the interview will be audio taped. It will last one to two hours and will occur on a day and at a time and location convenient to you.

The potential benefits of your participation in this study would be the contribution of information that could potentially benefit administrators, health care researchers, and professionals working in the hospital. Such information could improve the quality of hospital service for older people.

Participation in this study may cause some inconvenience to you, including a disruption in your day. Recalling problematic or unpleasant hospital experiences could also be distressing. Remembering and talking about situations that may have been unpleasant could cause you to experience sadness, fear, or anxiety. If you choose to participate and experience such distress, I will encourage you to pause or take a break if you need to during the discussion. I will make every effort to minimize your distress by offering to reschedule the interview. If you wish, the name of a community support resource will be provided at no cost to you for debriefing support. Any concerns that you might have from participating in this study can be registered with Chief Nursing Officer, at (604) 587-4649.

As noted earlier, your participation in this research is voluntary and therefore you have the right to refuse to participate or withdraw at anytime, without any explanation or consequence. Your decision to participate or not to participate will have no affect on your ability to access hospital services or hospital care currently or in the future.

If you do withdraw from the study, I will ask your permission to include the information you have provided before withdrawing in the final analysis. If you agree, this information will be destroyed once the analysis and writing is complete. If you do not give your permission for this information to be used, it will be shredded upon your request.

To make sure that you continue to consent to participate in this research, I will be checking with you to determine if you are interested in continuing with the study during the interview.

Your confidentiality and the confidentiality of the data will be protected by the use of identifiers that will code information with fictitious initials and numbers. This means that the information you provide will not be used to identify you personally. Your answers and the stories you tell will be kept strictly confidential. The only other person who would have access to this information is my supervisor, Dr. Chappell. All audiotapes and transcripts will be kept in a locked drawer in a filing cabinet in my home office. All data will be shredded and audiotapes erased when all scholarly activity is complete.

Study results will be shared with the hospital employees, in thesis format for library usage, in presentations at scholarly meetings and publications. I anticipate using the information from this study in my capacity as a registered nurse to improve care and service to hospitalized older people.

You may verify the ethical approval of this study or raise any concerns you might have by contacting the Associate Vice-President, Research, at the University of Victoria (250-472-4362).

Your signature indicates that you understand the conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers and that you have received a copy of this consent.

Thank you.

---

Name of Participant

---

Signature

---

Date

I agree to have the interview audio taped

---

**APPENDIX L****HOSPITAL EMPLOYEE INTERVIEW GUIDE****PART ONE - INTRODUCTION**

I would like to include some information about who you are. This information will be used for background information to describe the characteristics of those who were interviewed in this study. The information will not be used to identify you personally. The answers to the questions I will be asking you will be kept strictly confidential. The only other person who would have access to this information is my supervisor – Dr. Neena Chappell at the University of Victoria. You may refuse to answer any of these questions at any time.

GENDER: Male \_\_\_\_\_ Female \_\_\_\_\_

NUMBER OF YEARS WORKING IN HEALTH CARE

---

YEARS OF HOSPITAL EXPERIENCE

---

TYPE OF EXPERIENCES, ROLES, AND RESPONSIBILITIES WORKING WITH OLDER PEOPLE

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---

EDUCATIONAL PREPARATION

---

SPECIALIZED TRAINING IN GERONTOLOGY

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**PART TWO - OLDER ADULTS IN HOSPITAL**

1. Can you tell me about your experiences working with older people in hospitals?
2. What are the challenges you experience in your day-to-day work in hospital caring for older people?
3. I am particularly interested in issues that relate to older adult fit within the hospital environment. Could you please describe any problems you observe in your work that relate to older people and the hospital environment?\*
4. If there were opportunities to improve the fit between what older adults need and how the hospital environment responds to those needs, what changes would you make?
5. Is there anything else that you think is important for me to know about older people and the hospital environment?

\* Prompts will be used from observational dimensions when they are relevant to the conversation.

## APPENDIX M

### HOSPITAL ADMINISTRATIVE APPROVAL FORM

May 25<sup>th</sup>, 2004

Dear Administrator,

My name is Belinda Parke. I am a registered nurse and a graduate student at the University of Victoria's Center on Aging. This study is being conducted as a requirement for an interdisciplinary PhD in health and aging. The study is supervised by Dr. Neena Chappell of the Center on Aging. Dr. Chappell can be contacted at (250) 472-4465 and I can be contacted at (604) 703-2016.

The purpose of my study is to investigate how the hospital environment can affect older people. I believe it is important to know how the hospital environment affects older people so that improvements can be made. My study will look at both, hospital operations and the perspective of older people together. By observing older people in the hospital setting, I hope to be able to understand how hospital systems and processes contribute to positive and problematic experiences for older people.

This research is important because older adults are the primary users of hospital services and their use of hospital services will rise in the future. Findings from this study may contribute by laying the groundwork needed for determining what quality hospital service can be for older people. This research has the potential to set the stage for assessing hospitals and ensuring policies are better suited to the needs of older people.

**MSA** hospital is being asked to participate in this research because it provides the community a variety of acute interventions such as in-patient and outpatient and diagnostic services that older people require. If permission is provided for the research to be conducted at the **MSA** hospital, it will involve:

1. Interviews with eight to ten **MSA** hospital employees that will last one to two hours on a workday and at a private location in the hospital where they work or at another site of their choosing.
2. Hospital document review that includes at minimum administrative policy and procedure directives, hospital statistical data, clinical audit and health record data, and human resources information. If they exist, complaint and compliment letters with personal identifiers removed.
3. Interviews with eight to ten discharged patients 75 years of age or greater.
4. Health Records Department sending a letter (written by the researcher) to older discharged patients inviting them to participate in the study and documenting the contact information of those who respond to the letter volunteering to participate.
5. Observations of the hospital environment that could include the emergency department, waiting rooms, medical and surgical area, and diagnostic areas

such X-ray departments. Personal patient care areas are excluded from observation.

6. Administrative support to organize information sessions and introduction to key stakeholder groups in the hospital.

Information gained from this research may potentially benefit administrators, health care researchers, and professionals working in the hospital. The research may potentially contribute to improving the quality of hospital service for older people.

Participation in this research must be completely voluntary. In terms of protecting anonymity the hospital site will remain unknown. No personal information or identification of older adults or hospital employees will be used. All information will be coded, organized into themes, and presented in aggregate form.

Confidentiality of the people participating in the study will be protected by the use of identifiers that will code information with fictitious initials and numbers. All raw data will be kept in a locked drawer in a filing cabinet in my home office.

Data from this study will be disposed of by shredding when all scholarly activity has been completed. The audiotapes will be erased once transcription is complete.

It is anticipated that the results of this study will be shared with others in the following ways: thesis for library usage, presentations at scholarly meetings, and publications. I anticipate using the information from this study in my capacity as a registered nurse to improve care and service to hospitalized older people.

In addition to being able to contact myself, my supervisor Dr. Neena Chappell can be contacted at (250) 472-4465. You may also verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4362).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researcher and that you have received a copy of this consent.

Thank you.

---

Name of Administrator

---

Signature

---

Date

## APPENDIX N

### HOSPITAL EMPLOYEE CONSENT FORM

You are being invited to participate in a research study entitled:

**Understanding the hospital environment and older people: A social ecological analysis**

My name is Belinda Parke. I am a registered nurse and a graduate student at the University of Victoria's Center on Aging. This study is being conducted as a requirement for an interdisciplinary PhD in health and aging. The study is supervised by Dr. Neena Chappell of the Center on Aging. Dr. Chappell can be contacted at (250) 472-4465 and I can be contacted at (604) 703-2016.

The purpose of my study is to investigate how the hospital environment can affect older people. By conducting interviews with hospital employees, I hope to understand how hospital systems and processes potentially contribute to positive and problematic experiences.

This research is important because older adults are the primary users of hospital services and their use of such services will only rise in the future. Findings from this study could potentially contribute the groundwork for determining what quality hospital service can be for older people. This research has the potential to set the stage for assessing hospital environments and ensuring polices are better suited to the needs of older people.

You are invited to participate in this study because you have two or more years experience working in an adult acute care hospital. I would like to learn from your experience how the hospital environment supports or creates problems for older people.

Your participation will involve an interview to talk about your work experiences as they relate to older people in hospital. The interview will begin with questions on your professional background such as number of years working in health care, years of hospital experience. This information will provide background about the hospital employees who participated in my study. With your permission, the interview will be audio taped and it will last one to two hours at a day, time, and location convenient to you. You may wish to have the interview conducted during your workday or you may choose another time and place.

Participation in this study may cause some inconvenience to you, including a disruption in your day. Recalling problematic or unpleasant work experiences could also be distressing. You could experience sadness, fear, or anxiety by remembering or talking about situations that might have been unpleasant for you. If you choose to participate, I will remind you before we begin the interview that you may pause or take a break during the discussion. If you experience any distress, I will make every effort to minimize your distress by stopping the interview and offering to reschedule. If you wish, the name of a

community support resource will be provided to you at no cost to you for debriefing support. In addition, any concerns you might have about participating in this study can be registered with the Chief Nursing Officer at (604) 587-4649.

The potential benefits of your participation in this study would be the contribution of information that could potentially benefit administrators, health care researchers, and professionals working in the hospital. Such information can improve the quality of hospital service for older people.

Your participation in this research is voluntary and therefore you have the right to refuse to participate or withdraw at any time, without any explanation or consequence. If you agree to participate, you get to decide which questions you will or will not answer. You can skip any questions that you would rather not answer or you can add anything that you think would be important to include. You may also refuse to answer any question, without any explanation or consequence such as jeopardy to your work or status as an employee of MSA Hospital. Whether you agree to participate or not, your decision and the information you share will be kept confidential. What you say personally will not be reported to your employer.

If you do withdraw from the study, you will be asked to give permission so that the information you provided before withdrawing can be included in the final analysis. If you agree, this information will be destroyed following the analysis and after all writing is complete. If you do not give your permission for this information to be used, it will be shredded upon your request.

To make sure that you continue to consent to participate in this research, I will be checking with you to determine if you are interested in continuing with the study during the interview.

Your confidentiality and the confidentiality of the data will be protected by the use of identifiers that will code information with fictitious initials and numbers. This means that the information you provide will not be used to identify you personally. Your answers and the stories you tell will be kept strictly confidential. The only other person who would have access to this information is my supervisor, Dr. Chappell. In terms of protecting your anonymity, the hospital site will remain unknown and you have the choice to participate in the interview at a location away from the hospital.

All audiotapes and transcripts will be kept in a locked drawer in a filing cabinet in my home office. All data will be shredded and audiotapes erased once all scholarly activity is complete. Study results will be shared with the hospital employees, in thesis format for library usage, in presentations at scholarly meetings, and publications. I anticipate using the information from this study in my capacity as a registered nurse to improve care and service to hospitalized older people.

You may verify the ethical approval of this study or raise any concerns you might have by contacting the Associate Vice-President, Research, at the University of Victoria (250-472-4362).

Your signature indicates that you understand the conditions of participation in this study, that you have had the opportunity to have your questions answered by the researcher and that you have received a copy of this consent.

Thank you.

---

Name of Participant

---

Signature

---

Date

I agree to have the interview audio taped:

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## APPENDIX O

POTENTIAL AGE-RELATED PHYSIOLOGICAL ALTERATIONS<sup>40</sup>

Visual Changes	Hearing Changes	Skeletal/Muscle Changes	Physical Changes	Cognitive Changes
<ul style="list-style-type: none"> <li>• Greater incidence of glaucoma, cataracts, and macular degeneration</li> <li>• Increased sensitivity to glare</li> <li>• Decreased visual acuity and field of vision</li> <li>• Distorted depth perception</li> <li>• Decreased vision in low light</li> <li>• Eyes adjust to changing light levels with greater difficulty and more slowly</li> <li>• Greater incidence of poor color vision – decreased ability to distinguish blue-green colors</li> <li>• Ability to differentiate between contrasting surfaces is lessened</li> </ul>	<ul style="list-style-type: none"> <li>• Decreased hearing abilities</li> <li>• Greater sensitivity to high frequency noises</li> <li>• Increased reaction to environmental vibration increased</li> <li>• Poor ability to distinguish different pitch levels</li> <li>• Ability to identify sound direction or source is reduced</li> <li>• Background noise causes problems for older adults who can have difficulty ignoring ambient sounds</li> </ul>	<ul style="list-style-type: none"> <li>• Muscle strength reduced up to 40-60%</li> <li>• Decreased flexibility</li> <li>• Decreased coordination with drastic reduction in fine motor coordination</li> <li>• Decreased balance with loss of equilibrium</li> <li>• Reaction time and reflexes reduced</li> <li>• Dexterity reduced</li> <li>• Joint stiffness increased</li> <li>• Poor grip</li> <li>• Limited reaching range</li> <li>• Increased fatigue</li> <li>• Slowed reaction time</li> </ul>	<p>The consequences of the combined effects of medication, cardiovascular, and neurological problems contributes to:</p> <ul style="list-style-type: none"> <li>• Falls</li> <li>• Poor mobility and de-conditioning</li> <li>• Susceptibility to delirium</li> <li>• Incontinence</li> <li>• Thermal response is reduced: sensitivity to abrupt temperature changes increases and older patients' ability to tolerate lower temperature ranges</li> </ul>	<p>Greater incidence of:</p> <ol style="list-style-type: none"> <li>1. Ability to reason and think in the abstract is reduced</li> <li>2. Ability to focus on pertinent details is reduced</li> <li>3. Ability to form new associations impaired</li> <li>4. Memory decreased and information retrieval impaired</li> </ol> <ul style="list-style-type: none"> <li>• Communication abilities altered</li> <li>• Changes in visual perception</li> <li>• Slowed information processing – needs more time to learn new information</li> </ul>

<sup>40</sup> Compiled from numerous resources. Reader is directed to Ebersole, Hess, & Luggen (2004) for an overview of age-related physiological changes associated with normal aging.