

**A Comparative Study of empowering practices in
Voluntary and Statutory nursing homes
for Older People in County Cavan**

By

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A Thesis submitted to the Higher Education and Training Awards

Council for the award of Master of Arts, September 2004.

Abstract

This study sought to make comparisons between the voluntary and statutory services for older people in County Cavan with particular reference to the levels of understanding and application of the concept of empowerment in service provision.

The author undertook an extensive review of literature in relation to empowerment. The origin and various elements of empowerment were identified. The author identified the varying definitions and interpretations of empowerment from both human resource and social care perspectives. How the concept can be achieved was addressed and examined.

The author focused on the psychological factors of empowerment including the negative cycle of social breakdown. Strategies to combat and reverse this negative cycle were identified.

The author identified the levels of empowerment which can occur within residential settings and organisations. The author further identified the barriers which may exist within various care settings to militate against the adoption of empowering practices in service provision for older people.

The author carried out the study in eight organisations, comprising of four nursing homes from the voluntary sector and four care facilities from the statutory sector.

The author utilised both qualitative and quantitative research methodologies for the study. The knowledge obtained from each organisation identified the level of knowledge and awareness which exists among members of staff and management who took part in the study.

The data from each organisation further identified whether an empowering model of service provision existed in each organisation and what the main barriers were, as perceived and experienced by staff and management.

Strategies to overcome the challenges to empowerment were identified within each organisation.

Overall, members of staff and management who participated in the study were found to have a reasonable level of competence in terms of their understanding and practice of empowerment.

This research concludes on quite a positive note for the future of care services for older people. In addition, a number of recommendations for future service provision have been identified by the author.

Dedication

This study is dedicated to Mum, Dad, Jason, John

& Thomas,

Margaret, Kenneth, Ashley, Leeiona, Kenneth,

Shevlin, and Nicole;

Amanda, Lorraine, and Janice.

Love always

Gra

“No Love, no friendship, can cross the path of our destiny without leaving some mark on

it forever”

(Francois Mcuriac)

Acknowledgements

I would like to extend sincere thanks to the organisations which participated in the study from both the voluntary and statutory sectors. In particular the author would like to thank those who participated in the qualitative element of the study, for sharing their knowledge and taking time out of their busy schedule.

I wish to thank my supervisor, Eleanor for her guidance and support throughout this study whose wisdom replenished my spirit and enthusiasm.

To all those who helped me in so many ways to complete this study and provided me with the inspiration, guidance and support which I required to motivate and support me to greater heights— particularly my family, my friends, and colleagues.

Last but by no means least I would like to extend my thanks to the staff of the Institute of Technology, Sligo.

Declaration

I confirm that the enclosed is all my own work, with acknowledged exception

Signed : Grainne Geary
Grainne Geary B.A.A.S.S

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Introduction

1.0 Introduction

The author undertook this study due to the interest which she had in older people from an early age. As a result of this, the author worked in some care settings for older people during college. The author gained experience and knowledge of working with older people from these settings and in addition gained an insight on the perspectives relating to how they are cared for, their daily experiences and activities and aspects of institutionalisation.

The objectives of this research are to:

- To identify the levels of knowledge and awareness of management and staff in relation to the concept of empowerment in the organisations which engaged in the study.
- To investigate the perceptions of management and staff in relation to the levels of empowerment which exist within the selected organisations.
- To investigate the barriers to incorporating an empowering model of service provision for older people in the selected organisations.
- To investigate the factors which facilitate the inclusion of empowerment in service provision in the selected organisations.
- To compare and contrast the approaches to empowering practices as observed in voluntary and statutory organisations.
- To make recommendations with regard to the adoption of the principles and practice of empowerment in residential services for older people.

The study focused on eight organisations which care for older people. This comprised of four nursing homes from the voluntary sector and four care facilities from the statutory sector.

The focus of the research was based on the perceptions of staff members within these organisations, as opposed to the views of service users, i.e. residents / patients.

This study seeks to make comparisons between the voluntary and statutory services for older people in County Cavan with particular reference to the levels of understanding and application of the concept of empowerment in service provision.

The author hoped to identify the factors which militate against the adoption of empowering practices in the care of older people. In addition to investigate the influence of these factors in the voluntary and statutory sectors, as well as identifying aspects and areas of service provision, which successfully incorporate the concept of empowerment.

Finally, the author hopes to make recommendations regarding potential 'best practice' approaches to the incorporation of the principles of empowerment in residential care for older people.

*Theories of
Empowerment-
A Literature
Review*

2.0 Theories of Empowerment: A literature Review

This chapter sets out to identify what empowerment is and the definitions which exist in literature in relation to empowerment. The author seeks to identify how empowerment can be achieved on personal, psychological, societal and environmental levels. Empowerment and empowering practices are focused upon in organisations and within residential settings in particular. The chapter concludes by focusing upon the barriers and impediments to empowerment.

2.1 Origins of Empowerment

Empowerment as a concept has its roots in the discipline of Human Resource Management. Empowerment was identified as an advanced manifestation of employee performance, which would in turn lead to improved organisational performance.

Conger and Kanungo (1988:472) defined empowerment as a “process of enhancing feelings of self efficacy among organisational members through the identification of conditions that foster powerlessness and through their removal both by formal organisational practices and informal techniques of providing self efficacy information”. They were the first to integrate the approaches to empowerment found in management and psychology literatures and conceptualise it as a motivational process. They drew heavily from Bandura’s definition of the concept of self efficacy:

“Self efficacy is concerned with judgements of how well one can execute courses of action required to deal with prospective situations.....self efficacy judgements influence choice of activities and environmental activities. People avoid activities that they believe exceed their coping capabilities but they undertake and perform assuredly those that they judge themselves capable of managing” (Bandura 1982)

In summary, Conger and Kanungo view empowerment as a “process whereby an individual’s belief in his or her self efficacy is enhanced. To empower means to strengthen this belief or to weaken one’s belief in personal powerlessness”

(Conger & Kanungo 1988:481)

2.2 Empowerment in Organisations and its implications

Increased competition in the market place and government deregulation has increasingly led organizations to turn to their employees as a source of competitive advantage. In turn this has led many organizations to adopt schemes designed to encourage employee involvement. The concept of empowerment was therefore identified as a recent and advanced manifestation of employee performance, leading to improved organisational performance.

2.2.1 Models of Empowerment

Many theorists proposed models of the process of empowerment, each building upon the work and theories which were previously proposed.

Conger and Kanungo (1988) constructed and proposed a five stage model of the process of empowerment. Steps in the process include-;

- Diagnosis of organizational conditions which are responsible for feelings of powerlessness.
- This stage is characterized by organizational factors such as supervision, reward system and the nature of the job.
- Managers' use of techniques and behaviours to remove some of the conditions leading to powerlessness.
- This stage involves the use of empowerment strategies by managers where one undergoes participative management and its requirements of goal setting, job enrichment, feedback system, modeling and competence based rewards. Employment of these strategies is aimed at not only removing some of the external conditions responsible for powerlessness but also and more importantly at providing subordinates with self-efficacy information for the following stage.
- Providing subordinates with self-efficacy information from four sources which are inactive attainment, vicarious experience, verbal persuasion and emotional arousal.
- As a result of receiving such information, subordinates feel empowered by strengthening of efforts, performance expectancy or belief in self efficacy.
- Finally, the behavioural effects of empowerment are notices which can be demonstrated by the initiation and persistence of behaviour to accomplish task objectives.

Thomas and Velthouse (1990:672-3) built on Conger and Kanungo's work with their cognitive model of empowerment. They defined empowerment as "increased intrinsic task motivation which involves those generic conditions by an individual, pertaining directly to the task, that produce motivation and satisfaction". They identified four cognitions or task assessments which they felt to be the basis of worker empowerment-;

- Choice - the opportunity you feel to select task activities that make sense to you and to perform them in ways that seem appropriate. The feelings of choice is the feeling of being free to choose- of being able to use you own judgment and act out of your own understanding of the task.
- Competence - the accomplishment you feel in skillfully performing task activities you have chosen. The feeling of competence involves the sense that you are doing good, quality work on a task.
- Meaningfulness - the opportunity you feel to pursue a worthy task purpose. The feeling of meaningfulness is the feeling that you are on a path that is worth your time and energy- that you are on a valuable mission that your purpose matters in the larger scheme of things.
- Progress - the accomplishment you feel in achieving the task purpose. The feeling of progress involves the sense that the task is moving forward, that your activities are really accomplishing something.

In summary, Thomas and Velthouse improved upon Conger and Kanungo's model of empowerment in three ways; by making the concept of empowerment as motivation more precise, i.e. (by identifying the type of motivation, intrinsic task motivation); by specifying the task assessments that produce this motivation, i.e. Choice, Competence, Meaningfulness and Progress; and by outlining the cognitive processes by which workers arrive at these assessments.

Spreitzer (1995:1443) developed and validated a multidimensional measure of empowerment in the workplace. The dimensions which Spreitzer developed were similar to those which previous authors had identified in their work, namely- impact, competence, meaning and choice (which the author termed self-determination). The author also went on to develop a nomological network of psychological empowerment in the workplace, identifying and confirming antecedents and consequences of psychological empowerment as well as social structural characteristics of the work unit which are felt to be highly related to employees' feelings of empowerment.

While no definitive model of empowerment has been formulated, it is however possible to detail certain characteristics of the concepts from management literature. Many of the theorists have a background in the business / corporate sector as opposed to that of the caring professions. However an examination of the research that has been carried out in terms of the corporate sector can be almost directly compared to that of the social services.

Kirwan (1995:72) stated that there are four key ingredients for an empowerment program to succeed. These are as follows:

1. Top management must agree to support the program.
2. Program inauguration warrants fanfare.
3. Rewards must be offered for ideas generated and accepted.
4. Training is essential for team leaders, program coordinators and evaluation committee members.

It is a paradox that in order for empowerment to succeed, there must be initially more structure in the system. This applies equally to the case of the corporate world and that of the human services. Training, practice, trial and error are inherent within this process. As Thorlakson (1996:67) outlined in “An Empirical Study of Empowerment in the Workplace”, “Empowerment is not a product of any structure or system, it is a process, ongoing, dynamic and fluctuating”. He went on to further state that empowerment is “getting workers to do what needs to be done rather than doing what they’re told. It involves delegation, individual responsibility, autonomous decision making and feelings of self efficacy”. If the word “client” is substituted for “worker”, the same process can be applied to human services.

2.2.2 Relationship to Supervisory / Managerial Behaviours

Parker and Price (1994) undertook a study of the relationship between empowered managers and empowered workers to determine the effects of managerial support and managerial perceived control on workers’ sense of control over decision making. The study encompassed over eight hundred

workers and managers in several group homes. They found that employees' feelings of empowerment correlated positively with their perceptions of their managers as being empowered and in control, as well as with managerial support. "Workers feel most empowered when they perceive that their managers are both empowered and supportive" (Parker and Price 1994:704)

Keller and Dansereau (1995:128) undertook a study of 92 managers, professionals and hourly workers in a computer company to investigate the relationship between specific manager behaviours and employee empowerment. Specific manager behaviours of interest to them were the use of negotiating latitude and support for self worth. They defined latitude as "the extent to which superiors permit subordinates to modify their tasks in line with their own preferences". Self worth was defined as "the extent to which superiors have confidence in their subordinates' ability, pay attention to their feelings and needs and support their actions and ideas". The results of their study indicated that members of staff who enjoyed considerable latitude in terms of negotiation and who were affirmed in terms of their self worth by superiors, felt empowered because of their increased sense of control in the workplace.

Spreitzer (1996:500) found that working for a boss who supervises a large number of people, i.e. has a wide span of control, was found to be positively related to employees feeling empowered.

From the three studies which were carried out by the theorists mentioned above, the following points can be ascertained as to the perception of employees and the circumstances in which they were most empowered.

These are as follows;

1. Managers are empowered and supportive to their colleagues.
2. When the employees themselves are in receipt of negotiating latitude and support for self worth from superiors, thus the employees' perception of control is increased.
3. When employees work under a boss with a wide span of control, they have greater scope for working on their own initiative, making decisions, etc. As a result of this situation employees feel more empowered and in control.

Perceived levels of empowerment do not just correlate to employees and managers within the business sector but these same circumstances and contributory factors can be identified across a broad spectrum of working environments and conditions.

2.2.3 Relationship to reward systems

Spreitzer (1995:1457) investigated the relationship between individual performance-based rewards and empowerment. Spreitzer believed that “individual incentives enhance empowerment by recognizing and reinforcing personal competencies and providing individuals with incentives for participating in and affecting decision making processes at work

The results of the study provided support for the hypothesis that an individual performance-based reward system is positively related to empowerment. In effect this means that employees who are rewarded for the recognition and reinforcement of their competencies demonstrate an enhanced level of empowerment. As previously mentioned, this hypothesis can be identified across a spectrum of different working environments as the level of empowerment experienced by employees within the human resource sector does not become altered when one focuses on the experiences of employees from the caring professions.

2.2.4 Contextual Factors and their effects on Empowerment

Empowerment can also be affected by additional contextual factors. These factors are seen to be instrumental in the creation of an atmosphere which lends itself towards empowerment. One set of these factors was organizational which includes poor communication and network forming systems. Effective empowerment requires people to make good decisions in relation to their work and in turn to take the appropriate actions to carry out those decisions. Therefore poor communications and network systems could inhibit empowerment.

Chiles and Zorn (1995:24-25) found that sources of self-reported empowerment included the organizations macro-level culture and factors that underlie self-efficacy. Macro-level culture includes generalizations about superiors, patterns of management and the communication of organizational information. They found that a strict 'stuffy' atmosphere,

negative communication with and from management, and a lack of relevant information from management negatively affected empowerment.

2.2.5 Organisational factors beneficial to Empowerment

Quinn and Spreitzer (1997:37-49) addressed the issue of what organizational factors and elements create an atmosphere which is beneficial to empowerment. Among the organizational characteristics they identified as important were that:

- Employees understood the vision and goals of top management.
- The organization emphasized openness and teamwork
- Employees needed to have good communication with management
- Employees had to believe that it was possible to work together with each other in order to solve problems and in order for them to be willing and able to adopt empowered actions.

Randolph (1995:32) similarly stated that the three keys to empowerment included sharing information, communicating a vision and teamwork. Thus, it can be concluded that empowerment can occur where employees have a conceptual understanding of what management are trying to achieve, where openness, good levels of communication, information sharing, problem solving and a willingness to work as a team is evident. It is therefore possible for empowerment to occur, within any working environment where the organisational factors which create a suitable and beneficial environment for empowerment exist or can be introduced and incorporated into the culture of the organisation.

2.3. Empowerment and Older People

“Older people are one of the last groups in society with which the notion of empowerment has become associated. However the privileges which the term empowerment represents - the ability to make informed choices, exercise influence, continue to make contributions in a variety of settings and to take advantages of services - are critically important to the well being of older persons. These are choices often taken for granted by working-aged adults. As the world's population lives longer and more independent lives, it is clear that having choices and maintaining control over personal decisions has taken on new meaning and importance for older persons everywhere.”

(Nusberg, 1995: ix)

2.3.1 Definitions of Empowerment

‘Empowerment’ is a term that has become increasingly applied in various human service fields to the efforts directed towards giving power to individuals and in the removal of obstacles which people may face in attempting to make decisions for themselves. (Heumann et al, 2001: xi)

These decisions can occur in such diverse arenas of one’s life as education, health care, living and employment circumstances.

Heumann et al, (2001:4) went on to illustrate that empowerment signifies different aspects to different people. To some researchers and health care providers empowerment can signify better ‘informed’ clients, care managers and providers, to others it indicates clients who are better able to “voice” their perspectives and wishes to health care providers who are more willing

to listen. To some empowerment implies “expanding choices” and options in care delivery and to others it signifies giving older people greater participation in, and control over, their own care planning and management.

The centrality of personal control over important life choices is a common thread in the many definitions of empowerment which exist in the literature.

Thursz et al, (1995:111) define empowerment thus:

“Empowerment may be defined as a process of helping people gain, regain or maintain personal power or control over their lives, a sense that they can influence the people and organisations which affect them.”

The author feels that the definition which is offered by Thursz et al 1995 clearly demonstrates the importance of the role of empowerment as an active ongoing process in the lives of older people. The author has documented a number of definitions put forward by other writers, they are as follows:

Moonie et al (1993:151) define empowerment “as a means to give power to someone. The word is used to describe the results of maintaining client rights, so allowing people more freedom and control of their own lives.”

Empowerment for some people might be to give the power to someone else, to consciously allow another to make and implement decisions for them (Jones, 1998; Vander henst, 1997)

Croft and Beresford (1993:73) propose that "enabling people who are disempowered to have more control of their lives, to have greater voice in institutions, services and situations which affect them, and to exercise power over someone else rather than simply being recipients of exercised power".

Sykes (1995) stresses the importance of the resources that are required to develop autonomy, as opposed to focusing all energies on empowerment alone. For Sykes empowerment symbolises the delegation of authority, the assignment of responsibility, and "authorisation" for elders to assume new roles - often the same roles that society has systematically denied them" (Thursz et al 1995:49)

Alternatively some authors believed that empowerment is easier to define in terms of its absence. Rappaport (1984:3) described the lack of empowerment as a state of "powerlessness, real or imagined; learned helplessness; alienation; loss of a sense of control over one's own life". Those without power (the powerless or disempowered) can therefore achieve greater control over one or more aspects of their lives and an enhanced sense of personal or political gratification. Gibson (1991) stated that as empowerment is a complex concept to define, it is sometimes more easily understood in its absence: powerlessness, helplessness, paternalism, and an external locus of control and dependency. (Cited in Heumann et al 2001:9)

Adams (1990:43) provides a generic definition of empowerment as "...the process by which individuals, groups and/or communities become able to take control of their circumstances and achieve their own goals, thereby being able to work towards maximising the quality of their lives"

Similarly, Holdsworth (1991:12) describes the aim of empowerment as being "...to enable the formerly powerless to exert at least some measure of control over their lives" (as cited in Lupton and Nixon, 1999). Harvey (1989:109) utilised the term "Empowerment", within the context of the wider changes that will be required, if the powerless in society are to gain power. He felt that the term is often used far more loosely, as if Empowerment were a technique that individuals and communities could acquire in order to gain power. Logically, such an approach would imply that power in society is there for the taking - one just needs to learn how to avail of it, to be more assertive, for example.

Marxists would argue that power is not simply there for the taking, due to the fact that the "powerful" in society have vested interests in defending their power. Accordingly empowerment is a key concept with regard to power, but this is in the more specific and limited terms of enabling people and organisations to use most effectively the power that they do have. This may involve pressing for immediate improvements and meeting the long-term goal of social change.

Empowerment is more than just "enabling" clients to have their say, the commitment to Empowerment needs to be accompanied by"...a commitment to combating and challenging injustice and opposition, which shows itself in action as well as words" (Ward & Mullender (1991:22), cited in Lupton & Nixon, 1999).

For Brake and Bailey, the essence of empowerment is professional practice, which sets out to "bring together clients with common needs and problems, to engage in collective action on their behalf" (quoted in Lupton & Nixon, 1999:19).

Empowerment, as illustrated has many wide-ranging definitions, in its absence and its presence. Many authors have struggled to establish a definition for the concept. Its meaning implies various concepts, such as democracy, partnership, self determination, autonomy, independence and powerlessness.

Donelan (1995) provides us with a useful image to understand the concept of empowerment through the illustration of a story about a bear.

A bear is given to a city in a cage. The people of the city build a park for it. This park takes a year to build. When the park is finished, the cage is removed. Surrounded by the wide spaces that the bear now finds himself in, he continues to walk the now imaginary confines of the cage. The cage's boundaries are therefore etched on its mind, restricting its movements. (Brigid Donelan,1995, cited in Thursz et al, 1995:37). This bear story

illustrates that there are two sides of Empowerment "it resides within, in the psyche, and it lies without in the environment" (Donelan 1995:37).

Empowerment occurs throughout the life course as a result of acquiring knowledge and confidence. Rejuvenation can result from this, as noted by Pablo Picasso, who once remarked that it takes a long time to grow young. Picasso, who was creative into his 90's, deemed that invention and creativity are generally equated with youthfulness; responsibility and understanding are therefore equated with old age. From this perspective, "there are many who are old in youth, others who are young in old age and some who are both simultaneously" (Thursz et al, 1995:41).

2.3.2 Empowerment and the life cycle

Donelan (1995) believed that there is much to gain from viewing the life cycle as a continuous pattern of empowerment, focusing on the stages of the life cycle that Eric Erikson (1985) proposed. Each stage provides a useful working of the concept of individual development. In each stage - infancy, early childhood, play age, school age, adolescence, and early adulthood, adulthood and old age – the individual has something to learn. He/she learns trust, and in addition, acquires autonomy; initiative, industry, identity, intimacy, generativity and, in old age, ego integrity. Each earlier learning experience has the potential to mature into a different facet of wisdom in later years. Trust that is learned in infancy can potentially mature into appreciation of interdependence and relatedness in later life. Autonomy, if

learned in early childhood can lead to humour, empathy and resilience in later life.

From this perspective, each stage of the life cycle empowers us to move onto the next stage; therefore it is possible to be empowered every day of our lives, even in later years.

The concept therefore encompasses a wide domain of people - those with disabilities, children, older persons and additional groups. It is a universal concept and in general terms, means "to make able" or "to give power to". It can be initiated by factors in the environment or come from within the individual psyche. Finally, despite its complexities, it is a simple cry for a more egalitarian, democratic and humanitarian social order.

2.4 Interpretations of Empowerment

Empowerment was interpreted by Clark (1989) in his article entitled "The Philosophical Foundations of Empowerment". In this article he presented four interpretations of empowerment with regard to older persons and their health care. The interpretations are as follows:

- Empowerment as Effective Deliberation and Moral Reflection.
- Empowerment as Personal Process.
- Empowerment as Political Activism and Social Process.
- Empowerment as Balance and Interdependence.

2.4.1 Empowerment as Effective Deliberation and Moral Reflection

In this first interpretation Clark is referring to empowering individuals in contexts where personal decision making should be with the greatest reflection. The arenas of one's life which may have a major impact on the day to day quality of the person's life, e.g. level of service desired or provided from a care setting, may all be affected by how and what decisions are made. Clark states that the notion of autonomy is "helpful in drawing our attention to two essential decision making elements: effective deliberation and moral reflection. (1989:5) Liaschenko (1998) referred to these two factors as part of the 'four senses of autonomy'. The other two senses are free action and authenticity.

2.4.1 (1) Autonomy

The concept of autonomy had been extensively discussed in the field of gerontology and debated as to the extent of practical application that can be safely engaged in the design and implementation of services for older people. Collopy (1988:5) defined autonomy as "a cluster of notions including self-determination, freedom, independence, liberty of choice and action. In its most general terms, autonomy signals control of decision making and other activities by the individual. It refers to the human agency free of outside intervention and interference". However the application of the principle of autonomy in the variety of circumstances which many older people may find themselves in complicates the apparently non controversial notion of allowing people to make choices for themselves, based on their personal values and preferences.

Hofland (1990a) delineated two specific dimensions of autonomy where older people are concerned: the physical dimension and the psychological dimension. The physical dimension refers to environmental freedom of movement and the lowest level of physical restrictions. The psychological dimension is related to the ability to freely make choices about one's environment and to exercise control. If one is completely physically dependent or unable to exercise physical autonomy, this should not prevent that person from being able to exercise psychological autonomy in making choices about his/her care, environment, etc.

Collopy (1990:6) distinguished between decisional autonomy and autonomy of execution. Decisional autonomy is closely related to the physical dimension described above by Hofland (1990a). It implies the capacity and freedom to make choices and decisions. Autonomy of execution refers to the ability and freedom to carry out such decisions. Therefore while one may not be able to physically execute decisions, this limitation should not prevent one from being able to make a choice that directs others to implement their decisions.

However the nature of exercising autonomy and its value is called into question when older people may make decisions that are judged by others to be risky and not in their best interests. The question is then posed by family members and care providers as to when and under what circumstances should older people be allowed to exercise their autonomy, even when dangerous results may occur? There exists an inherent conflict in such

circumstances between the older person's judgement of what is best for them and the judgement of another with regard to the risks involved.

2.4.1(2) Incompetence

Collopy (1990) discussed the dangers in relation to the judgement of whether an older person is incompetent based on the fact that he/she is making a choice with which other people may not agree. Collopy states that "to judge the reasonableness of a decision, others ought to view her decision not from some outside professional standard of care, but from her perspective, from the woman's own attempt to balance pain and purpose in what might be the finale of her life" (cited in Heumann et al, 2001:7) This may be where Liaschenko's third 'sense of autonomy' may apply- that of "authenticity".

2.4.1(3) Authenticity

As Liaschenko (1998) defines it, "autonomy as authenticity means a person's actions are congruent with his or her beliefs, attitudes, values, dispositions and life plans". (Cited in Heumann et al, 2001:7) Therefore a person's actions are dependent on a combination of their beliefs, values and personal history. The notion of being authentic to one's own set of values is important as it assists us in understanding the complexities with regard to the choices which older people make which others may not agree with or understand.

Authenticity is related to another dimension of autonomy delineated by Hofland (1990b), namely the spiritual dimension. Hofland defines this dimension as “an expanded concept of self”. He believes that it is not that people are able to make choices for themselves, but that the decisions which they make must be consistent with people’s personal values and goals and the meaning with which they imbue their life. He provides an example of a lady living in a nursing home who might choose to bring with her personal items that have special meaning such as photos, a small table, books, plants, etc. Rubinstein et al (1992) feel that the ability which this lady exhibits in relation to shaping her environment in a meaningful way, contributes to an improved level of wellbeing and mental health for the resident in question. (Cited in Heumann et al, 2001:8)

Liaschenko (1998) poses the question of whether a person’s cognitive impairment necessarily insinuates that choices which are made by a person and more generally older people are inauthentic. He feels that with proper discussion and deliberation, as well as reflection upon the choices made by an individual, in light of who that person has been in the past, and who they hope to be in the future, support of the empowerment of the older person to make and implement those choices may be increasingly likely.(cited in Heumann et al, 2001:8) Therefore effective deliberation and moral reflection related to empowerment suggests that older people and their families can benefit from support when making decisions about the services which they require. Thus empowerment is a process rather than an outcome.

2.4.2 Empowerment as Personal Process

Clark (1989) defines empowerment as a personal process requiring the kind of time for effective deliberation, moral reflection and advance planning to help older persons and their families to make decisions and to prepare and / or access support systems required to help them face future challenges. A part of this process is in the helping of individuals and families to articulate not only their values, but their preferences, feelings and fears about possible future scenarios. (Cited in Heumann et al, 2001:8)

Gibson (1991:359) defines empowerment as “a process of recognising, promoting and enhancing people’s ability to meet their own needs, solve their own problems and mobilise necessary resources in order to feel in control of their own lives”. She views empowerment as a transaction between the individual and providers of care. She agrees with Clark (1989) that empowerment is a developmental process that will take different forms for different people.

The author wishes to note the compelling and apt definition of empowerment offered by Gibson (1991). Comparing this definition to that which was previously offered by Thursz et al (1991) it can be clearly seen as an advanced notion of the concept in which the individuals involved take an active part in the process by recognising, promoting and enhancing their abilities to meet their own needs.

2.4.2(1) The role of History- Individual and Social

An important issue related to the development of empowerment is the role of history- both individual and social- in allowing some people to claim power and others to be unable to claim any level of power. It is thought that empowerment can only occur when people have some prior experience of it in any arena in their lives. Therefore certain groups may not have experienced empowerment such as those with low income and low levels of formal education who may also have been marginalised and alienated from mainstream health and / or social services. Thus the notion that empowerment is only a personal process is quite a simplistic view as there are clearly a number of supplementary factors affecting any one individual's ability to engage in the process of becoming empowered.

Kari and Michels (1991:722) claim that empowerment is not something one does to or for another person but rather that it is "the ability to act collectively to solve problems and influence important issues.

Empowerment occurs when parties influence one another". Therefore to participate in empowering an individual means to participate with them rather than doing something for them or something to them. Kari and Michels (1991:724) stated that "the broader goal of the creation of an empowering environment in which persons can assume control over their lives and establish meaningful roles cannot be easily achieved".

2.4.3 Empowerment as Political Activism and Social Process

Vander Henst (1997:97) holds the view that the creation of an empowering environment requires more than a personal process; ultimately it must include political and social processes. Clark (1989) agrees with Kari and Michels (1991) when he notes that “it does little good to speak of personal empowerment without considering the need for sufficient social resources to enable individuals to exercise choice in their lives” In some cases people and older people in particular are requested to make decisions in a world possessing very few or no options.

Relevant strategies adopted by some policy makers and care providers have more recently focused on the expansion of the supply of services to enhance the opportunities for choice which older people can make. An example of this is the funding of community based services creating more opportunities and alternatives for the care of older people. However such efforts and strategies may be complicated by a myriad of factors which affect people’s ability to capitalise on options made available to them. For example in terms of the housing decisions which one makes, the choice of living alone in contrast to living in a nursing home or care facility may be based solely on the individual’s health status. In addition the absence of viable informal supports may also narrow the choice which people see for themselves.

2.4.4 Empowerment as Balance and Interdependence

Clark’s (1989) fourth interpretation of empowerment addresses another kind of balance; that is “ that each person represents a mixture of dependence and

independence, which are balanced by the individual in accommodating to the realities of his/her personal history and life situation”.(Cited in Heumann et al, 2001:14) He is concerned that focusing on autonomy only detracts from the reality of the need within all individuals, perhaps even more for older people, to be connected with others in a meaningful web of interdependence. The process of being able to strike such a balance may result in what Rawls (1971) refers to as ‘reflective equilibrium’. This is a state in which the thoughtful comparison of one’s principles and judgements has concluded in a relevant merger of the two.

There are however a variety of factors which can impede an individual from reaching a state of reflective equilibrium, which the author will briefly focus on:

- Family conflicts.
- Financial considerations.
- Rhetoric and the language of empowerment
- Paradigm shifts required from providers.

2.4.4(1) Family Conflict

Family conflicts can muddy the waters of clear and concise decision making by older people. Hofland (1990) points out that “the family caregiver faces trade-offs that relate to intergenerational responsibilities and balancing the preferences of the impaired family member against concerns for his/her safety or the needs of the rest of the family”. Unresolved family issues from the past can further complicate this conflict such as resentment for a parent

who spent little time with their child. Frequently, it is the breakdown of informal family support which translates to an older person entering care whether that is a nursing home or a care facility. It is also a possibility that the caregivers own health is failing or that there exists conflicts between family and paid employment responsibilities.

2.4.4(2) Financial Considerations

The emphasis of this factor is based on the financial burden of the provision of care for older people. In many countries, creative financing arrangements are being explored in order to lighten the load of individuals requiring expensive or long term care. In the Irish context, subvention is provided for residents who qualify for such while residing in a registered nursing home. The requirements and qualification for such is set out in part two of the Nursing Home Regulations handbook 1993 (S.I no 227).

2.4.4(3) Rhetoric and the Language of Empowerment

The kind of politically correct language that has more recently been adopted in relation to the issue of empowerment and the closely related idea of client participation often maintains the status quo in the substitution of appealing rhetoric for substantive change. An example of this is where the position of professional groups can be perpetuated by coercing people, in the name of autonomy and choice to engage in behaviours or to make choices which the professionals deem to be appropriate.

Constantini et al (1997) documents an Italian study which highlights the reasoning behind the use of physical restraints on residents in nursing homes. This study reveals a fascinating example of the distorted manner in which the 'values' of the providers outweigh the rights of the residents, within the context of seemingly reasonable and appropriate guidelines for safety. The investigators found that staff felt restraints contributed to greater degrees of dementia, anxiety, depression and aggression in residents. The staff 'rationale' however was that restraints prevented residents from falling, or from potentially harming themselves or others, and that this 'protective' function took precedence. In addition to this the vast majority of decisions made about the use of restraints did not include consultation with the resident and / or family. (Cited in Heumann et al, 2001:16)

The use of such language to rationalise certain behaviours or to achieve the goals of care providers is in stark contrast to the deeper spirit of empowerment. The lack of consensus as to what empowerment means or how it is defined contributes to the potential for manipulation of its better goals towards other ends. To conclude, Skelton (1994) notes that empowerment within nursing literature is regarded as "a way of organising teaching and learning; a strategy for equalising power in the health care division of labour; a practice of behaviour modification; a technique of pain relief; and as a political intervention aimed at reducing health inequalities between social groups". (Cited in Heumann et al 2001:16)

2.4.4(4) Paradigm Shifts Required From Providers

For health professionals to truly participate and encourage a shift in control from themselves to older people, they must be prepared to give up some of their power and status. These changes require a reorientation in training and education of all health and social care workers around the world (Beckingham & Watt, 1995; Clark, 1989; De Friese & Konrad, 1993). A part of these changes would be for care providers to ensure that their initial assessment of older persons is framed by a resolve to support self care and as much autonomy as possible and which is experienced appropriately by the resident.

The point is made under this section that health care professionals cannot empower people and that only people can empower themselves. However it is additionally noted that professionals are in the position to create an environment in which personal empowerment can occur, and to work actively to help balance care providers concerns and clients' concerns in a functionally interdependent way. Gibson (1991:16) views empowerment as the result of self awareness, self growth and resources and not any particular programme or service which may be provided. Clark (1989:283) concludes by stating that "unless empowerment becomes a theme characterising the philosophies of consumer, provider, and policy maker alike, it is likely that the empowered consumer will become the disappointed and disillusioned recipient of policies, programmes and decisions made by others.

To conclude this section the author wishes to draw on the thoughts of Heumann et al (2001:24) in their book 'Empowering Frail Elderly People'. They believe that the most basic principles of autonomy suggest that older people have the right to live at risk if they so choose, i.e. to make decisions with which family members and care providers may not agree with or understand. They form the collective opinion therefore that the "goal must be to create the most empowering environment possible, as a society, as care providers and as informal caregivers, so that at least older people who choose to live more healthfully and happily, have the freedom, resources, and power to make that choice".(Heumann et al, 2001:24) Heumann 2001 pertains to the notion of the creation of an empowering environment to the greatest extent possible, in as many ways as are achievable in society.

2.5 The Achievement of Empowerment

As previously mentioned, the ultimate goal of empowerment is the enablement of persons so that they can live in a manner whereby their ability is maximised to develop independent, positive and satisfying lifestyles. The achievement of this goal has been the subject of much consideration.

Myers, J (1995:111) proposed two perspectives through which this goal can be reached: external and internal. The external perspective sees empowerment being reached through groups, agencies, organisations and governmental policies. However, since the processes of ageing have their initial and greatest impact on individual members of the older population, it

is essential to focus on individual approaches to empowerment. Individual approaches to empowerment are those which are internal to the individual and affect their perceptions of empowerment.

2.5.1 Individual Empowerment

Individual Empowerment can be viewed as a complex, multidimensional and psychological process. It is best understood in terms of individual psychological factors. These factors when combined with environmental and societal changes in response to ageing can lead to a lack of empowerment in a previously independent person. The interaction which occurs between individual and societal changes in later life sets the stage for a negative, self-perpetuating cycle of “disempowerment”. At the same time factors which may lead towards reversing this negative spiral downturn become evident, so that a positive spiral of "re-empowerment" may occur.

2.5.2 Psychological concomitants of Empowerment in later life.

Let us now look at the psychological concomitants which have been aptly detailed by Thursz et al (1995). They propose that one of the major characteristics that older people have in common is the ability they possess to cope with the challenges and changes of later life and to adapt successfully to their varied life circumstances. The authors take the view that the majority of older people adjust successfully to the processes of ageing and experience a sense of life satisfaction in their later years. The authors go on to list the factors which they believe correlate with a feeling of morale (high life satisfaction) in later life. The factors include:

- a satisfying social support network
- adequate income
- good physical health
- adequate housing
- access to transportation
- independence

Even in the absence of these factors, the authors suggest that many older individuals still manage to experience a sense of contentment. While recognising this, the authors also recognise the negative sense of adjustment that can occur with the experiences of ageing. They state that “it is clear that some older people do not experience satisfaction or contentment, and that their internal reactions are unrelated to their objective life circumstances” (1995:112). The differentiating factor therefore is the personal opinions and attitudes of older persons towards their life situation. These are in turn affected by psychological factors related to empowerment, such as locus of control, self-efficacy and self- concept. Let us examine each one of these in greater depth.

2.5.3 Locus of Control

The term locus of control refers to how a person evaluates the level of responsibility that he/she correlates with events in his/her life. There are two different types of locus of control - those existing internally and those external to the individual. People possessing an internal locus of control perceive themselves to be responsible for, or in control of, the events in their

lives. People with an external locus of control perceive themselves as having little or no control over the external circumstances and forces which tend to determine the events in their lives.

A young person has the potential to experience a greater sense of personal power and therefore satisfaction, as they make decisions, which lead them in desired directions. On the other hand as people age they tend to experience changes over which they have less and less control and which can often lead them in undesired directions. Older persons may experience a loss of health, income, spouse or friends. They did not choose these losses but they must be endured. A young person may also stand to have any number of such losses. It can be argued however that they have “youth” on their side and the degree of finality of such losses is greatly reduced, compared with that of older persons. The consequence of such experiences for older persons is that their locus of control may shift from being internal to increasingly external. This may occur as they objectively re-evaluate their ability to influence the major events which occur in their lives.

2.5.4 Self Efficacy

The term self-efficacy was originally proposed by Albert Bandura (1982), as an explanation of behaviour and behaviour change. People are said to avoid the activities which they deem to exceed their coping abilities. Instead they undertake those which they consider themselves capable of handling.

Efficacy expectations can influence ones decision to attempt behaviour, the duration for which it will be attempted and the effort which one puts in.

Low-efficacy expectations in the face of obstacles can result in one experiencing serious doubts or of actually giving up. High efficacy expectations on the other hand, can result in greater levels of effort being extended in order to achieve desired results.

Many persons reach their later years with a high sense of self-efficacy, having learned that throughout their lives they were capable individuals whose efforts were rewarded. However circumstances and losses which can occur in later life, particularly those over which they have no control may lead to a dwindling sense of self-efficacy. This can occur in persons who may have felt far more confident in their younger years.

2.5.5 Self Concept

As older people experience a decreased and declining sense of personal power, they may also begin to question their own self worth, leading to a decline in their sense of self -esteem and self - concept. They adopt a new form of themselves, generally one that is less positive, determined and independent than was previously the case.

2.5.6 Social Breakdown

To look at how individual empowerment can be achieved it is necessary to first of all identify social breakdown the context in which it occurs and how it can be overcome or reversed. The social breakdown syndrome depicts the process by which vital, active older persons experience negative adjustments in later life. It illustrates the process of disempowerment and

defines the relationship between social inputs and self-concept, which results in a self-perpetuating cycle of negative psychological functioning.

A process of social breakdown sets the stage for and contributes to a self-perpetuating loss of personal power. Even older people who cope successfully with ageing may find that at some point the coping strategies utilised by them, which were once successful in helping them maintain independence, may be unsuccessful in helping them to meet the rising demands of later life.

Thursz et al (1995:113) illustrate this by the learning experiences of a man who experiences difficulty in reading. As the years pass the eyesight of the man gradually deteriorates. However, a visit to an ophthalmologist and the purchase of "stronger" glasses, correct the problem. Over the next 30 years, this pattern is repeated over and over again. At 75 years, he is diagnosed as having macular degeneration, which will eventually result in blindness. He cannot accept this fact, particularly from a "new and younger" doctor. He considers this new doctor to be the source of his problems and is instrumental in finding the response that he wants from the "right" doctor. His situation had worked for so many years but his changed circumstances now cause his solution to be ineffective. The process involves four stages, which replicate themselves in an increasingly negative pattern.

Stage 1-:

Older people experience a pre-condition of vulnerability, often resulting from pervasive negative attitudes towards ageing. Negative societal attitudes are often internalised by older people as self-descriptions - e.g. the loss of health and declining physical strength can cause doubts as to one's ability to continue living independently.

Stage 2-:

This stage is initiated as one or more people begin to express doubts as to the capabilities of an older person. Frequently, family members and friends innocently initiate this stage when they encourage an older person to re-think some of their activities, hopes or dreams. A series of suggestions, comments and advice from 'the professionals' sends a clear, though often unintended message to an older person suggesting that they are no longer the independent, respected person of earlier years. The older person is increasingly likely to question his/her abilities, when messages that one is "less capable" are sent from trusted friends, professionals and society in general.

Stage 3-:

At this stage, the older person is inducted into a 'sick role', synonymous with illness and dependence. Such a role is often adopted and deemed to be desirable by younger people, due to its temporary nature and the fact that it provides relief from responsibilities for a more or less infinite length of time. For older people the time out which the sick role provides is valuable

especially from work tasks, responsibilities and dysfunctional relationships, until one is 'well' again. However such secondary gains may not be realised due to the fact that they may not regain their health. As the older person enters more deeply into the sick role, he/she may lose their skills and capabilities for independent living as a result of disuse.

Stage 4-:

The fourth and final stage of social breakdown occurs as older persons continue to experience dwindling independent skills and behaviours. They continue to view themselves as increasingly sick and incapable. They internalise new self-perceptions of inadequacy and incapability's of continued levels of independence. Their level of self-efficacy becomes increasingly impaired and they experience few expectations of successful outcomes in relation to independence.

This cycle repeats itself, and with each repetition gains momentum and pessimism. As the individuals increase in age, they become increasingly susceptible to the negative evaluations and attitudes of others. The level of individual vulnerability also increases due to internalisation of new roles and increasingly negative self-perceptions. Gradually this cycle will lead, eventually to incapacity and death, in the absence of interventions.

The vulnerability of older people can be exacerbated by a number of important factors such as changes in perceptions of control from an internal to an external base, decreased self-efficacy and a reduced self-concept.

Additionally, psychological reactions, which contribute to breakdown include depression, discouragement, or learned helplessness.

2.5.7 Reversing Social Breakdown

The question that now needs to be asked is how one can reverse this negative, downward spiral?

The most effective way of achieving this is deemed to be, initially, paying attention to the underlying cause of social breakdown, which is a perceived and /or actual loss of personal power. It is possible to reverse the cycle so that it may be self –perpetuating in a positive direction.

2.5.7(1) Societal Perspective

From a societal perspective, this will require a change in the pervasive negative attitudes towards aging. The particular form of oppression arising from the social construction of older age had been called Ageism. Ageism has been defined by Butler (1987) “as the process of systematic stereotyping and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender.....Ageism allows the younger generation to see older people as different from themselves; thus they suddenly cease to identify with their elders as human beings and thereby reduce their own fear and dread of ageing

(Biggs,S 1993:85)

Societal inputs include the need to change ageist stereotypes and beliefs and to develop valued roles for older persons during their retirement years. In societies where older persons fill valued roles, the susceptibility to social breakdown does not exist. Many activities and roles can be meaningful for older people if valued by society. These include keeping ones extended family, grand parenting, and providing volunteer or community service. Roles which contribute to a sense of meaning and purpose for older people serve as barriers against social breakdown.

The encouragement of self-efficacy through empowerment is a vital strategy for interrupting and reversing the breakdown cycle. By helping older people experience a sense of control in the management of their lives, and by promoting older people as capable and self-determined, a sense of empowerment can be fostered.

Many older people could remain living independently if they had assistance with housekeeping, preparation of meals, transport to community services, hospitals, doctors, shopping centres, etc. Independent living will, in and of itself, foster feelings of self worth among older individuals. Interventions for independent living will have the most potential for being successful if they are consistent and occur early, thereby empowering the older person to be independent and capable of doing things for themselves.

2.5.7(2) Environmental Interventions

Environmental interventions are aimed at improving the adaptability of older people through the nature of and access to social services. These services constitute external empowerment and will be examined later in this section.

Empowerment is said to be self-perpetuating, through personal involvement in the decisions that affect one's life. Older people can therefore become increasingly empowered as they continue to make decisions that affect their lives in a positive direction.

Choice is a factor by which older people can also be empowered. To structure the environment whereby the older person can be allowed and even encouraged to make independent choices would be essential and valuable to the empowerment process.

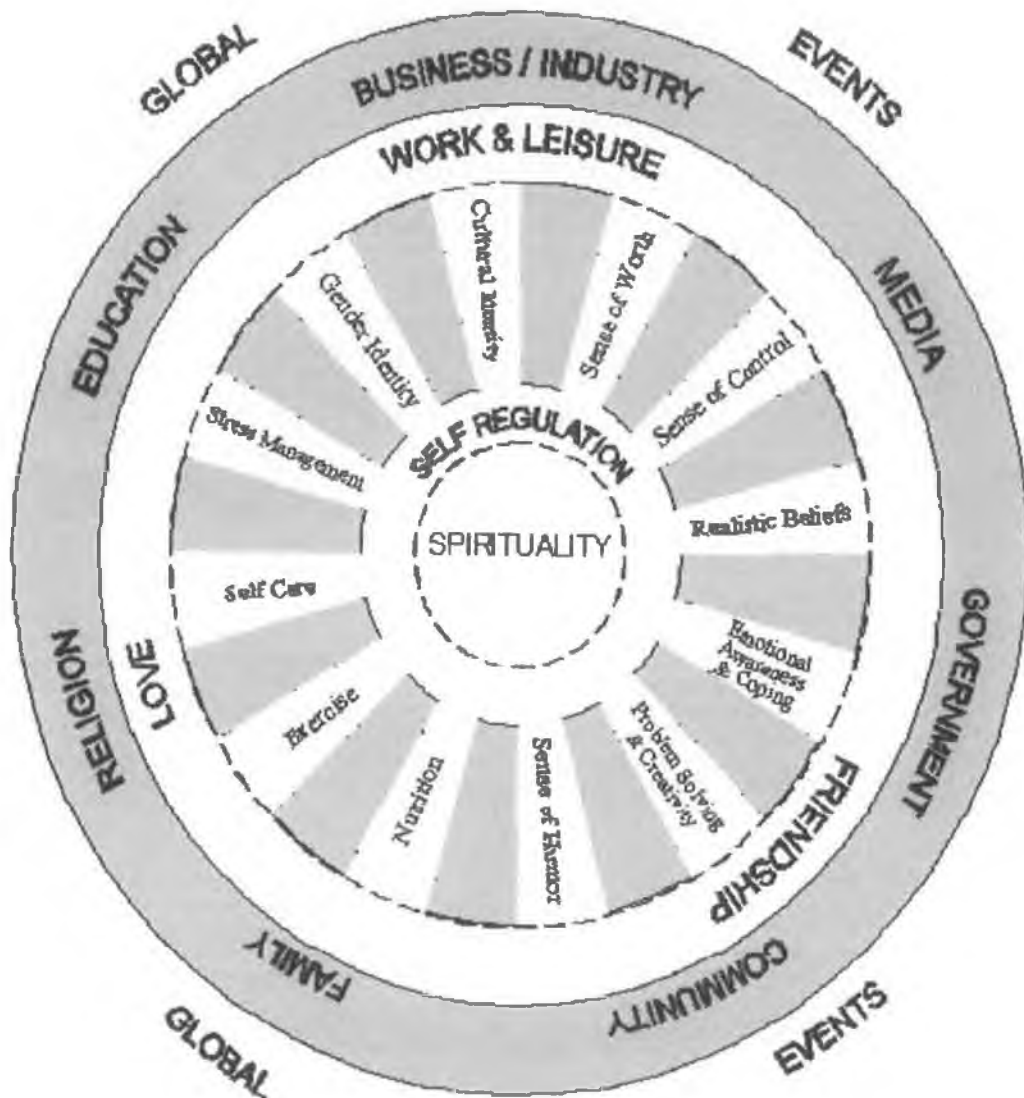
2.5.8 Empowerment through wellness

Viewing social breakdown from the perspective of prevention leads us to an emphasis on wellness. This in turn focuses on self-responsibility, on the requirement to be assertive in creating one's desired life rather than the passivity of simply reacting to circumstances. A wellness approach places a great deal of emphasis on freedom of choice, thereby increasing the responsibility of individuals for their own self-care. Wellness is essentially an empowering philosophy. It has the goal of helping individuals to identify areas of their lives over which they have control, and assisting them to make

healthy lifestyle choices which enhance their physical and emotional well being.

Witmer and Sweeney (1992) defined a useful model of wellness in assisting older persons to experience a sense of empowerment. These authors presented a holistic model for wellness and prevention, illustrated by a “wheel of wellness”. The model incorporates research and theoretical concepts from a variety of disciplines including anthropology, education, medicine, psychology, religion and sociology. It provides an integrated paradigm that can serve as a basis for theory building, clinical interventions, education, advocacy and consciousness raising.

Spirituality is the core of the wheel. The other four additional tasks are self regulation, work, love and friendship. The five life tasks exemplify the characteristics of a healthy person and interact dynamically with several life forces: family, community, religion, education, government, media and business/industry. The life forces and life tasks interact with and are affected by global events, natural and human, positive and negative. In a healthy person, all the life tasks are interconnected and interact for the wellbeing or detriment of the individual.



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 (Witmer & Sweeney's Wheel of Wellness (1992) adapted from www.mindgarden.com)

Witmer and Sweeney (1992) assert that a philosophy that emphasises wellness across the lifespan is one way to respond to the challenge of creating a world where empowerment is the norm for all persons, regardless of their life circumstances. Positive changes can occur through the facilitation of a positive and healthy environment, whereby 'professionals' communicate to older persons an inherent belief in their ability to assume responsibility for their lives and total well being.

Ruben Schindler, who spoke of “empowering the aged” in the *International Journal of Aging and Human Development* (1999:165), suggested a post modern approach. He felt that as the elderly population increases, so too does the theme of empowerment. He suggested that by introducing a post modern approach, the basic principles of social work could be enriched. Within this context, empowerment that includes opportunities for growth, mastery, significance and meaning could be substantially increased.

Mc William et al. (1994:327) writing in the *Journal of Science and Medicine*, spoke of a new perspective on the threatened autonomy in older persons- ‘the disempowering process’. They felt that empowerment strategies must encompass a client-centered approach, which would include an understanding of the clients’ mindset, goals, aspirations and sense of purpose within a larger life context. They firmly believe that such an approach is essential to enable older persons to maintain autonomy particularly in cases where continued health care is required.

In focusing on how empowerment can be achieved, the various elements of independent empowerment were addressed. The author identified social breakdown and the context in which it occurs, its various stages and strategies to reverse the cycle. In addition the author addressed the personal involvement of older persons within decision-making and the ability to make choices. Finally, linkages were formed between empowerment and wellness.

*Empowerment
Practices in
Residential Settings*

3.0 Empowerment Practices in Residential Settings

As noted earlier the external perspective sees empowerment as being attained through groups, agencies, organizations and governmental policies. Barnes and Walker (1998:198-206) identify what they believe are the key principles which should underpin attempts to empower users of health and social care services. They argue that the concept of empowerment needs to be understood as extending beyond those who are currently using the services.

Campling, J (1991) feels that for real empowerment to occur, power would have to be diverted from a number of groups, including professionals, informal carers, friends, central and local government and voluntary activists. For the actual power to be taken and used effectively by the service recipients, they would need to come to terms not only with the methods of utilising power but to be sufficiently self-assured as to their right to have it.

The substance on which empowerment is based is reiterated in the six service accomplishments as proposed by O'Brien (1990). These include presence, choice, autonomy, competence, status and participation. For the author, empowerment is not an additional value, since self-determination adequately covers it.

3.1 Self determination

The concept of self- determination was coined by Mc Dermott (1975), when he referred to that condition in which an agent's behaviour emanates from his own wishes, choices and decisions. Most human beings have a capacity for self determination, i.e. capable of making their own choices and decisions. This is essentially a form of freedom.

Those who are critical of the principle of client self-determination argue that the recognition of such a right is incompatible with the authority vested in social workers and other professionals- and the often controlling function they are required to exercise. They feel that any serious attempt to implement it in practice would be unworkable. In addition, they argue that self-determination is valuable either as a means towards the client's development, or as an end towards which he is to be led. Therefore the notion of the client having a right to self-determination is in any case superfluous.

3.2 Empowerment in action

Despite these opinions however, empowerment is being attained through groups and associations for older persons. Many such examples exist in society today. "Age and Opportunity" is one example of an empowering agency that works on a national level to challenge the negative attitudes to ageing and older people and to promote the participation of older people in society. They publish a newsletter entitled 'Challenging Attitudes' on a quarterly basis. Within its covers, one may access information on physical

activity, participation in the arts, education and lifelong learning, health, equality issues, etc. All these topics enable and encourage the participation of older persons and provide on-going support to help older persons respond to the challenges they face as they grow older. The distribution of this newsletter is on a nationwide basis, however despite this it is not freely available to staff and patients/residents in statutory and voluntary facilities.

One programme documented in the newsletter is a programme of Adult Arts Education at the Irish Museum of Modern Art (IMMA). The programme had a tremendous impact on the lives on the participants. “It has brought a greater sense of self-empowerment, more confidence, a greater ability to speak out and the ability to be, once more self-reliant and more connected. The participants also believed that they would live longer as a result on their participation on the programme.”

(Challenging Attitudes, Autumn/Winter 2000)

The Helping Hand organisation, based in the United Kingdom, had Empowerment as its agency theme 2000-2002. This organisation is concerned with issues in relation to older persons, promoting help and support and ameliorating their life chances. They define empowerment as “to give power or authority to someone - someone powerless”. It is a process in which social workers help diminish the feeling of “powerlessness of the elderly”.

By “Empowerment” they mean the ‘core’ of power, their self-esteem.

People living in old age homes frequently put themselves down, diminish their qualities, abilities and achievements, and blame themselves for having to live in nursing homes. Self-blame is disempowering and self-destructive.

"Empowerment" they feel is about how elderly residents can be encouraged to feel part of the home and to make the sort of decisions they would make at home. The role of the care staff is therefore to create an open and friendly environment where the residents feel at ease to voice their problems and to help them get assistance when required.

In essence empowerment is a concept, which enables older people to become more actively involved in the decisions which affect them and which are often made by others on their behalf. Organisations which enable older persons to become more active participants in their lives are invaluable to the older person and equally society. If such empowerment interventions are invoked early, they may even increase the longevity of individual lives and possibly decrease the need for alternative forms of care if social breakdown should occur.

Many organisations that exist to enable and empower the elderly have in the past had a relatively low status in society. This may be due to the lack of governmental recognition, funding and awareness of their existence among the older population. In the past their true value and contribution to society may have been under played and unrecognised.

3.3 Government Policies

The Government has been instrumental in the promotion of lifelong learning or 'learning for life' through the white paper on Adult Education (2000).

This paper allows older people to return to education through its 'back to education' initiative. It acknowledges that older people are particularly disadvantaged in relation to information technology by comparison with younger people. To this end a National Information Technology Programme is to be established. It also recommended the establishment of a National Learning Council and Local Adult Learning Boards. However it is difficult to initiate a lifelong learning programme without these relevant structures being put in place. The author believes that this 'back to education' initiative not only recognises the disadvantage which older people have in relation to education, in particular information technology but that such initiatives foster self empowerment, increased confidence and feelings of value and worth within society.

Similarly legislation is frequently put in place which often excludes the interests of older members of society. The Employment Equality Act, which came into law in October 1999, is one such act. It affirms the right to equal treatment for older people in the workplace and it is intended to protect the rights of older workers in recruitment, conditions of employment, training, promotion and dismissal. Despite this fact, the act excludes people aged 65 and over from its protections. The act itself discriminates against older persons of 65 and over, leaving opportunities for age discrimination by employers. Niall Crowley, chief executive on the Equality Authority said,

“The bulk of enquiries received under the new legislation are based on the gender ground. However age and disability are emerging as the most prominent of the new grounds”.

(Challenging Attitudes, Spring/Summer 2000: 3)

However, talking and writing about concepts such as participation, involvement, partnership and empowerment, even understanding the concepts at a theoretical level, does not necessarily make them happen. This has been highlighted by Kemshall & Littlechild (2000:9) who stated: “What makes a difference in practice is the will and commitment in the hearts of those with power to meet the challenge and demands of those excluded and to change the nature of the relationship between them.”

3.4 Local Initiatives

Health Boards and Local Authorities are relied upon to empower older people through programs such as Health Promotion and specialist programs, such as Choice. Choice is an action plan to enhance quality of life for older people. It was prepared by a Project Group Representative of older people, Health Board staff and voluntary groups. This action plan recognises that older people are a growing proportion of the population and with this in mind they pose different economic and social challenges which are only beginning to be identified. How these challenges are to be addressed should be influenced by older people themselves.

From this perspective older people seek a new vision of care, which is to be firmly established on the important principles of respect, dignity and choice. This vision highlights the need for the holistic approach of the consumer orientation and an acceptance of the importance of home and community care.

Thus a new perspective is introduced which moves the planning and delivery of care from a service driven approach to a needs led programme of care which places the recipient of care at the centre- person centred care delivery. This new perspective embraces the notion of totality of human needs where physical health is not the only element of the well being of older people-social, emotional, intellectual and spiritual care needs must also be taken into account.

The overall objective of the Choice programme is to build a system of care on the choices of older people and respond to their lifetime opportunities and needs. This action plan embraces and supports the principles outlined in “Shaping a Healthier Future”- A Strategy for Effective Health Care. The principles are: equity, quality, effectiveness, accountability and efficiency. The target area of this action plan is Sligo, Leitrim and West Cavan. Such a program is a significant development for the health, care and independence of older persons. In addition the Choice programme moves service delivery away from:

- Over protective care.
- The “doing for” mentality.

The acceptance of the principles underlying the Choice program and their anticipated practical effects challenge the thinking of health professionals and change the way services are delivered. Such programmes are important for the achievement of empowerment and social change. Services are therefore shifted in the direction of encouraging independence and choice, working 'with' as well as 'for' people and the provision of flexible services which support self sufficiency in older people. (North Western Health Board 2001)

3.5 Community and Residential Services

The strategic aim of the Health Strategy is to enhance the quality of life and improve longevity for older people. It is hoped that this strategic aim can be achieved by promoting lifestyle changes, the creation of supportive environments and the provision of appropriate services for older people.

Empowerment can be achieved within organizations that care for older persons. Health statistics featured in the Health Strategy (2001) referred to extended care for the elderly in Ireland. The following information was highlighted:

- 32% of older persons are in Private Nursing Homes.
- 12% of older persons are in Health Board District / community Hospitals.
- 31% of older persons are in Health Board Geriatric Homes / Hospitals.
- 5% of older persons are in Health Board Welfare Homes.
- 19% of older persons are in Voluntary Geriatric homes / Hospitals.

The principle of consumer-oriented services was adopted in the 1994 Health Strategy document “Shaping a Healthier Future”. Shaping a Healthier Future (1994) sets out the overall objectives which guide the health and social service provision for older people. These are -:

- To maintain older people in dignity and independence at home.
- To restore to independence at home those older people who become ill or dependent.
- To encourage and support the care of older people in their own community by family, neighbours and voluntary bodies in every way possible.
- To provide a high quality of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

The central thrust of these objectives is to promote independent living and community based care for older people, and to regard hospital and residential care as a last resort, rather than a first option for those who can no longer live satisfactorily in the community. The principles underlying the strategy as previously mentioned are equity, effectiveness, accountability, and efficiency.

The action plan of the strategy reiterated the objectives of the 1988 ‘The Years Ahead Report’ and placed a priority on promoting healthy ageing, funding the Health (Nursing Homes) Act 1990 and the provision of additional convalescent care and small scale nursing units.

3.5.1 Preferences for Long term Care

The preferences for long term care were explored by the Health and Social Services for Older People report (HESSOP). This study was commissioned by the National Council on Ageing with support from the Western Health Board and the Eastern Regional Health Authority Area Health Boards. This study was conducted and undertaken by the Health Services Research Centre, Department of Psychology and the Royal College of Surgeons in Ireland (2001:23). It documents older people's views on their health and social services use, experiences and needs.

When older people, who took part in the study were asked about their wishes were they to need long term care in the future, there was a clear preference for being cared for in their own homes with minimal health service involvement. The majority of those studied 87% wished to continue to live in their own homes. Over half of the group was hopeful that they would be cared for by family and friends, while one quarter of the group did not have a preference and a similar number stated that they preferred the help of professionals. Professionals were preferred for the more intimate personal care tasks as opposed to household tasks.

In relation to considering options which involved moving from their current residence to another residence while still remaining in the community, the strongest preference was for an independent dwelling attached to a relatives home, such as a 'granny-self contained' flat. Forty per cent said that they would opt for this while twenty five per cent would accept living with a

relative- either with or without respite services. One in four of those studied would accept moving to sheltered housing as a community based option,

Smyth (1992) recognized that the care of the older client takes place in many settings. Wherever possible, it was felt that the aim should be for this care to take place without the older person having to leave his or her home on a permanent basis.

3.6 Consultation Orientations

The HESSOP study (2001) in conjunction with the National Council on Ageing and Older people notes that the rhetoric of consumer orientation had found its way into the strategy and policy document of the Irish Health and Social Services system. However it also recognised that the aspiration is far from being realised. The report looks at two models of consultation orientation in terms of social services, namely the Consumerist approach and the Democratic model.

The Consumerist approach refers to a situation where people are given only limited opportunities for involvement and participation. The Democratic model, in contrast, is where service users take an active role in the decision making process, including how services are developed, structured or provided. Democratic strategies for consultation are empowering and capable of strengthening the commitment of people to a better health and social system, while increasing their own sense of control over their lives.

3.6.1 Strategies and Values as the basis of Good Quality Care

The Helping Hand organisation which is based in the United Kingdom, believes that principles espoused in programs, projects and activities will enable the elderly to empower themselves, through how they think, feel and behave. This organisation is concerned with issues in relation to older people, promoting help and support and ameliorating their life chances. Staff too, must enable the elderly in residential settings, to see how past and present situations and interpersonal relations impact on their present lives. These undertakings empower the individual to identify where to change attitudes, strategies and behaviors in order to live a life as he /she wants.

This organisation believes that both the elderly and staff members should be encouraged to harness their inner power by the following strategies:

- Strengthening their knowledge of rights and responsibilities, both in their communities and in society.
- Enabling them to acknowledge their qualities, abilities and achievements.
- Showing them ways to take care of themselves both physically and psychologically.
- Enabling them to confront difficulties as they arise.
- The harnessing of such ‘inner power’ aids the process of empowerment within the residential setting. (www.Helpinghand.org)

The 1990 British Social Services Inspectorate published a report about the care of older people in residential homes. It proposed six important values

that ought to form the basis of good quality care for the older person.

Although primarily concerned with residential care, the values also apply to good care in general:

- Choice- the opportunity to select independently from a range of options.
- Rights-the maintenance of all entitlements associated with citizenship.
- Fulfillment- the realization of personal aspirations and abilities in all aspects of daily life.
- Independence-opportunities to think and act without reference to another person including a willingness to incur a degree of calculated risk.
- Privacy-the right to be alone or undisturbed and free from intrusion, or public attention in relation to individuals and their affairs
- Dignity-recognition of the intrinsic value of people regardless of circumstances by respecting their uniqueness and their personal needs.

(Caring for Quality; Guidance standards for residential homes for elderly people (1990))

3.7 Advocacy in residential settings

In addition to empowerment, another concept has been utilised in relation to residential settings, namely advocacy. Brearley (1990) defined advocacy as “enabling residents to express their views freely and seek satisfaction for their needs because they have a right to do so” (1990:198)

He provides an example of advocacy in terms of a person with learning difficulties and is assured that the same principles equally apply to elderly residents. He identifies the various types of advocacy such as:

- Helping residents to assert their own rights.
- Legal advocacy.
- Financial advocacy.
- Formal guardianship arrangements which may involve a legal element.

He also identified the strategies through which the different advocacy types can be achieved- providing emotional support, companionship, spokespersonship, opportunities to learn new skills and help in obtaining needed services. Advocacy has been equated with speaking out. Perhaps this is what Sir Peter Ustinov meant when he gave advice to older people during the UN International Year of the Older Person (1999):

“Speak louder, listen more and say what you think”

Residential care for older people is closely linked in many people’s minds to old age, both for younger people considering their own ageing and as a concrete option for elders who encounter increasing difficulties in daily living (Biggs 1993:146). Older people themselves may view such an option in negative terms as it may equate with powerlessness, routine, lack of choice, exclusion from ones peers, family, community and everyday life. It is an option of last resort when the person experiences a failure to cope with difficulty rather than finding an arena in which further potential can be achieved.

It is apparent that the same degree of choice, independence and freedom exercised by someone in the community is less available to the average resident, for whom such things as meal times or choice of food tend to be determined by routine and convenience. However this need not be the case.

3.7.1 Nursing Home Regulations

Under the regulations for Nursing Homes (1993), the welfare and well being of residents is set out under articles 5 & 6. Choice is provided for under Article 5 Section (f) of the Act: ‘freedom to exercise choice to the extent that such freedom does not infringe on the rights of other persons’.

The personal possessions of older people are provided for under Article 8, which states that the registered proprietor and person in charge of the nursing home shall ensure that:

- (a) Provision is made for the safe keeping of the personal belongings of a dependent person and a record kept of valuables signed by the person or a person acting on his or her behalf;
- (b) Adequate space is provided for a reasonable number of personal possessions.

This article allows for older people to have a number of their personal possessions around them so that they remain individuals while they reside in residential care services.

Having one’s possessions in close proximity generates feelings of comfort, familiarity and individual identity for all of us, particularly those in care,

who have been required due to illness, dependency, etc, to leave their familiar surroundings and possessions behind them. The implication of this document for each individual in care ensures that their sense of identity, dignity and belongingness are maintained despite the circumstances and surroundings which they find themselves in.

3.7.2 Promotion of Independence and Participation

The International Federation on Ageing (IFA) Declaration on the Rights and Responsibilities of Older Persons (1991) contains subsections with regard to independence, participation, care, self –fulfillment and dignity of the older person. Residential care is included under each provision stated. Similarly there is a Charter of Rights for the Elderly in Ireland. Both of these documents provide sufficient evidence and appropriate provisions for the empowerment of older members of society, particularly those in residential care. The Irish Congress of Trade Unions, and the National Federation of Pensioners Association, has adopted the Declaration on the Rights and Responsibilities of Older Persons and the Charter of Rights for the Elderly in Ireland, for promoting independence and participation of the older person in society.

3.8 Empowering Practices in Residential Settings

The key initiatives for empowerment have been addressed by Braye and Preston-Shoot (1995). They provide an illustration of the various steps which should be taken to reach the level of empowering practices in residential settings.

Empowering practices can occur within the residential setting with the co-operation, willingness and the combined ability of the staff team. The flexibility of management and staff within each nursing home and their willingness to adopt an empowering model of practice are essential components to its achievement. Practices that are carried out on a daily basis, e.g. choice of food and meal times, choice of getting up early or staying in bed late, choice of part taking in activities, etc, can be altered from being determined by the routine of staff members within the nursing home to the choice and preference of each individual resident. Other matters to be considered include personal possessions, pets and personal finances.

Questions need to be addressed such as:

- Are residents allowed to have a say in the way in which their rooms are arranged?
- Are residents given tasks and responsibilities?
- Are residents encouraged to be as independent as possible?
- Are residents afforded the freedom to develop friendships and relationships?

A study carried out by the National Council for the Elderly (1986: 77), focused on Nursing Homes in the private and voluntary sectors in Ireland. The research identified the proportion of Nursing Homes for the elderly which provided selected facilities for residents. These facilities included:

- * Curtains around beds in multiple rooms
- * Facility to lock own cupboard

* Permission to keep personal property

The results indicated that a higher proportion of people were permitted to keep personal property than the other two categories. This research indicates the level of facilities which were provided to residents in 1986 in the nursing homes selected for the study. The results obtained from this study identify that greater emphasis was placed upon possessions as opposed to a limited level of privacy.

Times for retiring to bed and getting out of bed were highlighted as part of the same study (1986:77). The focus of this part of the study was placed upon the person(s) who determined the bed times of residents. Three categories were selected and focused upon, these are:

- * Set by the home
- * Up to the residents
- * Times set for some residents

The findings which resulted identified that 60.3% of the time, bed times were determined by the residents, 26.6% were set by the home for some residents and only 13% were set by the home. These results are quite positive, particularly when derived from a study completed in 1986 as over sixty per cent of the time, bed times were determined by residents. These results imply that residents played a role within the nursing home as they decided on their own bed times. As a result their preferences were taken into account. It is however unclear, beyond these results, as to the level of involvement which older people had in practices within each nursing home.

3.9 Barriers to Empowerment

The barriers and defenses to empowerment have been identified by Braye and Preston-Shoot (1995:109). They provide an eloquent account of the barriers, which they have subdivided into forces working for, and resisting change. These are illustrated by the use of a diagram, (1995:111)

3.9.1 Organisational Resistance

Lupton and Nixon (1999:30) maintain that the greatest barrier to empowering ways of working is that of professional resistance. The fear derived from professionals in the form of resistance stems from the fact that, by empowering those with whom they work professionals will have to limit or surrender their own power and control. This perception fails to recognize the possibility that working in more empowering ways may enhance the power of the professional as well as that of clients. Professional insecurity and fear can manifest as defensiveness and resistance, as defeatism, oversimplification, endless debate, reliance on rhetoric and discounting of users abilities.

3.9.2 Service Users

Barber (1991:109) felt that service users often enter the relationship with social care agencies from a structural position of powerlessness, suspicious, perhaps through previous experience, of the motives of professionals and in personal distress compounded by services which deny choice and dignity, and are sometimes underpinned by the threat of compulsion.

Many older persons may be disinclined to empowering ways of working. Several writers have made the point that it may be extremely difficult to take up the opportunity of empowerment if one has been disempowered all one's life. (Ward and Mullender, 1991; Braye and Preston-Shoot, 1995)

Long-term service users often resign themselves to the fact that the "professional knows best". This arises from a phenomenon of 'learned helplessness', in the face of professional decision making, resulting from an acquired inability to make choices for oneself. This desire to retreat from responsibility, choice and decision making may be the result of wanting to avoid regret over the unsuccessful outcomes of choices made (Shackley and Ryan, 1994).

Clients may be disinclined to speak out against a service which is provided to them due to several factors:

- * Fear of further deterioration of the service
- * Fear of repercussions for 'speaking out'
- * Lack of confidence that things will change

Finally for those who are not committed to the idea of empowerment, the belief in the apathy of service users may be taken to justify more traditional, paternalistic, ways of working.

3.9.3 Institutionalisation

Smyth (1992:28) believed that institutionalisation is a barrier to the process of empowerment whereby older people simply conform to and accept the

routine which is in place. Residents in nursing and care homes are especially vulnerable to institutionalisation as they may be less mobile and often less psychologically alert to assert themselves. He provided a list of symptoms whereby one could recognise institutionalisation in older people. These are:

- Apathy- little motivation is displayed to do more than conform to the routine.
- Withdrawal- no wish to communicate with others apart or beyond what is absolutely necessary.
- Reduced eye contact.
- Few changes in facial expressions.
- Head in a bowed position.
- The failure to argue or answer back and simple acceptance of whatever happens.

In addition Smyth proposed some causal factors of institutionalisation.

These include:

- Staff attitudes- being rather bossy, even in a kindly way.
- A regime of care that is rigid and cannot respond to individual needs.
- An environment that is drab and institutional, with little opportunity for clients to make it their own.
- A closed rather than an open atmosphere, where few outside visitors are seen.
- A low level of stimulation, with very few activities on offer.
- Lack of opportunities for residents to get out regularly.
- Little privacy for residents. (Smyth 1992:28)

3.9.4 Additional Factors

Several other factors may contribute to the lack of empowerment, or its less than frequent implementation within a residential setting. These may include the time factor, staff shortages, lack of resources, attitudes of management and staff and the client's own perceptions of being disempowered.

3.9.5 Conclusion

Empowerment is a concept that has evolved over time. It is a concept which has been accepted internationally and valued as an end in itself and as a means of achieving social change. Change dictates that old philosophies are no longer valid and possess little value. New perspectives are dawning with regard to the care of others, in particular older people. These new perspectives encapsulate choice, respect, rights, independence, fulfillment, privacy and dignity for older people. The planning and delivery of care is moving towards a client/person centered needs led programme as opposed to the earlier service driven task orientated approach.

As a concept empowerment is firmly rooted in the discipline of Human Resource Management where theorists integrated the approaches to empowerment from management and psychology literature, conceptualising it as a motivational process. It can be ascertained from the work of theorists with a background in management the value of effective empowerment and the factors instrumental in the creation of an environment which lends itself

towards empowerment, both from the aspect of organisational characteristics to that of members of staff and management.

Empowerment has a political history which is firmly rooted in British social policy and public service development. Its significance has spread to all areas of the social care arena, particularly those with disabilities and older people. However Heumann et al, (2001:254) assert that society as a whole must embrace the values and commit to the planning, research and use of resources towards the goal of empowerment of all people.

They assert that as a society we continue to embrace our fears of ageing, to see ageing as pathology rather than a natural and fulfilling completion of life. Service approaches to ageing are predominately focused on the extension of life, not the quality of living in old age. As long as this value system exists, we fail to bring resources or human creativity to restructure the existing conceptualisations, fail to design environments to facilitate and empower older people and fail to completely encourage and support older peoples' efforts to empower themselves.

In essence, the achievement of empowerment requires both clients and professionals to become jointly involved to ultimately ameliorate their apparent positions. When this occurs, both groups ideally are enabled to work together to maximise their circumstances and quality of life.

Research

Methodology

4.0 Research Methodology

This study aims to make comparisons between the voluntary and statutory services for older people in County Cavan with particular reference to levels of understanding and application of the concept of empowerment in residential service provision.

The author had set out defined objectives with which to achieve the aim of the study:

- To identify the levels of knowledge and awareness of management and staff in relation to the concept of empowerment in the organisations selected for study.
- To investigate the perceptions of management and staff in relation to the levels of empowerment which exist within the chosen organisations.
- To investigate barriers to incorporating an empowering model of service provision for older persons in the chosen organisations.
- To investigate factors which facilitate the inclusion of empowerment in service provision in the selected organisations.
- To compare and contrast the approaches to empowering practice observed in voluntary and statutory organisations.
- To make recommendations with regard to the adoption of the principles and practice of empowerment in residential services for older people.

In fulfilling the objectives the author initially undertook an extensive review of literature related to empowerment and its practice in many different areas- Human Resource Management, Politics, Social Policy and Social Care. Current and historical documentation were reviewed as well as the application of models of empowerment in care settings from a national and international perspective. In addition to academic publications, sources of information that were utilized included various publications by voluntary and statutory organizations, such as the National Council for the Aged, The North Eastern Health Board and the Department of Health and Children.

The author wished to identify and focus upon the nursing homes and care facilities within County Cavan. The author sought to adopt a comparative approach to the level of empowering practices observed in voluntary and statutory organisations which offer care for older persons.

County Cavan is served by five statutory care services for the elderly, provided by the North Eastern Health Board. The voluntary – privately run sector has six care facilities throughout the county. The author initially intended to conduct the research in all existing services for the elderly. However, only eight services were willing to participate in the project. As a result the research was carried out within four services from the voluntary sector and four from the statutory sector. The organisations which took part in the research process are as follows:

Voluntary Sector

- *Esker Lodge Private Nursing Home*
- *Fairlawn's Private Nursing Home*
- *Omega Private Nursing Home*
- *St. Josephs Private Nursing Home*

Statutory Sector

- *Breffni Care Centre*
- *Jack Sullivans Memorial Home*
- *Virginia Health Care Centre*
- *Lisdaran Unit for Elderly*

4.1 Scope of the Study

The author wished to focus specifically on the perceptions of staff in relation to the concept of empowerment. It was hoped that this specific focus on the perception of members of staff would provide a varying perspective in relation to pieces of research which had been carried out in relation to older persons, in the past – the perspectives of older persons as clients are often brought into focus as opposed to the perspectives of staff. It was felt that if members of management and staff possessed a good knowledge of the concept then this would be reflected in their work ethic and practices and would be conveyed to those in their care.

The author felt that it was necessary to utilise a combination of Quantitative and Qualitative data for this study in order to yield the greatest results possible. The author initially adopted a qualitative approach in the form of semi structured interviews with a senior member of staff, namely a matron or nurse manager. The author chose to adopt a qualitative approach to gain in-depth information and to adequately explore topics which the author felt warranted deeper exploration and analysis than any quantitative method could yield. The author felt that the perceptions of those who lead and influence others is vital, as the feelings, thoughts and abilities which they possess is in part transferred to those who work with them and those who depend on the care they deliver.

In addition the author felt that in order to gain an insight into the perceptions of the various members of staff in each organisation and to gain general information from respondents in each organisation, it was necessary to carry out a questionnaire survey utilising closed and open ended questions. The author distributed ten questionnaires to each organisation and these were in turn distributed to ten members of staff in each of the nursing homes and care facilities who took part in the research process. Distribution among the various members of staff in each organisation was left to the discretion of each person who had been interviewed by the researcher.

The author chose to provide each organisation with ten questionnaires despite the possibility that additional questionnaires may have been completed in various organisations. The author felt that due to the size of some of the organisations, it would be better to provide an equal number to each, with the knowledge that there were sufficient staff members to complete and return them in each organisation.

4.1.1 Respondents in this Study

The author sought to interview a leading member of the staff team within each Nursing Home. The researcher's criteria for selection were as follows:

- Each person interviewed must hold a managerial / senior position within the Nursing Home.
- Each person selected must be willing to participate without coercion and must be previously informed by the researcher as to the nature of the study.
- Each person must have a key role in influencing others with whom they work.
- Each person must, in addition be willing to distribute the questionnaires to other members of staff and be responsible for the collection of such.

4.1.2 Seeking Organisations for the research process

The researcher initially wrote to all the Nursing Homes to inform them of the nature of the proposed study and to request their participation in the research. This letter was then followed some days later by a telephone call to a leading

senior member of staff, usually a Matron/Nurse Manager. After this stage of contact, particularly when the previous efforts of the researcher had not yielded a positive result, the researcher sent an additional letter stating that the sole purpose of the researchers visit was academic research. This action was deemed to be necessary as some potential respondents expressed concern regarding the research process and the intended purposes of the material collected. In addition it was necessary also to point out that the research was not an inspection of any kind nor an opportunity on the part of the researcher to be critical of the current level of service provision that was provided in each organization. After a further telephone call the participation of all those who wished to co-operate with the research from the voluntary sector, was established.

In order to secure the participation of the statutory services, clearance had to be sought from the North Eastern Health Boards Freedom of Information Officer and NMPDU. The researcher was required to forward a copy of the proposed questionnaire, interview format and any additional aspects and information relating to the research process, before the research process could be instigated.

4.2 Qualitative Methods

Qualitative research refers to a number of methodological approaches, based on diverse theoretical principles, employing methods of data collection and analysis that are non-quantitative, and aiming towards exploration of social relations, and describes reality as experienced by the respondents (Sarantakos

1998:6). For some, qualitative methodology is everything that is not quantitative, for others it is viewed as its opposite or alternative and as a supplement to quantitative research.

Smith (1992) found that in principle, qualitative methodology demonstrates the following characteristics:

- Assumes that the social world is a human creation not a discovery; consequently interpretative science tries to capture reality as it is- as seen and experienced by the respondents.
- Attempts to capture reality in interaction.
- Attempts, to present the information gathered verbally in a detailed and complete form.
- Perceives the researcher and the researched as two equally important elements of the same situation. Respondents are seen as parts of the whole.
- Aims to study reality from the inside not from the outside.
- Interprets meaningful human actions and interpretations that people give of themselves or others.
- Aims to understand people, not to measure them
- Employs research procedures that produce descriptive data, presenting in the respondents' own words their views and experiences.
- Leads to an interpretative inquiry which ultimately is a moral inquiry.

(Sarantakos, S 1998: 46)

Four important criteria distinguish qualitative interviews from that of quantitative measures:

- They use open ended questions only
- They are predominantly single interviews, questioning one person at a time
- The question structure is not fixed or rigid; allowing change of question order even the addition of new questions where necessary.
- They offer interviewers more freedom in presenting the questions, changing wording and order, and adjusting the interview so that it meets the goals of the study.

(Sarantakos, S 1998:255)

Lamnek (1989) identifies the following methodological aspects and technical elements of qualitative interviewing:

- *Reflexivity* - employs methods and a process of analysis that reflects the nature of the research object rather than the methodological conviction of the researcher.
- *Naturalism* - directed towards studying everyday life events.
- *Primacy of the respondent* - respondents are experts who provide valuable information. They are as important as the researcher and not just a source of data.

- *No standardization* - guiding element of the interview process is the respondent in his everyday life, not the methodological expertise of the researcher. As a result, qualitative interviews are unstandardised interviews
- *Communicativity* - expressed in communication; this system of communication determines the course and structure of the interview.
- *Openness* - Qualitative interviews do not use a strictly standardized approach but they employ a readiness to change, to correct and adjust the course of study as required by the research. Interviewers are expected to engage in an open discussion with the respondent, and to maintain a passive and stimulating, but not dominating role.
- *Flexibility* - The researcher remains flexible and follows the course that emerges through the interview.
- *Life as process* - Qualitative interviews ascertain aspects of personal experience as displayed in everyday life.
- *Grounded theory* - In most cases the aim is to develop a data-based, grounded theory.
- *Explication* - Findings emerge through the study and are interpreted during the process of interviewing.

(Cited in Sarantakos, S 1998:256)

4.2.1 Accuracy and Validity

The use of qualitative research methods calls for particularly rigorous attention to be paid to accuracy and validity in the collection and interpretation of data.

Informal interviewing gives much greater scope to the personal influence and bias of the interviewer than the formal interview, in that the interviewer at least partly determines what form the interview takes, what questions are asked, and what details are recorded. There is, in the report of the informal interview, “more of the interviewer than on standard survey questionnaire, which is another way of saying that the process is often not so reliable” (Moser and Kalton, 1971:299)

Another objection to informal methods is the difficulty in quantifying and summarizing the material. Moser and Kalton view this quandary as having three distinct aspects:

1. As interviewers are free to determine the run of the interview, different items of information may be obtained from different respondents, so that it is difficult to compare and aggregate the results.

However the diversity in responses while making comparison and aggregation more difficult, also allows for the free expression of multiple perspectives and the elicitation of unprompted accounts.

2. Even in cases where interviewers have asked for the same items, differences in wording and so forth may make the answers not truly comparable.

Although the responses obtained may not always be comparable, the unique perceptions and perspectives of respondents can be expressed and attributed importance by the researcher.

3. The results of the descriptive, non-quantified interviews do not easily lend themselves to statistical analysis as answers to straight questions do.

Statistical analysis is important for many aspects of research however it does lend itself to the presentation of multiple perspectives associated with and reliant upon descriptive responses, such as those which the author wished to focus upon.

Given that the main objective of qualitative approaches is to obtain a more enhanced holistic representation of a person's attitude than a formal interview would, the analysis must preserve a substantial amount of detail.

The advantages of qualitative interviewing have been stressed by many writers, such as control over the identity of the respondent, order of the questions, environment, time, date and place of interview. Ease of administration, opportunity to observe non-verbal behaviour, to record spontaneous answers and the additional capacity of correcting misunderstandings by respondents are also regarded as advantageous. However the greatest advantage of the qualitative approach is the quality and depth which can be ascertained from respondents. The acquisition and presentation of such quality and depth is by far a more laborious process, conversely, as it provides an insight into the perspectives held by those who hold a position of influence, leadership and authority upon other staff members.

4.3 Interview Technique

The interviews were semi- structured, the researcher having an inventory of topics and areas to cover. The researcher encouraged the respondent to talk freely and to raise issues which he or she believed worthy of inclusion. A relaxed and quiet setting set the ambience so that the respondent was at ease and free to formulate responses the way he or she deemed to be most appropriate. A guided or focused interview was the method chosen as it permitted the respondent freedom to develop those issues of greatest significance to their personal experience whilst also aiming for a given set of topics to be covered in a systematic way. There was no set format, but the interview was guided around certain issues which were initially felt by the researcher to be relevant in the light of the overall research focus. This method provided ample freedom to formulate questions and to determine the order of the questions. In addition it maintained the possibility to embrace further issues, not anticipated by the researcher. The researcher could decide the order of the questions and the depth of exploration required to clarify related issues as they evolved, while at the same time adhering to the framework of issues to be discussed

4.3.1 Items of information

The interview explored a variety of areas in relation to all nursing homes and care facilities in the study. The information collected from the interview

provided a base of general knowledge regarding each nursing home and care facility:

1. Categories of staff.
2. Staff / Client ratio.
3. Facilities which the organisations possess and which currently exist on the premises.
4. Existence of a Mission / Quality / Safety statement.
5. Whether Empowerment is looked upon as a working principle or an abstract concept that has no place in reality.
6. Frequency of the occurrence of empowerment.
7. Examples of typical empowering practices which occur.

4.3.2 Exploration of topics

The interview explored a number of topics in addition to the exploration of general information regarding each organisation:

1. The respondents' perception of empowerment.
2. Impact and influence of the role of members of staff and the extent to which they engage in empowering practices.
3. Barriers and impediments to the practice of empowerment within each nursing home and care facility.
4. Factors which facilitate the inclusion of empowerment.
5. Strategies to overcome challenges and limitations to empowerment.

A total of eight interviews were conducted, one within each facility which participated in the study. Interviews took place within each Nursing Home on a previously agreed date and at a time suitable for the respondent. Interviews frequently took place at quieter periods, e.g. between meals. Interviews were completed between the periods of February 2004 to April 2004. Each interview varied in length, the shortest being half an hour and the longest lasting just over an hour. The interview lengths varied depending on a number of factors such as time constraints, workload, comprehension of the issues involved and ability to engage in and articulate the subject matter. At the conclusion of each interview respondents were afforded the opportunity to offer any additional comments or raise any issues which they deemed worthy of note.

4.3.3 Interviewer Bias

As previously noted, informal interviewing allows for greater scope for the bias and personal influence of the researcher, as the interviewer initially determines what form the interview takes, the questions that are raised and the details and comments that are subsequently recorded.

Interviewer bias can cause problems and distortions which the researcher must isolate and eliminate or at the very least be in command of. It is important therefore to identify such biases and error producing factors before they occur.

These include:

- *Quality of the interviewer* the interviewer can influence the results through lack of administrative and professional abilities, sloppiness, or through contacting the wrong person, omitting or misreading questions, recording the wrong answers, misunderstanding the respondent and leaving questions unanswered.
- *Misconduct* The interviewer can intentionally alter or omit answers, reword questions, replace respondents and cheat by not contacting the respondent but answering the questions personally.
- *Presentation* The interviewer's own presentation may cause distortion and influence the data. Appearance, tone of voice, attitude to the respondent and the research, reactions to answers or comments made are some examples.
- *Expectations* The expectations interviewers have of the respondent's answers as a result of his or her appearance and living conditions may influence the process and outcome of interviewing.
- *Probing* The research can also be influenced by the interviewer's use of probing, that is, whether probing is done, where and when, and also whether it was carried out as instructed. Improper probing is a definite source of distortion which should be avoided.

(Sarantakos, S.1998: 259)

From a researcher's point of view, acknowledgement of the nature and source of errors can help to eliminate problems or at least reduce their occurrence by the initiation of appropriate measures.

4.4 Quantitative Methods

Quantitative research is based on the methodological principles of positivism and adheres to the standards of strict research design developed before the research begins. It employs quantitative measurement and the use of statistical analysis.

Questionnaires, as methods of data collection, have certain strengths and weaknesses which have a significant impact on a researcher's decision about whether or not they should be utilised. Advantages include:

- Production of quick results.
- Can be completed at the convenience of the respondent.
- Offer greater assurance of anonymity.
- Offer less opportunity for bias and errors caused by the presence or attitudes of the interviewer.
- Stable, consistent, and uniform measure without variation.
- Use of questionnaires promises a wider coverage since researchers can approach more easily than with other methods.

In the light of these advantages, the author deemed the questionnaires to be an appropriate method of data collection for this aspect of the study. A

questionnaire survey was undertaken using closed and open ended questions. The survey was conducted with ten members of staff from each organisation. In addition the survey was self-administered by the researcher and is therefore completely anonymous and confidential.

The types of questions utilized in the questionnaires reflected the intention of the author to gain general information from the respondents, e.g. personal details- age, gender, length of time in employment. The author also wished to gain an insight into the opinions of the respondents on particular issues, e.g. the value of empowerment and how they felt that empowerment could have been achieved.

The researcher brought the questionnaires to each selected Nursing Home on the day of the agreed interview with a senior member of staff. Each Nursing Home regardless of its size or differentiation received ten questionnaires. The person selected for interview was then asked to distribute ten questionnaires amongst their staff team. Ten questionnaires were distributed as the study was an exploratory study to determine the levels of understanding and application of the concept of empowerment in service provision for older people. The only requirement to be fulfilled was that the questionnaires were to be allocated to varied members of staff among Nursing, Care and Support staff- provided that each person did in fact have adequate contact and involvement in the continuing care of older persons.

Each questionnaire was contained in a separate envelope which was to be sealed by the respondent on completion. A stamped self addressed envelope was included with each questionnaire. The time allowed for completion of the questionnaires was one – two weeks, by which time they were to be posted or left for collection by the researcher.

4.5 Analysis of Data

- **Qualitative Data**

The author took extensive notes during each interview, transcribing opportune quotations, feelings, thoughts and perceptions conveyed by each respondent. Additional notes were added where necessary following the interview, which the researcher may not have time to take note of while conducting the interview. These notes were edited and transcribed onto computer disk. Typographical errors and contradictions within the text were then eliminated. The findings were further analysed to identify varying and similar perceptions, to contrast and compare these perceptions and identify any trends which emerged.

- **Quantitative Data**

The author collected all questionnaires, those which were completed by respondents and the remaining questionnaires from each organisation which

were uncompleted. A total number of eighty questionnaires were dispersed, ten to each of the eight organisations. Each questionnaire was clearly labelled with the name of the organisation and whether the organisation was from the voluntary or statutory sector.

The author placed the responses on to a coded table which documented and highlighted the respondents' responses within each particular organisation. The results which were obtained were checked and re-checked to ensure that they were accurate and valid. The responses were analysed in-depth for interpretation and presentation. The author then attempted to identify the trends which were evident among staff members within the same organisation, within organisations from the same sector, i.e. voluntary or statutory, and within organisations from a different sector. Analysis and interpretation of the data obtained will be presented in the following chapter.

*Analysis of
Qualitative
Data-
Interviews*

5.0 Analysis of Qualitative data –Interviews

The researcher carried out eight interviews, one in each of the selected nursing homes and care facilities. For the purposes of analysis, the researcher accorded each nursing home with a letter A-D and each care facility with a letter E-G, to protect the confidentiality and anonymity of each respondent.

As previously noted, the interview explored a variety of topics and areas which the researcher wished to gather information upon. These topics had previously been deemed as being relevant to the study. The researcher attempted to gain some general information from each respondent with regard to each nursing home and care facility researched.

The first topic which was covered and addressed by the researcher to each person interviewed was the number of staff members that each facility possessed and how these were broken down into the different distinct working shifts in existence. The following is an account and profile of the levels of staff which exist within each care facility researched.

5.1 Levels of staff within each facility

The researcher wishes to note that when this question was put to respondents, the respondent frequently provided an account of the number of members of

nursing and care staff in their particular organisations without mentioning additional members of support staff such as domestic staff, catering staff, etc. A further account of additional staffing levels was usually provided following a prompt from the researcher. However additional members of staff were not always subdivided into their distinct categories, for example two members of catering staff, two members of domestic staff, etc.

The researcher identified the varying levels of staff in the various organisations in the voluntary sector and statutory sector. It can be noted that each respondent from the voluntary sector specified whether a staff member held a part time or full time position within the organisation. The researcher identified that in the voluntary sector nurses may hold the position of a nurse manager or a staff nurse. However in the statutory sector, nurses may be classified within the realms of staff nurses, clinical nurse manager grade 1 or a clinical manager grade 2.

The results of this question illustrate that the levels of staff which exist in any one nursing home or care facility is directly related to the number of residents/ patients which each organisation possesses and the levels of care which these require on a daily basis.

Maximum Capacity of each Organisation

Name of Care Facility	No of Residents
Nursing Home A	44
Nursing Home B	35 - 30 of which comprise of long term/ respite
Nursing Home C	19 Short & long term
Nursing Home D	42
Care Facility E	25 beds Assess & Review – 5 beds Day Rehabilitation- facilities for 15 Clients each day
Care Facility F	33 in total, including 4 Respite beds and 4 Assess & Review beds
Care Facility G	25 beds- 10 of which are short term, the rest are extended Nursing Care.
Care Facility H	30

Table 1A

Table 1 A as previous, provides an account of the varying capacity levels of each nursing home and care facility. The table illustrates the number of residents / patients which each organisation caters for. It can be identified from analysis of the table that nursing homes in the voluntary sector tend to cater for larger numbers of residents compared to care facilities in the statutory sector. Overall it can be identified that there exist a fairly standard ratio of Staff: Clients.

5.2 Ratio of Care

The researcher asked each respondent whether a ratio of care existed within their particular organisation. This was a point of information to ascertain if each nursing home and care facility possessed such a ratio and whether or not this was operational. **The only facility which expressly discussed a ratio of care was within the voluntary sector.** The respondent in nursing home A provided the researcher with a ratio of 1:6.

All other nursing homes and care facilities which were researched, responded to the question by reiterating the levels of staff which each particular organisation possessed and expressing the capacity of each.

5.3 Profile of Facilities in each Organisation

The facilities which existed within each care facility was explored by the researcher. Encapsulated within this area, respondents again related the number

of beds on the premises, as well as the facilities which they offered that were deemed to be beneficial to residents, including services offered to them on a regular basis.

Profile of Facilities in the Voluntary Sector

Voluntary Sector- Nursing Homes				
Facilities	A	B	C	D
Profile				
Single Bedrooms	18	29	14	22
Double Bedrooms	13	6	5	8
En-suite rooms	Y	Y	?	Y
TV in rooms	Y	Y	?	?
Phone in rooms	Y	N	N	N
Nurse Call System	Y	?	?	?
Treatment room	Y	?	?	?
Hair Salon	Y	N	N	N
Dining room	Y	Y	?	?

Day room with TV	Y	Y	Y	Y
Quiet room	Y	N	N	N
Lounges	2	?	Y	Y
Oratory	Y	N	Y	N
Laundry facilities	Y	?	?	?
Landscaped grounds	Y	Y	?	Y
Courtyard	Y	N	N	N
Patio	N	?	?	Y

Table 2A

(? Denotes an unclear response or a reply not provided by the respondent)

Tables 2 A and B set out the facilities which are offered and provided by each organisation. **It can be clearly identified that nursing homes in the voluntary sector offer a range of facilities which are not offered or provided by care facilities in the statutory sector.** The majority of nursing homes offer single and double bedrooms which are usually en-suite. Some nursing homes provide telephones and TV's in the residents' rooms.

Profile of Facilities in the Statutory Sector

Statutory Sector – Care Facilities				
Profile of Facilities	E	F	G	H
Residential rooms	2 5	25	15	30
Assess & Review	5	4	?	?
Respite	?	4	10	?
Rehabilitation facilities	1 5	?	?	Y- pathway
Day room with TV	Y	Y	Y	Y
Dining room	?	?	?	Day /dining room
Conservatory	N	Y	?	N
Landscaped grounds	Y	Y	Y	Y
Courtyard	?	Y	Y	N
Snooze LAN room	N	Y	N	N
Modern equipment	Y	?	Y*	Y

Table 2B

(? Denotes an unclear response or a reply not provided by the respondent)

In the past, people had preconceptions in relation to the level of care provided within nursing homes as opposed to facilities under the auspices of the health board. Part of these conceptions included the facilities and services which were on offer to a resident. Nursing homes were perceived as being superior in luxury and care. However analysis of the tables above suggests that **the level of facilities offered by nursing homes in the voluntary sector is quite similar to that of the statutory sector.** The distinct differences lie in the arrangement of accommodation facilities in each organisation. Nursing homes tend to offer single and double rooms whereas care facilities offer accommodation in a ward like setting. Bathrooms are communally shared by those in care facilities in the statutory sector while most residents in nursing homes can enjoy their own en-suite bathroom.

To conclude, the researcher feels that a **slightly greater level of facilities is offered by nursing homes in the voluntary sector as they offer additional facilities which are not offered by their counterparts in the statutory sector** such as an oratory, dining room, quiet room, hair salon, etc. Despite this, the **researcher wishes to note that services in the statutory sector appear to offer a fairly reasonable level of facilities.**

Care Facility G

This care facility is situated within a new building, which is being leased by the Health Board. However it is apparent that the building is not particularly built

to suit its purpose. In recognition of this fact many interior design and layout issues were raised during this part of the interview. A design and layout discussion ensued with regard to same. A brief tour of the ward in question confirmed the issues that were being addressed by the respondent. As a result the researcher feels that a few issues are worthy of note and consideration.

- **Planning is paramount for a facility catering for the elderly.** This facility demonstrated in a real way the effects of adverse design and how it hindered daily activities and put limitations upon the level of care delivered.
- The facility demonstrated the lack of coordination and communication between the building contractors and current tenants. This building evidently does not adequately cater for the needs of its residents.
- This is an example of a **modern building that externally is visually effective but internally inadequate.**

Despite these structural limitations, the building has a range of assets, due to the fact that it is a new building. It is fresh, airy, and warmly decorated with all new contents, furniture and equipment.

The ward which the researcher focused upon has 25 beds and is designed to facilitate residents who may require medium, high or maximum dependency care. The health care centre caters for 50 residents in total, divided between two wards. In addition it boasts a range of services including a primary care centre.

This includes General Practitioners, Public Health Nurses, Occupational therapy, Speech and Language therapy, Mental Health Services, etc on site. A day hospital for older people on the site is planned in the near future. * The following is a list of equipment, which is unique to the facility-;

- Comfort fall – out chairs- which are specially designed to provide comfort and safety to those who sit in them. They are preventative of injuries and pressure sores by their structure, shape and soft covering.
- All mattresses are composed of peutriflex – a special mattress that are safe to be nursed upon. They are very expensive but worth obtaining in terms of projected future needs and the overall upgrading of facilities.
- Adjustable chairs and armchairs that can be adjusted to meet the needs of residents differing sizes, shapes and dimensions.
- Shower trolleys for residents who are unable to sit or stand
- In addition to the services that are provided from the primary care services, diversion therapists deliver activities to the residents in a relaxed non-structured way. The new role of diversion therapists will be discussed later.
- Alarmed and coded doors for the safety of the residents.

Care Facility H

This facility is situated within an old building. In previous years it was formally a Maternity Hospital. It is divided into two distinct units, unit 1 being the

female ward and unit 2 being the male ward. The particular ward which the author based her research upon was within unit 2. The majority of the beds are 6 bedded as it has retained its former layout and design. The building is bright particularly the rooms as they look out upon the landscaped gardens. The Day room is the room in which the residents spend the majority of their time and it is the room in which activities are undertaken and meals are served. The General hospital is in close proximity and as a result the services and care of the professionals which support a care team are always close at hand.

5.4 Services which are provided by Organisations

The author asked each respondent to provide an account of the services which were offered to residents in each facility. Table 3A documents the services offered by nursing homes and care facilities in the voluntary and statutory sector.

Analysis of the table identifies **some services which are common to both sectors, namely 24hr nursing care, chiropody and the availability of a doctor**. All nursing homes offer hairdressing services to their residents. Half of the nursing homes offer occupational and recreational therapy, services of an optician and access to members of the clergy. Only one nursing home out of four offers the services of a dentist, social activities, pastoral care and varied menus to their residents. Three nursing homes out of four provide physiotherapy to their residents.

Services Provided by Voluntary & Statutory Sector facilities

Services provided	A	B	C	D	E	F	G	H
24 hr Nursing Care	Y	Y	Y	Y	Y	Y	Y	Y
Occupational therapy	Y	N	?	Y	N	N	Y	Y
Recreational therapy	Y	N	?	Y	Y	Y	Y	Y
Physiotherapy	Y	Y	?	Y	N	N	N	Y
Chiropody	Y	Y	Y	Y	Y	Y	Y	Y
Optician	Y	N	?	Y	N	N	N	N
Access to Clergy	Y	?	?	Y	Y	Y	Y	Y
Pastoral Care	Y	?	?	?	N	N	N	N
Hairdressing	Y	Y	Y	Y	?	?	?	?
Social Activities	Y	N	N	N	N	N	N	N
Doctor	Y	Y	Y	Y	Y	Y	Y	Y
Dentist	N	N	N	Y	?	?	?	?
Varied Menu's	Y	N	?	?	?	?	?	?
Primary Care Services	N	N	N	N	N	N	Y	Y
Modern Equipment	?	?	?	?	Y	Y	Y	Y
Diversional Therapy	N	N	N	N	N	N	Y	Y

Table 3A

(? Denotes an unclear response or a reply which was not provided by the respondent)

In the statutory sector, all care facilities provide recreational activities, access to members of the clergy and modern equipment to patients in their care. Half of the facilities researched provide occupational therapy, diversion therapy and primary care services to their patients. Only one facility provides physiotherapy to its patients.

5.5 Mission Statement

The existence of a mission statement was the fourth topic proposed by the researcher. Some facilities spoke of safety statements and others of quality policy and objectives. **The majority however did not possess any such documents.**

Nursing Home A

This facility's mission statement was as follows "Excellence in the delivery of compassionate care to our residents". The methods by which they felt that they could achieve this mission included:

- Engaging courteous and caring staff to deliver a professional service.
- Responsive management.
- Teamwork, Teamwork, Teamwork.
- Offering superior accommodation and services in a relaxed setting.
- Maintaining the dignity and respect of our residents.
- Constantly seeking ways to improve our service levels.

Nursing home B and C did not possess a mission statement of any kind, nor did the respondents associated speak of quality objectives or policies for enhanced care.

Nursing Home D equally did not possess a mission statement. However the respondent did speak of a safety statement that was currently being updated.

Within the statutory sector, the researcher found that only one facility – **Care facility E**, possessed a Quality Policy and Objectives which are framed at reception. **Care facility G** is currently in the process of adopting quality measures and setting them out within the realms of a document. The remaining two **facilities F and H** did not possess a safety statement nor did the respondents in these facilities offer any additional alternatives to the researcher.

5.6 Perceptions of respondents in relation to Empowerment

The researcher wished to explore the perceptions of the respondents in relation to empowerment. The researcher found that nursing homes in the voluntary sector possessed a perception of empowerment steeped in the elements of decision making, freedom of choice, transfer of powers, dignity and independence for the resident in an environment of holistic care. When asked about how they perceived the role of empowerment in the context of how they cared for the residents, the following comments were made by respondents from the voluntary sector:

- *“Ensuring that residents are involved in all decisions in relation to their care”*
- *“Allowing freedom of choice”*

- *“Resident focused approach to care”*
- *“Holistic approach with the patient, with the elements of encouragement, giving assistance and making them feel at home- extension of their own home”*
- *“Encouraging independence as much as possible”*
- *“Ensuring that the residents keep their dignity and independence within safety limits”*

Respondents from the statutory sector possessed a different conception of what empowerment entailed. As a whole their perception of the term had a broader base which acknowledged the wider aspects of the term from the viewpoint of both patients and staff. The responses provided by respondents in some facilities focused on the elements of empowerment from a staffing perspective which they felt encapsulated empowerment, such as the maintenance of good morale, autonomy, taking new ideas on board, encouraging suggestions and listening. Some facilities excluded the possible aspects in relation to the patients in their care.

When respondents from the statutory sector were asked about how they perceived the role of empowerment in the context of how they cared for their patients, the following comments were made:

- *“Patients’ having lots of choice- no drastic changes. They should continue to make choices and express themselves the way that they should do”*
- *“Elements include maintaining good morale; keeping on top of training- Autonomy in staff has a domino effect”*
- *“Looking under the microscope at the small issues – boosting morale”*
- *“Excellence”*

- *“Getting people to be independent in the field where they work and overall that the quality of care can be enhanced”*
- *“Staff need to continue to progress, get new ideas, training, etc to ensure that the care that is given is appropriate and of the highest level of care”*
- *“Holistic Care- encouraging them to help themselves”*
- *“Try to feel what the patient is feeling, talking to them, asking them and listening to them is very important”*
- *“Helping them to make choices”*
- *“Empowering supervision, assistance and guidance”*

From close analysis of the perceptions of the respondents from both sectors, it can be concluded that respondents from the statutory sector appear to have a greater perceptual basis of empowerment and what it entails for both patients in their care and staff, who can incorporate these empowering elements in the delivery of that care. In comparison, respondents from the voluntary sector are orientated towards the practices which come together to ensure the practice of empowerment for residents. The elements which staff may require to encourage empowerment are generally not considered.

5.7 Empowerment- a working principle or an abstract concept

The researcher put forward the question as to whether empowerment is a working principle or an abstract concept that has no place in reality, to each respondent. When asked how they perceived the role of empowerment in the

context of whether it represented a working principle or an abstract concept, the following comments were made by respondents from the voluntary sector:

- *“Empowerment is a working principle that needs to be focused on more and more”*
- *“Empowerment is a concept-as opposed to a working principle that can be put into practice”*
- *“Empowerment is a routine which takes place daily- it is a natural process which occurs naturally- nothing new”*
- *“Empowerment is something which has to be worked at- qualified staff has a role to play in ensuring that it is constantly worked at”*

The respondents from three nursing homes out of the four researched felt that empowerment is a principle which can be incorporated into the daily routine and delivery of care. Two respondents make the point that it is a principle which requires effort from others and needs to be ‘continuously worked at’. One respondent took the view that empowerment is a concept rather than a working principle which can be incorporated into practice.

Similarly when respondents from the statutory sector were asked how they perceived the role of empowerment in the context of whether it represented a working principle or an abstract concept, they made the following comments:

- *“Empowerment is a working principle”* -The respondent made the point that some staff members may be actively taking part in the process of empowerment but may not actually view it as such.
- *“Empowerment is a working principle which needs to be continuously worked at”*

- *“Empowerment is a working principle that can be improved and worked upon every day. It is practicable, workable and achievable.”*
- Empowerment is viewed by the respondent to be the definitive way forward and paramount in the delivery of care. The respondent stressed the fact that for this to occur it was necessary for all members of a care team to be “singing from the one hymn sheet”. Empowerment can, be incorporated into work practices on a daily basis. The respondent felt that the level of empowerment which can be delivered depends also on the abilities of the patients in their care.

Respondents from the statutory sector collectively held the view that empowerment is a working principle. Two respondents offered a similar view with regard to the necessity to continuously work on the practice of empowerment as their colleagues in the voluntary sector. Nevertheless empowerment is seen to be ‘practicable, workable and achievable’. The respondent from care facility H took a very enthusiastic view and felt that empowerment is the definitive way forward and paramount in the delivery of care, as long as all members of a care team share the same vision.

Randolph (1995) similarly stated that the three keys to empowerment included sharing information, communicating a vision and teamwork. Empowerment can therefore occur where employees have a conceptual understanding of what management are trying to achieve, where openness, good levels of communication, information sharing, problem solving and a willingness to

work as a team is evident. The response put forward by the respondent from care facility H reiterates the views of Randolph (1995) as previously mentioned.

5.7.1 Empowering Practices

Respondents were asked to provide some examples of typical empowering practices which take place within each care setting.

Voluntary Sector

A central theme which runs through the responses proposed by respondents from the voluntary sector is the element of choice which is provided to residents through different aspects of their daily living. Choices are a very important element of empowerment and every resident should be afforded as many choices as is possible. However choices are not the only element which comprises the concept of empowerment. One respondent felt that providing independence for residents was worthy of note. In addition this respondent stated that for independence to occur it was necessary to practice the attributes of encouragement and assistance where necessary. Some examples provided focused on the task of getting the resident up in the morning and the ensuing encouragement required empowering residents to tend to their own needs in so far as they are physically capable.

Statutory Sector

The responses provided by the respondents from the statutory sector diverge from those deriving from the voluntary sector in terms of the focus which they attribute to empowerment and its practice within a caring facility. **Three out of the four facilities researched focused on the practice of empowerment from a staffing point of view.** Respondents were concerned primarily with engaging staff members in practices such as good observation, enabling active participation in care and presenting ones views to be considered by others. **Only one facility specifically focused on the empowerment of its residents and the practice of enabling them to make decisions and have choices.**

In general the responses from the voluntary sector placed an emphasis on the empowerment of residents with strategies such as the provision of choice, independence and encouragement. However as previously mentioned empowerment is a complex concept, possessing many elements. While choice and independence are vital, other elements are also important such as privacy, dignity, respect, to be listened to and have wishes considered and to be allowed to take risks.

In contrast the respondents from the statutory sector emphasised the empowerment of staff in order to enable and enhance the quality and delivery of care to older persons in their care. Their focus is strategically broader than that of their colleagues in the voluntary sector in that they

recognise the importance of initially empowering staff that care for others. The mentality is that if members of a staff team are empowered then they will be enabled to empower those with whom they work and those who depend on their care.

5.7.2 Impact of role on the empowering practices of staff members

The next topic which the researcher focused upon was the impact which role played on the level of empowering practices which staff members engaged upon. On a very basic level, the author wished to identify the particular staff members which engaged in empowering practices- nursing staff or care staff.

In the **voluntary sector**, two respondents felt that empowering practices were undertaken by nursing staff. One of these respondents also felt that while empowering practices begins with nursing staff, it also filters downwards to members of the care staff. One respondent felt that empowerment was undertaken equally by both nursing and care staff, while another respondent felt that it is care staff who deal directly with residents, while nurses are often removed from empowering residents. As there are basically four different responses from the respondents in the nursing homes, it is difficult to see a pattern emerging from those working in the voluntary sector. **However it is clear that nursing staff feature more highly in the data, even if care staff engage in empowering practices, they are listed after nursing staff, for example empowerment begins with nursing staff and then filters down to the care staff.**

The researcher noted that three out of the four respondents within this sector concentrated on the realities for nursing staff in relation to the focus of the majority of the questions addressed to them and the issues which were raised as a result. Care staff only featured where necessary and the researcher felt that the abilities and role of care staff were often overlooked.

In the statutory sector a somewhat clearer pattern emerges with regard to the staffing sector which initiates empowering practices. Two respondents stated that teamwork and an equal team mix ensures that both nursing and care staff take part in the process of empowerment. One respondent felt that empowerment was solely attributed to the efforts of nursing staff; members of the care staff were not even considered to be a part of the process. The final respondent from the statutory sector felt that empowerment was initiated by nurse managers and then it filtered downwards to nursing and care staff.

Overall over half of the facilities from the statutory sector placed an emphasis on the attributes of a team and the contributions which each member of a given team can offer in an environment of cooperation, high levels of effective communication, clearly defined roles and the ability and willingness to function as a team.

5.7.3 Barriers to Empowerment

The researcher focused upon the various elements which are present within each nursing home and care facility as highlighted by each respondent, which they perceived as barriers to the process of empowerment. Table 4A identifies the factors which respondents from the voluntary sector deemed to be challenges to empowerment. Table 4B identifies the factors which were perceived as limitations to the process of empowerment, by respondents in the statutory sector.

Respondents from two nursing homes felt that **levels of staff** which existed were barriers. One of these respondents was concerned with the **levels of staffing at night**- where only one nurse was on duty without the assistance of any care staff. It should not be permissible that only one member of staff is on duty during night time hours as it is impossible to deal with a crisis single handily. Two members of staff should be on duty in this nursing home despite its low capacity level (19 residents).

Another respondent was concerned with the **current levels of staffing within the facility due to the rapid turnover of residents and the resulting heavy workload**. Additional members of staff are required during times of high turnover and admissions as this facility caters for more residents than any other facility researched (44 residents).

Two respondents were concerned with regard to the **safety of residents** in their care while engaging in empowerment. As previously discussed in the review of literature each older person should be afforded the opportunity to take risks as this will ensure quality of their life as opposed to the longevity of their life. No one wants to live a long life during which they are unable to do the things that they wish and to take the risks that they would like to. Everyone possesses the ability to decide what they want to do and what they would like to be doing when they grow older. Placing too much emphasis on safety can be disempowering as it takes away power from older persons to engage in activities, to make decisions for themselves, to exercise choice in their lives. Engaging in practices which reduce the element of hazards within the environment of older persons, such as preventing wet and slippery floors are more effective measures than being overly concerned with the inherent safety issues of each movement made by persons in care. **The author understands that safety is and must be a huge feature of services for older people, however over emphasis on safety issues can be disempowering.** The only exceptions to this rule are residents who have Alzheimer's disease.

One respondent stated that the **ability of residents** was a barrier as residents were more dependent on the time and resources of staff so that little time was left in the day for engaging in activities or providing each resident with 'quality time'. This is a barrier which can not be easily overcome as some residents may require more time than others. The only strategy which can lessen the extent of

this barrier is supplementary members of staff which ease the workload of other staff members.

Table 4A below identifies the factors which each respondent felt were barriers to empowerment within their particular nursing home.

Barriers to Empowerment -Voluntary Sector

Barriers to Empowerment	A	B	C	D
Staffing levels	Yes		During the night	
Safety of the Residents		Yes		Yes
Ability of Residents				Yes
Heavy workload	Yes			

Table 4A

Table 4A illustrates that some of the barriers presented by respondents are common to one or more facilities.

Within the statutory sector, respondents held differing views and beliefs as to the barriers to empowerment as compared to their colleagues in the voluntary sector of care as table 4B illustrates.

Barriers to Empowerment -Statutory Sector

Barriers to Empowerment	E	F	G	H
Staff shortages		Yes		
Institutionalisation	Yes			
Difficulties with staff			Yes	
Training & retraining of care staff			Yes	
Dominant personalities			Yes	
Time limitations				Yes
Inflexible routine		Yes		
Heavy workload				Yes

Table 4B

Institutionalisation was a barrier which was put forward by one respondent. In this regard the respondent felt that staff who worked in the same setting for a number of years becomes almost institutionalized to the extent that they are not interested in training or educational opportunities. Such staff members do not feel the need to keep up to date with current training, new ways of completing tasks or new ways of thinking about and delivering care. Although institutionalisation affects both residents and staff, it is borne out of static routines and work practices which people become accustomed to through a

period of time. Good management and training programmes can assist in breaking down the cycle of institutionalisation. Affording members of staff opportunities to train and gain new knowledge coupled with respect and rewards for work well done are strategies which are in place to counteract and prevent institutionalisation.

It is true that some staff members may reach a stage where they feel that they know everything there is to know about working with and caring for older persons. However it is important from a managerial aspect to firstly dispel any misconceptions regarding the views of older members of staff and to encourage continuous training and quality in the delivery of care. Providing each member of staff with responsibilities in accordance with their training is also important so that staff may comprehend that the work of each person regardless of the role they play is vital to the overall process of care and empowerment. Finally, the author feels that it is a good idea for staff members to present material which they have acquired while training to other staff members.

Staff shortages were identified as a barrier by another respondent. The provision of additional members of staff would ameliorate the situation within the particular facility. In addition, in terms of the provision of meals to residents, the respondent felt them to be restrictive and therefore mitigated against the resident's choice of what they might like to eat on a given day. It was agreed by the respondent that it would be beneficial to the residents to have

a varied menu. This idea was further developed by a discussion as to how to go about overcoming these limitations such as liaising with staff and catering staff to draw up a menu with varied options each day to cater for the individual needs and tastes of each individual resident.

The barriers perceived by another respondent included **laziness of staff members, training and retraining of caring staff and the dominant roles and personalities of various staff members which may change the attitudes of others.** With regard to laziness, the respondent felt that the attitudes which staff held such as “it’s not my job” and notions such as why do something if someone else will, hindered the process of empowerment. The respondent felt that each staff member should be accorded with specific roles and tasks so that there would be no confusion regarding each person’s tasks and responsibilities. In particular, the respondent noted that it was essential that all care staff are trained and retrained into concepts such as empowerment, advocacy and appropriate delivery of care. All members of staff require training and continuous retraining with regard to the appropriate delivery of care to older persons. Elements of such training should focus upon empowerment, advocacy and working together as members of a team.

In addition it was noted that **dominant roles and personalities have the ability to change the attitudes of others.** An example of this instance was given in terms of a weak member of nursing staff who could be influenced by a

dominant care assistant. However each member of staff plays a different role within a team, one must fulfil this assigned role and carry out the responsibilities involved.

Time was perceived to be a factor which greatly hindered empowerment within another Care Facility. The respondent explained that time was paramount to the daily schedule and that all members of staff were extremely busy in the delivery of care. The daily schedule was very demanding and left little additional time. Time is a difficult barrier to overcome with any strategy other than additional members of staff to ease the workload for others.

The respondent also felt that they were too involved with the daily hands on caring as their position demanded additional tasks to be completed and it was suggested that a more supervisory role would be appropriate. The author feels that although this respondent works on hands on basis with patients, a supervisory role would change the delicate balance and spirit of teamwork which exists in this facility. In particular the author feels that due to this direct role the respondent is more appropriately in tune with the needs of staff and patients alike and therefore possesses a greater general knowledge than those who play a separate supervisory role.

It is emerging from the responses which the respondent from care facility H has made from the beginning that they are extremely in tune with important aspects

of care and its delivery to older persons. The respondents' various perceptions regarding empowerment and its practice are precise and enthusiastic. The respondent is an obvious team player who expects only the best from the team which has evolved in this facility. In addition the respondent previously spoke to such a high degree regarding empowerment and how they viewed it as "the definitive way forward and paramount in the delivery of care". If this respondent holds this view of empowering care, then it is more likely to pass to all other staff members in this facility until it has been effectively incorporated into practice.

Overall, from table 4B it can be identified that the care facilities in the statutory sector were unique in terms of the barriers which they identified. Each respondent from the different care facilities provided unique barriers, i.e. no care facility presented the same factor as being a barrier.

Another respondent felt that difficulties with staff, training and retraining of care staff and dominant personalities were barriers within their particular organisation.

In general it can be seen that in the voluntary sector the barriers which respondents provided were common to two nursing homes, namely the current levels of staff and issues relating to the safety of residents. This pattern cannot

be identified within the statutory sector from the responses which respondents provided as each care facility possessed unique barriers.

5.7.4 Factors facilitating the inclusion of Empowerment

The respondent in nursing home A raised many factors which they felt facilitated the inclusion of empowerment. These included **good communication between management, staff and residents. Good communication between staff and residents, including relatives is also a facilitative factor.** Other factors include:

- Being open to new ideas.
- Keeping up to date with changes in present practice.
- Encouraging evidence based practice.
- Running trails and assessing.

Communication is a vital element as well as the ability to keep up to date with changes in care and care practices. Openness to new ideas and changes are paramount in the adoption of practices to enhance care. Engaging in trail procedures and assessments of practices to verify effectiveness is equally important.

The respondent in Nursing Home B did not offer any facilitating factors to the researcher. It is therefore difficult to be confident as to its practice in this nursing home.

Good management was found to be one of the facilitating factors by the respondent in Nursing Home C. The respondent spoke of the trust and respect that each member of staff held for each other and due to the small number of staff each person knew the other well. There were no restrictions placed upon any person and that each was valued for their unique knowledge and skill base. **Others factors included a homely environment, the absence of a medical base to the delivery of care and prioritisation of the needs of residents.**

Good management is evident by consideration of a number of factors and particularly when spoke of by senior staff members. Trust and respect foster good relations between staff members and management so that there are no conflicts and decisions are easily made by inclusive consultation. To conclude the author wishes to note the importance of the factor provided by the respondent – prioritisation of the needs of residents. This is essential in the delivery of care to older persons, that the care which they receive considers their wishes and needs.

The abilities of staff were presented as a factor which facilitated empowerment. The respondent in Nursing Home D expanded on this factor and conceded that the process of empowerment benefited greatly from the ability of staff members to encourage residents to partake in activities during the course of the day. While this factor is beneficial in encouraging residents to part take in activities it is not an essential element of the practice of

empowerment. Other factors are important such as good communication, good management, teamwork, etc. The willingness and ability of staff to engage in empowering work practices, to care for others, to listen, to encourage independence in older persons are all important traits but when their only ability is accorded with engaging residents in activities, then these additional traits diminish.

The author feels that while reasonably inclusive factors were presented by respondents from the voluntary sector, additional factors could also have been identified and provided. The factors ranged from the provision of a homely environment and being open to new ideas to good levels of communication and the prioritisation of the needs of residents. Despite the range of factors presented, the author feels that additional factors could have been adapted to the list such as the presence of teamwork, listening to residents, allowing residents to be involved in their care planning, promotion of quality rather than longevity of life.

The author feels that additional factors which facilitate empowerment could have been provided by the respondent in nursing home D. The respondent only provided one facilitative factor, namely the abilities of staff. As previously mentioned, the ability of members of staff is vital to facilitating empowerment when they are encouraged to engage in empowering work practices, to care for and listen to those in their care and to encourage independence in older people.

However when the ability of staff is presented as an attribute only in terms of their ability to encourage residents to take part in activities, then the additional traits which members of staff may possess diminish. The ability of staff is one of the many factors which the respondent in nursing home D could have provided as a facilitative factor.

The author wishes to note that the respondent in nursing home B did not offer any factors which facilitated empowerment in their nursing home. This respondent could have provided any number of factors which facilitated the inclusion of empowerment from teamwork, to good communication, listening to residents, etc. As this respondent failed to provide any such factors, is it reasonable to suggest that there are no facilitative factors in existence in this nursing home, that empowerment does not occur or that this respondent is unaware of the concept and its implications for practice in services for older people??

The motivation of staff was deemed to be the main facilitating factor with regard to the inclusion of empowerment within a Care Facility in the statutory sector. From a management point of view, **encouraging staff to think what and why they are doing something** is paramount to incorporating empowerment on a daily basis. Staff members are encouraged and empowered to think for themselves and from their own base of knowledge, new ideas and ways of thinking are therefore fostered, which in turn benefits all members of staff and residents in their care.

A good skill mix among staff members is paramount to the facilitation of empowerment. Good communication and good handovers are all essential factors. In addition a respondent from the statutory sector felt that **teamwork** for all ranks and all members of staff is vital to the ongoing empowering process.

Many factors are in place in Care Facility G to assist in the process of empowerment. These include:

- Keeping appropriately and effectively skilled.
- Availing of all educational and training opportunities.
- Taking note of how other facilities have succeeded in improving their delivery of care.
- Communications is vital to any level of care delivered especially ‘Quality Care’- this can often be a generalized statement so it is vital that it is operational.
- Tackling and addressing the concerns of staff and boosting morale are very important elements.

An example provided by the respondent is that if the statement “there’s no communication in this place” is put forward, it should be addressed by all concerned and handed back to those who initially had the issue. Often the respondent found that communication increases through the very act of handing the issue back to those who initially made it.

The factors determined by the respondent in Care Facility H include:

- Good Communication between all members of staff.
- Having a good leader with the ability to motivate, support and encourage staff to be empowered and to empower.
- Respecting the opinions and ideas of others is essential, fostering trust and the feeling of self worth.
- Listening to one another from colleagues to those in your care and fairness to all are vital facilitating factors.

All respondents placed an emphasis on factors such as **motivation, encouragement, good communication, teamwork, availing of all possible training opportunities, addressing the concerns of staff, respect and listening to one another.** While these are vital elements in empowering members of staff, it appears from the responses provided that older persons have become removed from the process of empowerment – they appear to have become secondary to the empowerment of staff. Patients have not featured in the responses provided by respondents in the statutory sector. Care is delivered to them by empowered staff but are older persons empowered as a result?

Overall the author feels that while reasonably facilitating factors are presented by the respondents, the majority of the factors are concerned with staff related issues. This dependence on staffing issues means that factors relating to patients are often overlooked such as a homely environment, trust

and respect, being open to new ideas and prioritisation of the needs of patients. As previously mentioned, in relation to the responses provided by respondents in the voluntary sector, the author feels that additional factors could have been provided by respondents in the statutory sector such as allowing patients to be involved in their own care planning, listening to them and spending 'quality' time with them, etc. In the absence of these factors one might not be blamed in assuming from the list of factors provided that the organisations were not involved in providing care for older people but were in some way related to management and human resources.

5.8 Strategies to overcome challenges to Empowerment

The researcher asked each respondent to list how they could go about overcoming challenges to empowerment.

Analysis of table 4A (Barriers to the process of empowerment as identified by respondents in the voluntary sector) and the responses provided by respondents from the voluntary sector identifies that the strategies which respondents felt would overcome the barriers to empowerment in nursing homes B, C and D correlated exactly to the barriers which had previously been identified by the respondents. For example the respondent in nursing home C initially felt that the levels of staff at night were a barrier to empowerment. The strategy which the respondent felt would overcome empowerment was appropriate staffing levels at night.

Voluntary Sector

Many strategies were offered by the respondent in Nursing Home A. These are as follows:

- In-house education.
- Study days.
- Communicating the importance of empowerment to all staffing levels.
- Requesting multidisciplinary teams to be more flexible with appointment times.
- Increased time allocation to residents in relation to discussing their needs.

These strategies are not directly related to the factors initially identified as being barriers within this nursing home. The barriers which were initially identified were the current staffing levels which existed and the heavy workload which staff endured on a daily basis. Therefore the strategies which the respondent provided will not be able to overcome the factors which were identified as being barriers as they are not related to them in any way.

The respondent in Nursing Home B felt that it was possible to overcome the barriers which existed. The respondent went on to talk about the need to use restraints and appeared to be **concerned with the issue of safety**. The researcher wishes to make a further note as to the practice of locking the external doors in this establishment. The researcher put this issue to the

respondent who confirmed that the majority of their residents were incapacitated and in any case could not reach the doors.

In Nursing Home C, the respondent previously noted that a barrier which existed were the levels of staff at night- as only one nurse was on duty during this time. It is therefore fitting that more **appropriate staffing levels during night time** should be a positive step to overcoming the barrier.

The respondent in Nursing Home D felt that **ensuring that the environs and surrounding area are safe and free from potential dangers, e.g. wet, slippery floors** would be a positive step towards overcoming the challenges to empowerment, previously noted as being aspects and issues related to the safety of residents . In addition **encouragement, support and praise for residents would be beneficial to the process of empowerment.**

Overall respondents from three out of the four nursing homes research provided strategies which were directly related to the barriers which they had previously identified. One respondent offered strategies which were not in any way related to the barriers which they had previously identified.

Statutory Sector

The respondent in Care Facility E felt that it was paramount to continue to **educate and train staff**, to help them to understand that a care facility is a

home from home for residents. It is essential therefore to maintain an appropriate focus as to why staff members are there and what their roles are as a result. These strategies were provided to **combat the effects and onset of the institutionalisation of staff** within care facility E, as institutionalisation had previously been identified as being the only barrier which existed within this facility. The author feels that these strategies are appropriate and will be effective in overcoming institutionalisation as a barrier to empowering processes.

In Care Facility F, the respondent felt that **increased staffing levels would allow additional time to be given to residents - 'Quality time'**. A revised menu and liaisons between staff and catering staff could also assist in the process of empowerment. This respondent had previously identified staff shortages and an inflexible routine as being barriers to empowerment within care facility F. Therefore strategies were provided by the respondent to tackle the barriers which existed and additional issues which they felt should be altered such as the lack of menu choice.

The respondent in Care Facility G felt that **communication** was vital for all staff and residents alike. Identification of personal strengths and weaknesses were also seen as important so that all skills could be tailored so that they would be applicable and appropriate to the particular ward. From a management point of view it was deemed important to stress the importance of being up-

skilled and the benefits attributed to such. It is necessary also to communicate to all members of staff the potential costs of training and the obligation which staff members have to attend such courses. For this reason a lot of courses are mandatory and if any person fails to attend they must have a good reason for not doing so. On return from training days and courses staff members are expected to present the contents and information obtained to their fellow colleagues. The respondent also expressed the difficulties which arise when one must attend a course from the view of other staff members covering a shift.

The respondent from care facility G initially identified difficulties relating to staff, the training and retraining of care staff and dominant personalities as being barriers to empowerment within their particular organisation. Therefore the strategies which were offered by this respondent can be identified as being directly related to the barriers which they had previously identified.

In Care Facility H the respondent spoke about **overcoming staff shortages and the difficulties associated with obtaining trained, professional, efficient and competent members of staff**. The respondent from care facility H had initially identified time limitations and a heavy workload which was borne by staff on a daily basis, as the barriers which existed within their particular facility. The strategies which were offered cannot solely overcome the barriers which were identified. While the strategies put forward will go some way to ensuring that the barriers are overcome, the author feels that additional strategies are

required. An additional strategy which the author feels would be effective is managing time more efficiently. If this strategy was utilised in conjunction with additional staffing levels, then both barriers would be addressed and overcome to a greater extent than previously thought possible.

5.8.1 Additional Comments from Respondents

This was an open ended question whereby the respondent could raise any issues or details which they deemed worthy of note. The respondent in **Nursing home A** felt that every person should be afforded the opportunity to make their own choices.

“I think it’s a fundamental right of every individual to be able to make their own choices and be involved in their care plans – unfortunately as noted earlier time factors can impinge on this.”

“Different medical conditions can also affect empowerment, i.e. some residents may be unable to make their own choices”.

The respondent in **Nursing Home B** reiterated the main barriers to empowerment.

“Safety & Comfort are the main barriers”

In **Nursing Home C** the respondent spoke of the quality of management within the Nursing Home and how they valued each member of the staff team regardless of their defined roles. Each person's opinion and decision on a particular issue is taken into account "*You are an important person in the care process*".

The respondent in **Nursing Home D** spoke of the additional activities which both staff and residents get involved in on a weekly basis. The author will discuss these in a later section.

In addition, the respondent spoke of the additional things which they would like to be able to initiate with their residents. An example provided was going on day trips. However due to the high costs related to such activities e.g. insurance, they have been unable to fund and resource such events.

The respondent spoke of the local personalities and singers who regularly visit the residents throughout the year particularly at Christmas time.

Statutory Sector

In **Care facility E**, the respondent made additional comments with regard to its current staff profile which are deemed by the respondent to be "*old*".

The respondent felt that the centre *“needs new staff members as some of the staff are as institutionalised as the patients”*

The respondent in **Care Facility F** spoke about having transport to go on more outings with their residents. The respondent was very enthusiastic in relation to the concept of getting together and going away for day trips, outings, etc.

The respondent from **Care facility G** addressed numerous issues under this section, while reiterating other previously mentioned topics. The respondent reiterated the expectations which are placed on staff when they return from courses and training days. *“Staff members are expected to present material and knowledge obtained on return from a training day so that all can benefit from the knowledge gained.”*

The respondent spoke of catering for the needs of individual patients and the importance of doing so. *“Dietary needs are catered for and adverse reactions are recognized and made known to all members of staff- this is seen as very important”*

The respondent addressed the issue of the policy that is currently in place with regard to undertakers when overseeing a removal – this policy has been drawn up by staff and management and is available on the premises.

A new and innovative idea has been put in place to ensure quality in the delivery of care and to ensure that services can be improved accordingly. Each person following their discharge is requested to complete a 'client comment card' and return it with confidence in the envelope enclosed to the Matron. The information and contents of these questionnaires will then filter downwards to staff members and decisions will be made with regard to changes that may need to be incorporated into future policy and care delivery.

Menus in the facility get a three week trial period and after this time feedback is given to the catering officer and cooks. A decision is then made as to whether to maintain these food types or search for more appropriate ones.

Care Facility G demonstrates a more direct way of getting things done in terms of a maintenance white board as opposed to a maintenance book. Members of staff are therefore able to write what needs to be completed or adjusted on this board and this will be carried out by maintenance personnel.

The respondent spoke of the policy of accountability with regard to patients by staff members. This means that patient numbers are checked each day to ensure that all are present and also to ensure that relatives have not brought an older person home without notifying staff.

The building is a smoke free zone. This was originally a bone of contention with some relatives and short stay/ respite patients. However staff members argue that the facility is “not a nursing home” and therefore does not come under the exceptions proposed by government with regard to permitting smoking within nursing homes.

The respondent noted that often a better level of communication existed and was demonstrated among the newer and younger members of staff, particularly those who had changed jobs. The respondent rationalised that their previous environment had been different and a greater emphasis may have been placed upon communication, among other things. In general the respondent concluded that such newer members of staff are less institutionalised to a certain position and niche within an organisation. They are therefore more open to changes and expressing their thoughts on various issues, i.e. they welcome change as opposed to those who wish to keep policy, care delivery and practice static and at a level which they are comfortable with.

To conclude the respondent discussed the many advantages and advances which had been inaugurated as a result of moving premises to a modern, updated building. Additional items such as upgraded hoists which have a scales attached, allow for care to be delivered in an improved way and to more accurate and measurable levels. Peg feeds allow staff to monitor whether a patient is receiving enough or too little, etc.

The last interview which the researcher conducted was in **Care Facility H**. The researcher conducted an interview with both Matrons as the facility comprises of two units. Only one respondent advanced additional comments with regard to the existing facilities for staff members. The respondent felt that staff should be adequately rewarded for their work by providing them with an improved level of facilities in which to shower, to relax during a lunch / tea break and overall to feel that they are valued and empowered. Without this backup staff may feel under valued, lethargic and that the efforts which they make go unnoticed. The respondent also noted that there were three issues which they felt worthy of note, namely:

1. Staff shortages at the weekends in particular.
2. Limited spaces for storing/placing hoists.
3. Reduced space for residents to accommodate the ‘pathways programme’.

Despite these issues the respondent reiterated the existence of a strong level of teamwork and hands on approach, which is vital to the process of empowerment.

5.9 Conclusions to be drawn from Qualitative data.

Analysis of the data derived from the qualitative interviews illustrates the many similarities and differences between the different nursing homes and care facilities and between the two different sectors- voluntary and statutory.

The interview process sought to collect general information regarding each facility and more specific areas which were based on the perceptions and perspectives of the respondents interviewed.

Staffing issues

The interview process yielded results regarding the different classifications and positions which members of staff hold in the different sectors. In addition the levels of staffing within the voluntary and statutory sector were focused upon and it was identified that the levels of nursing staff were greater in the statutory sector while the levels of care staff were greater in the voluntary sector. The author concludes that these staffing levels may be attributed to a lesser medical base within nursing homes compared to care facilities in the statutory sector.

Residential capacities of each facility

The nursing homes researched tend to cater for a larger number of residents than the care facilities researched. The fact that larger numbers of residents are catered for in the voluntary sector is attributable to many factors such as larger facilities, absence of residents who are extremely ill and therefore absence of a strong medical base to the care delivered.

Nursing homes in addition to possessing larger residential capacities, also offer an enhanced range of facilities which the statutory sector do not. The main differences lie in the arrangement of accommodation facilities- single and

double bedrooms with en-suite bathrooms. Comfortable and luxurious surroundings are also found in the majority of nursing homes who took part in the study.

Services offered by facilities

The services offered by both sectors are quite similar and some are common to both such as 24hr nursing care, Chiropody and the availability of a doctor. It can also be seen that both sectors offer some different services to their residents.

Perception of empowerment

The perception of empowerment by respondents from both sectors was very interesting. Respondents from the voluntary sector perceived empowerment as a concept deeply steeped in the elements of decision making, freedom of choice, transfer of powers, dignity and independence for the resident in an environment of holistic care. Respondents from the statutory sector possessed a diverse conception of what empowerment entailed. As a whole their perception of the concept had a broader base which acknowledged the wider aspects of the term from the viewpoint of patients and staff. Higher levels of training and skill development in the statutory sector have led to greater professionalisation of staff. They are thus more familiar with the formal concept of empowerment and how it might be implemented into practice.

Empowerment- working principle or abstract concept?

Three nursing homes out of the four researched felt that empowerment is a principle which can be incorporated into the daily routine. The remaining nursing home felt that empowerment is an abstract concept as opposed to a working principle which can be utilised and incorporated into practice.

In contrast respondents from the statutory sector collectively held the view that empowerment is a working principle rather than a concept. Respondents from both sectors did however stress the point that empowerment is something which needs to be continuously worked at.

Empowering practices

In relation to empowering practices a central theme which runs through the responses provided from respondents in the voluntary sector is the element of choice. Independence, encouragement and assistance where necessary, were also deemed to be worthy of note. In contrast respondents from the statutory sector focused on the practice of empowerment from a staffing point of view.

Three out of the four facilities researched placed their emphasis solely on practices from a staffing point of view.

Only one facility focused on the empowerment of its residents and the practice of enabling them to have choices and make decisions.

Initiation and practice of empowerment

In terms of which members of staff are more likely to initiate and practice empowering ways of working, the author found it difficult to identify the emergence of a pattern from the respondents in the voluntary sector as all four responses were different. A somewhat clearer pattern can be identified in the statutory sector as over half of the facilities researched placed an emphasis on the attributes of working as a team and the contributions which each member of a team can offer. One respondent felt that empowerment could be solely attributed to the efforts of nursing staff.

Barriers and limitations

A range of different barriers and limitations were offered by respondents from both the voluntary and statutory sector. The voluntary sector was concerned with the following factors:

- Staffing levels
- Safety of residents
- Ability of residents
- Heavy workload

Respondents from the statutory sector were concerned with the following factors which served as barriers to the process of empowerment:

- Staff shortages
- Institutionalisation of staff

- General difficulties related to staff such as laziness
- Training and re-training of care staff
- Dominant personalities and their effect on other staff members
- Time limitations
- Inflexible routine
- Heavy workload

Factors facilitating the inclusion of empowerment

The factors which allowed for the facilitation of empowerment in the voluntary sector were different to those in the statutory sector. Some factors are common to both sectors such as good communication, keeping up to date with current practices, trust and respect and good management / leadership. The factors offered by both sectors focused on the abilities of staff, their strengths and weakness, teamwork, motivation, openness to new ideas, etc. Residents were only briefly mentioned by respondents in both sectors, e.g. listening to residents, provision of a homely environment and prioritisation of the needs of residents. The statutory sector placed a greater central emphasis on staff and the importance of empowering staff before attempting to empower residents.

Strategies to overcome challenges

The strategies provided by respondents in the voluntary sector include:

- In-house training & study days
- Appropriate staffing levels

- Ensuring environs are safe
- Encouragement, support and praise for residents
- Stressing the importance of empowerment to all
- Increased time to be afforded to residents to discuss their needs

Strategies suggested by respondents in the statutory sector include:

- Educate and train staff
- Increased staffing levels
- Enhanced Communication
- Maintaining an appropriate focus as to why staff members are there
- Identification of personal strengths and weaknesses
- Obtaining trained, professional, efficient and competent members of staff
- Provision of Quality time to residents
- Being up- skilled

As the results above suggest some factors are common to both sectors. These are as follows:

- **The education and training of staff, which includes in-house training and study days.**
- **Revised levels of staffing in all facilities so that appropriate, increased and effective staffing levels exist.**
- **The provision of quality time for all residents.**

Some factors can also be attributed to each individual sector, as the results indicate.

The strategies offered by the voluntary sector place a greater emphasis on residents than those of the statutory sector. Respondents from the statutory sector are almost entirely concerned with boosting the morale of staff and engaging in each strategy to ensure this. The only strategy offered regarding residents is to afford them some quality time. A greater emphasis needs to be placed upon the needs of residents by the statutory sector and to overcome the challenges which prevent their empowerment.

The author believes that the statutory sector places a greater emphasis on empowering staff and in boosting morale due to a number of factors. All care facilities in the statutory sector are governed by the North Eastern Health Board. The Health Board monitors the progress and challenges which each care facility engage in. The staff members who work in each individual facility and the development which they make while working there has been identified as a vital aspect to the core of the delivery of care services to older people. To this end there is a recognition that staff must be empowered before the services which they deliver have the ability to create the environment necessary for older persons to empower themselves. In contrast, the voluntary sector are not monitored or regulated in this way, i.e. by the Health Board so less emphasis is

placed upon the impact which members of staff have upon the overall level of care that is delivered to older people.

Additional Comments

Respondents from the voluntary sector spoke of the fundamental rights of residents to be able to make their own choices. They made the further point that some medical conditions can in fact affect empowerment by removing an older person's ability to make choices. Another respondent spoke of the quality of management and how this has an impact on members of staff who works there in that they feel valued and important in the process of care. Another respondent spoke of the additional activities which both residents and staff get involved in and also the things which they would like to be able to do such as day trips and outings. All respondents from the voluntary sector provided additional comments.

Respondents from the statutory sector provided a lot of additional comments over a wide spectrum. All respondents from that statutory sector provided additional comments. One respondent felt that new staff members were needed as their current staff profile is 'old'. One respondent reiterated a similar comment from a respondent in the voluntary sector when they spoke of having transport to go on outings and day trips with residents. One respondent felt that it was important to adequately reward staff for their work so that they feel valued and empowered. Staff shortages at the weekends, limited spaces for

storage of equipment and reduced space for residents due to the initiation of an additional programme in the facility were all issues of concern to this respondent. However they were quite adamant that despite these difficulties a strong level of teamwork and hands on approach existed in the facility. The final respondent reiterated a lot of issues which had been previously addressed and some new points such as the policy of accountability and other policies in place in the facility. The advantages and advances due to moving to new premises were ascertained as well as the practice of 'client comment cards'.

At this point the author feels that the majority of respondents possess varied levels of understanding with regard to empowerment. The author feels that the respondents from nursing homes A and C possess a superior knowledge in relation to empowerment and its practice within services for older people. The respondents from nursing homes B and D possess a lesser notion of what empowerment implies and entails. This can be ascertained from their responses of their perception of empowerment, whether empowerment is a working principle or an abstract concept and the barriers which they presented which challenges the process of empowerment.

In terms of respondents from the statutory sector, respondents from care facilities F, G and H appear to have a superior knowledge of empowerment in relation to older people. This is very clear from the perceptions which they held of empowerment. In contrast, the respondent from care facility E possesses a

great knowledge of empowerment relating to empowering staff and boosting morale but has forgotten to include older people in their notion of empowerment.

The author feels that respondents who demonstrate a good understanding of empowerment have also utilised the concept of empowerment to inform their care plans and to guide their care practices in the services which they offer to older people.

The author is however concerned that the respondent from nursing home B while demonstrating quite a low level of understanding regarding empowerment, may not be utilising the concept of empowerment to inform their care plans or to guide their care practices.

In addition to this the respondent from care facility E appears to have been concerned with the empowerment of staff throughout the qualitative process. The author is uncertain whether this respondent possesses an adequate knowledge of empowerment in relation to older people to incorporate it into care planning and daily care practices.

*Analysis of
Quantitative
Data –
Questionnaires*

6.0 Analysis of Quantitative Data- Questionnaires

Ten questionnaires were sent to each Nursing Home and Care Facility. All questionnaires were to be dispersed by the respondents who have previously been interviewed in each facility, among both nursing and support staff. In addition, the researcher requested that all questionnaires should be completed only by staff that had daily contact with the residents/patients.

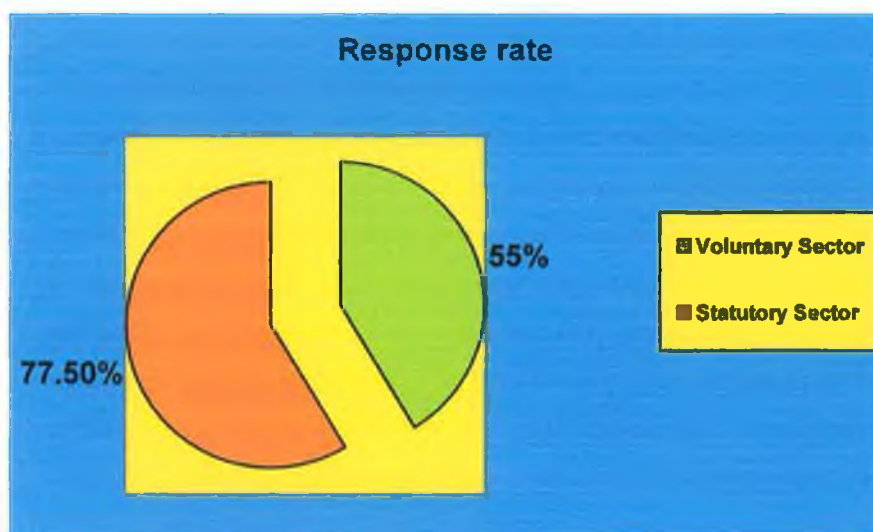
Questionnaires were distributed after the interview took place to be returned within a fortnight. Questionnaires which were not completed were to be returned in the stamped addressed envelopes provided.

For the purposes of analysis, the author felt that it would be better to deal with each facility separately and then to compare the voluntary and statutory facilities. For the purposes of the presentation of quantitative data, each facility will be accorded a letter as in the analysis of qualitative data.

Response rate

The rate of response from the voluntary sector was 55%. The highest rate of completion from the voluntary sector derived from Nursing Home A with 7 questionnaires returned. Nursing Homes B, C and D all completed five questionnaires each.

The statutory sector had a higher rate of response at 77.5%. Care facility G completed all questionnaires. Care facilities E and H both completed 8 questionnaires, while facility F completed five.



Graph 1

Two factors could account for a higher response rate in the statutory sector. The first factor is that as the Care facilities in the statutory sector are run by the North Eastern Health Board, they are therefore subject to a lot of supervision, quality checks and inspections as well as research studies carried out by other students. Therefore it is the opinion of the author that members of staff and management who work in the statutory sector are more open to research processes and to the importance of their cooperation and involvement in such. Secondly, the author had to go to some lengths to get permission to conduct the research from a senior Health Board official. Once this permission was granted

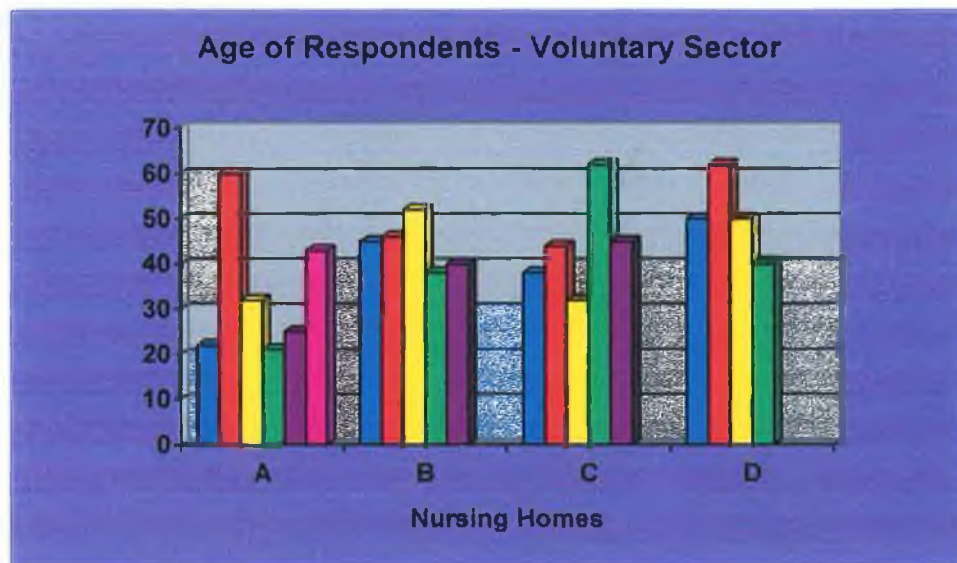
all facilities were requested to cooperate in the research. In comparison respondents in nursing homes are not subject to the same level of scrutiny as those in the statutory sector and are therefore more willing and co-operative regarding the completion and return of data.

6.1 Section 1 Personal Details

Voluntary Sector

All respondents from Nursing Homes in the voluntary sector were females.

Twenty respondents out of twenty two stated their age. Both of these questions were covered in the questionnaire to gain general information in relation to the respondent and in order to identify possible differing opinions, between male and female workers for example. There may also have been the possibility of differing views between persons of similar positions but of a different age group. As all the respondents were female there was no opportunity to compare the results of male respondents. Graph 2 below illustrates the varying ages of respondents who took part in the research. It can be seen from the graph that nursing home A has the youngest employees as it employs three respondents in the 20 – 30 year age bracket. All other nursing homes appear to have respondents from age 30 upwards.

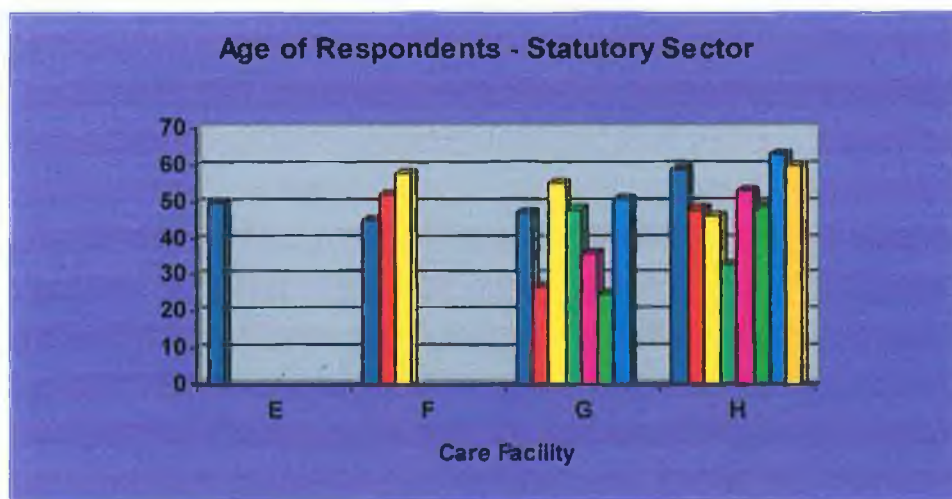


Graph 2

Statutory Sector

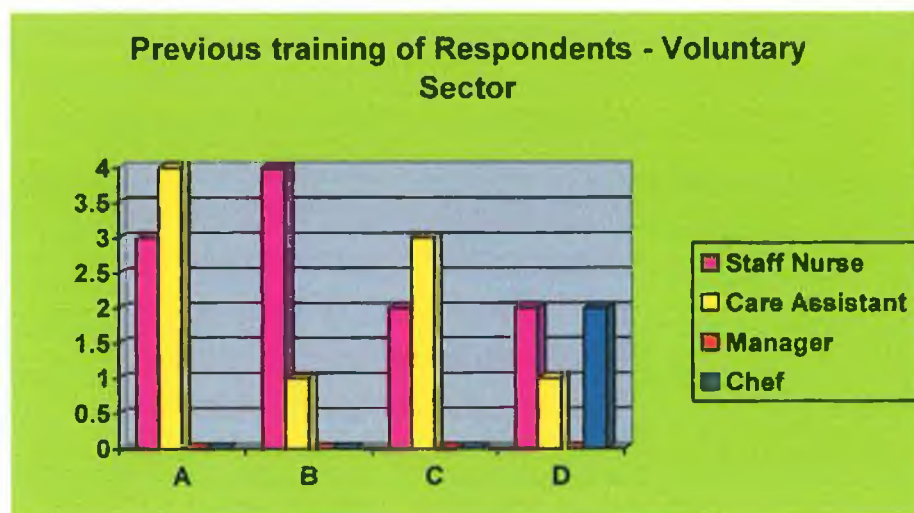
Thirty one respondents returned questionnaires from care facilities in the statutory sector, thirty of these respondents were females while only one was a male respondent. Nineteen respondents out of thirty one stated their age. As previously mentioned the author will be aware of any differing views which may present with regard to differing ages or differing views determined by gender. However the results could not be called conclusive as there is only one male respondent.

Graph 3 across shows the varying ages of the respondents who took part in the research. It can be identified that care facility G appears to employ some younger employees than other similar facilities. This pattern can also be identified in a facility in the voluntary sector and is attributable to the fact that both these facilities are relatively new to the services for older people.



Graph 3

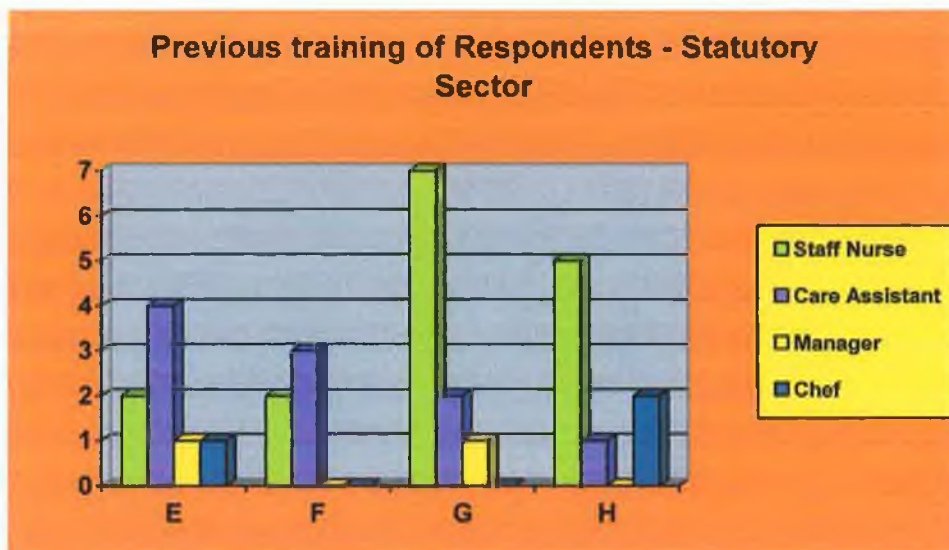
6.2 Section 2 History of Employment and Training



Graph 4

Voluntary Sector: Staff Qualifications

Overall respondents from the voluntary sector included eleven who trained as nurses, one of which trained and worked as a nurse manager. Eight respondents had trained as care assistants and two respondents as chefs.



Graph 5

Statutory Sector: Staff Qualifications

Overall, respondents from the statutory sector include nineteen who trained as nurses, three of whom had received additional training in relation to management and one in relation to pastoral care. Ten respondents trained as care assistants. Two additional respondents trained as a manager and one as a chef.

6.2.1 Positions held by respondents

Question 4 identified the current position that respondents hold within the Nursing Home and Care Facilities researched. The results obtained within each Nursing Home in the voluntary sector, yielded exactly the same results as those in question three.

Within the statutory sector, the results obtained within Care facilities E and F, correlate exactly to the results obtained in question three. In Care Facilities G and H, respondents hold somewhat different positions to what they originally trained as.

To summarise, in the voluntary sector all staff who completed the questionnaire and who had previously trained in a certain area such as nursing, carried on to hold a position in the area in which they specialised. In the statutory sector all respondents similarly held positions which they trained and specialised in except for one respondent who had trained as a nurse and currently worked as a care assistant. In the statutory sector it can be seen that respondents who trained as nurses also completed additional training to advance their positions to clinical nurse manager's grades 1 and 2.

This information is relevant to the study as the author wished to ascertain whether respondents did indeed hold positions which they originally trained for and whether they had progressed within the organisation by the completion of additional in-house training. As a result of which they may now hold a better position than that which they had initially held.

6.2.2 Length of service

Question 5 looked at the period of time that the respondents were working in each Nursing Home or Care Facility.

Voluntary Sector

- **Nursing Home A**

Respondents in this Nursing Home were relatively new to their positions, since the longest length of time worked was just over a year and a half.

- **Nursing Home B**

Respondents in this Nursing home have good experience of working with older people as the longest time worked by respondents is thirteen years and the shortest is two years.

- **Nursing Home C**

Respondents from this nursing home varied from those with many years of experience, to those who were relatively new to the field.

- **Nursing Home D**

Respondents in this nursing home possess a significant and lengthy experience of working with older people as the majority have worked for long numbers of years in this particular setting.

Statutory Sector

- **Care facility G**

Respondents in this nursing home worked for relatively short periods of time, the shortest being two months and the longest being two years.

- **Care facility F**

Respondents in this nursing home worked for varying periods of time, the longest being six and a half years and the shortest being seven months.

- **Care facility E**

Respondents in this nursing home worked for relatively short periods of time, the shortest being one year and the longest being three years.

- **Care facility H**

Respondents in this nursing home worked for a varying periods of time, the shortest being six months and the longest period is ten years. One respondent worked in this facility longer than any other respondent in any other facility.

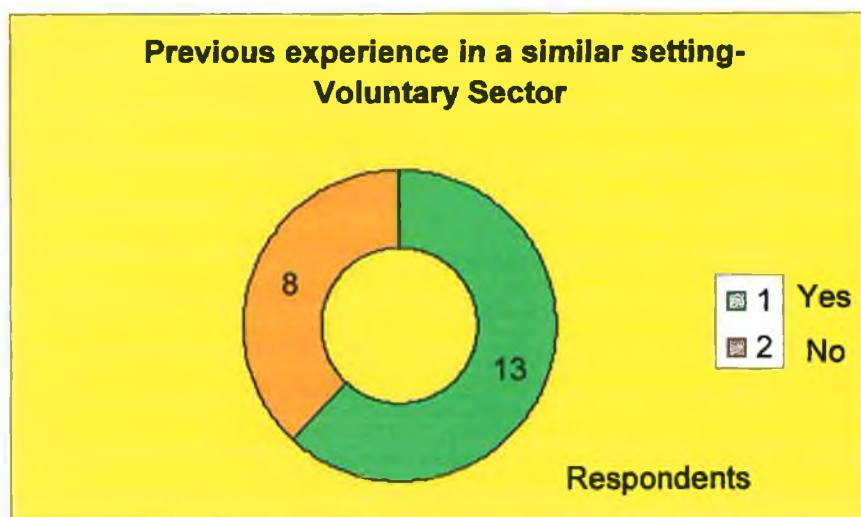
Overall it can be identified that respondents from the voluntary sector worked for a greater number of years compared to their colleagues in the statutory sector. The longest period of time worked by a respondent in the voluntary sector was seventeen years while the longest period of time worked by a respondent from the statutory sector was ten years.

The author feels that the length of time which an individual works within a particular setting is directly related to a number of factors such as position within the setting, job satisfaction, conditions and monetary rewards. However for the majority of people, the satisfaction which they derive from their work is the primary reason for continuing employment. One must then ask are respondents from the voluntary sector satisfied in their work. Or are respondents from the statutory sector less satisfied with their work so they continue to search for better horizons, better conditions?

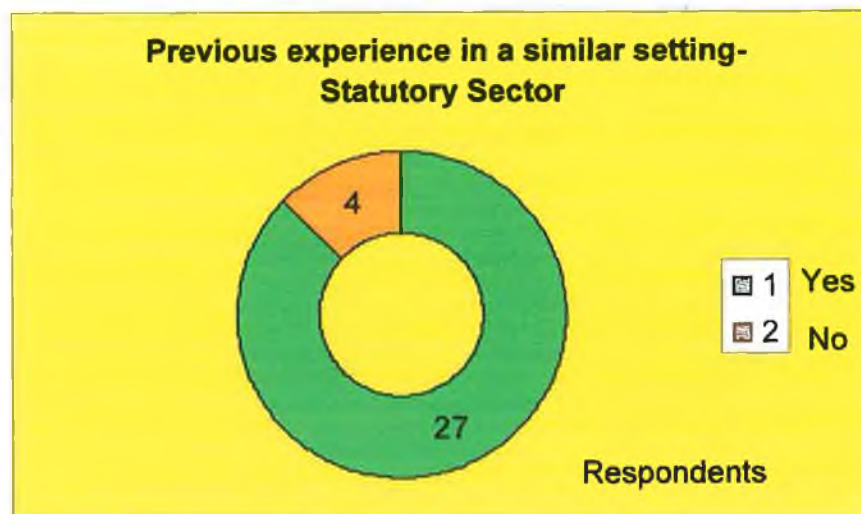
6.2.3 Previous experience in similar settings

Question 6 asked the respondent to specify whether they had previously worked in a similar setting and if so, the length of time they had worked there.

In the voluntary sector, from a total of twenty two respondents, thirteen had previously worked in similar settings and eight respondents had not previously worked in similar settings.



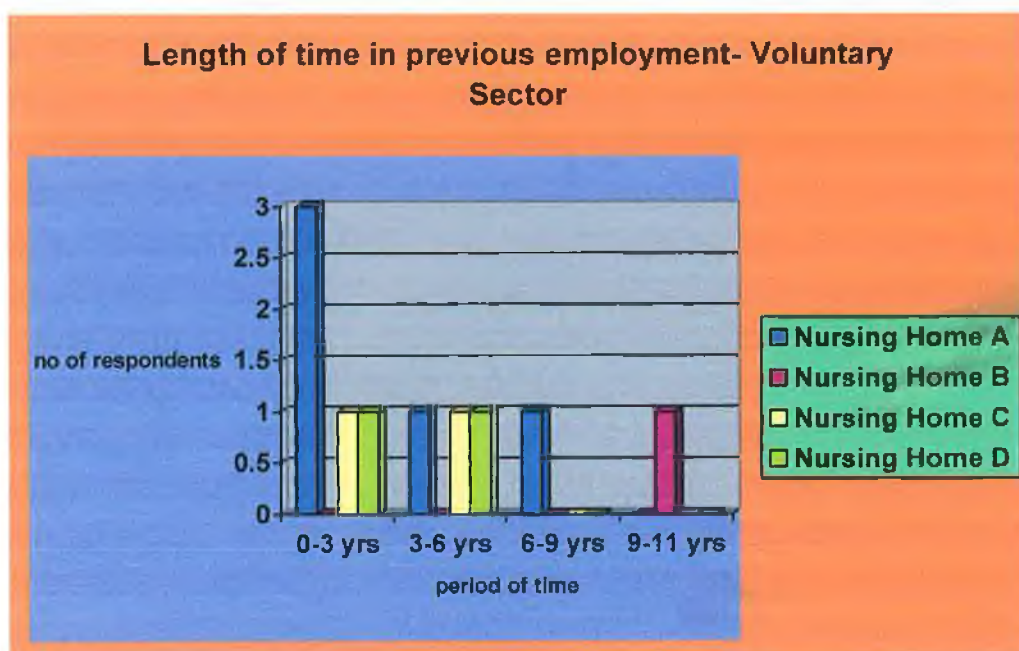
Graph 6



Graph 7

In the statutory sector, from a total of thirty one respondents, twenty seven had previously worked in similar settings and four had not previously worked in similar settings.

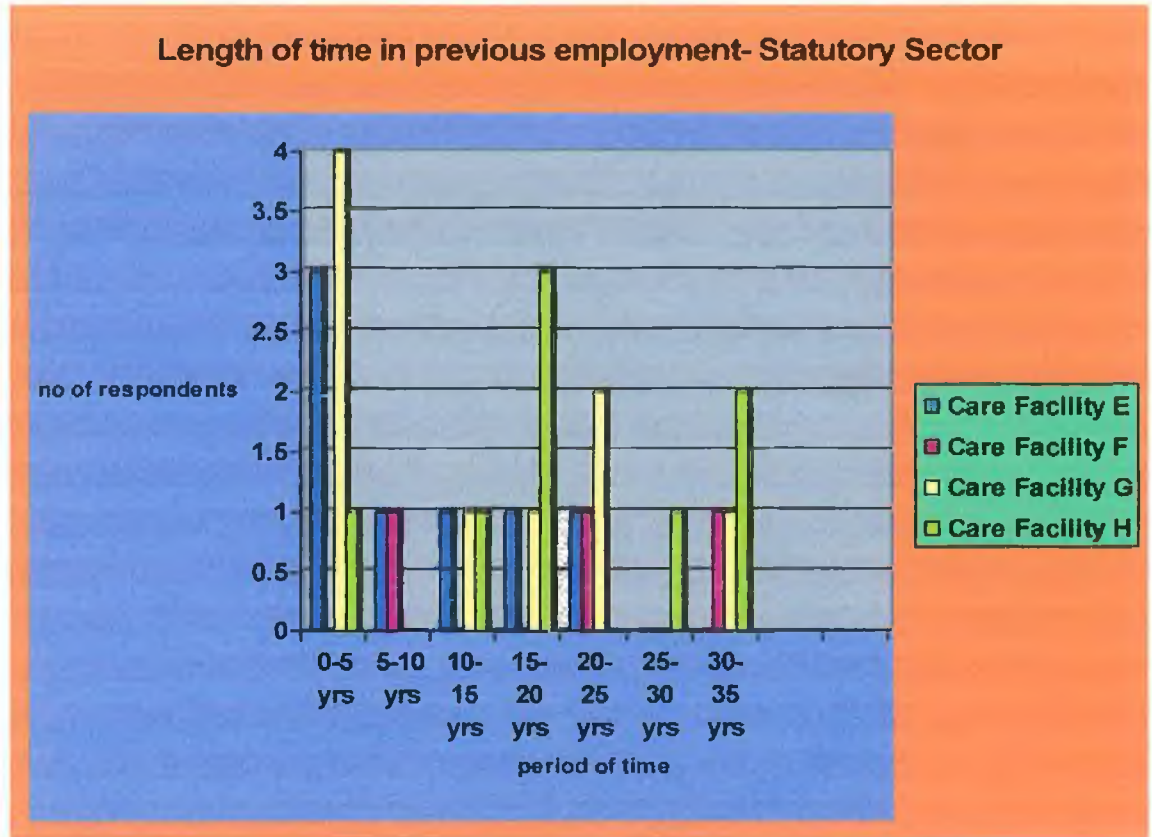
In the voluntary sector, thirteen respondents had previously stated that they had worked in a similar setting, however only eight respondents went on to reply to this question. The following graph number nine provides an illustration of the periods of time which respondents worked in previous employment.



Graph 8

The graph illustrates that a higher percentage of respondents in the voluntary sector worked for shorter periods of time, such as one to three years. Only one

respondent from the voluntary sector had previously worked for a period of more than nine years.



Graph 9

In the statutory sector, twenty seven respondents had previously stated that they had worked in a similar setting prior to moving to their current job. A further twenty four respondents went on to state the periods of time in which they worked in a similar setting. From the graph it can be identified that the periods of time in which respondents worked in previous employment were much greater than respondents from the voluntary sector. A high percentage of respondents from the statutory sector had previously worked in similar settings for more than fifteen years, and not exceeding thirty five years.

In terms of the length of time which each person worked in a similar setting, it can be concluded that **respondents from the statutory sector possess an overall greater level of experience of working with older persons, due to the periods of time in which they worked in similar settings.** In contrast **respondents from the voluntary sector have worked in similar settings for much shorter periods of time than their colleagues in the statutory sector.** This can be identified from graphs 8 and 9.

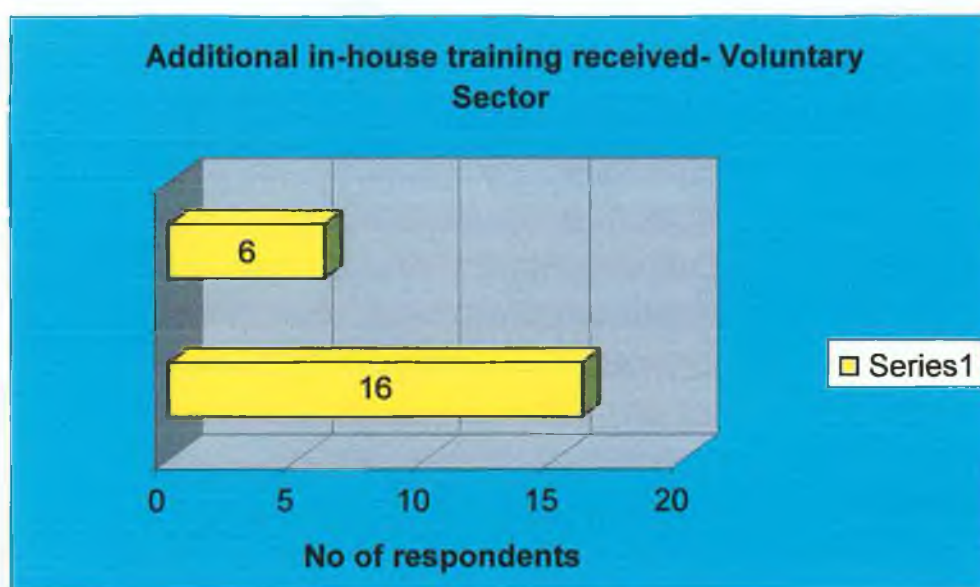
The author feels that it is very positive that respondents from the voluntary sector have worked in the same setting for longer periods of time, than those in the statutory sector. It is possible that a greater level of experience is developed when one experiences numerous similar settings as opposed to remaining static in one facility.

Another factor may also have some bearing on the results, namely that staff have a tendency to remain in a facility when they are happy with their job, their role within the organisation, management of the organisation, the level of care which is provided to older people. Therefore it is very difficult to ascertain the best approach and the most assured level of experience which respondents possess in the voluntary or statutory sector.

6.2.4 In-House training received

This question was utilized to ascertain the type and level of training received by members of staff in the Nursing Homes and Care Facilities researched.

Voluntary Sector



Graph 10

Out of a possible twenty two respondents, sixteen had received additional “in-house” training, while the remaining six respondents had not received any additional training opportunities.

Respondents who had not received additional training included one Nurse, four Care Assistants and a Chef. In the case of the Nurse, the author wishes to draw the reader’s attention to the fact that she had failed to receive any training over her working period of twelve years. Other Nurses however within the same

Nursing Home had received additional training after four years in one case and thirteen years in another case.

In the case of the Care Assistants, it is clear that they do not receive any additional training in Nursing Homes in B, C and D. This can be ascertained by the author as no other Care Assistants who responded had received training of any kind.

Only one member of the catering / support staff failed to receive training. It is a possibility that due to the fact that this person had previously trained and sought qualifications as a chef, it was deemed unnecessary by management to present training opportunities to this person. They may also anticipate that a chef must seek their own training courses if they feel that it may be necessary to do so.

From the perspective of training it is reasonable to assume that the level of training received depends greatly on the position held and the length of time in employment. It is therefore difficult to explain the fact that -;

- a) A Nurse employed for twelve years did not receive training of any kind.
- b) Care Assistants from Nursing Homes B, C and D had not received any training despite being employed for periods from two eight, eleven and a half and twelve years. Care Assistants need to receive training and education regularly, particularly between the periods aforementioned.

- c) A Chef employed for a period of two years did not receive any additional training appropriate to their particular role and function.

Statutory Sector



Graph 11

Overall out of thirty one respondents, twenty three had received additional 'in-house' training, while eight respondents had not received training of any kind.

The respondents who did not receive any additional training were as follows;

- a) 3 respondents did not receive any training in Care Facility E. The three respondents comprised of a Nurse who had been employed for three years, a Care Assistant also employed for three years and a Nurse who worked in a managerial role for a year.

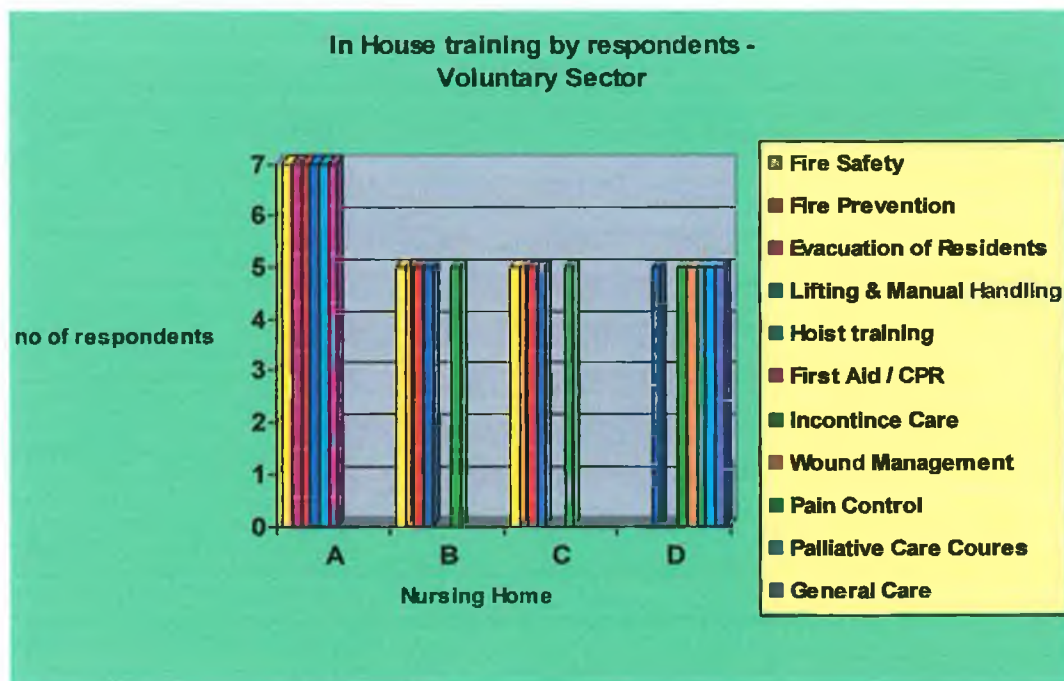
- b) Three respondents did not receive any training in Care Facility F. The three respondents comprised of two Care Assistants who had been employed for three and four and a half years and a Nurse who had been employed for seven months.
- c) 2 respondents did not receive any training in Care Facility G. Both of these respondents work as Care Assistants. Due to the fact that both of these respondents are relatively new to their positions- 2 months and 6 months, the author cannot infer that Care Assistants do not receive any training while working in this facility.

Overall, the author found that higher levels of training opportunities exist in nursing homes A and D while much lower levels of training are offered to respondents in nursing homes B and C. In the statutory sector, the author found that higher levels of training opportunities exist in care facilities G and H while much lower levels of training were offered to respondents in care facilities E and F. Therefore half of the nursing homes and half of the care facilities researched offered greater levels of training opportunities in both sectors.

In general it can therefore be identified that in relation to the levels of training opportunities which are offered to staff there is lack of standardisation in both the voluntary and statutory sectors. Training seems to happen on an ad hoc basis, which means that some staff members who should definitely receive training do not.

6.2.5 Training received

The training received by the respondents as previously noted depends greatly on positions held and the length of time in employment.



Graph 12

Voluntary Sector

The author feels that a reasonably high level of training is offered by Nursing Home A, as both nursing and care staff receive similar levels of training. The author however feels that the training that is provided to staff members should also be geared towards empowering older persons and should cover all members of staff, i.e. house-keeping and kitchen staff, as they are equally important in the empowering process.

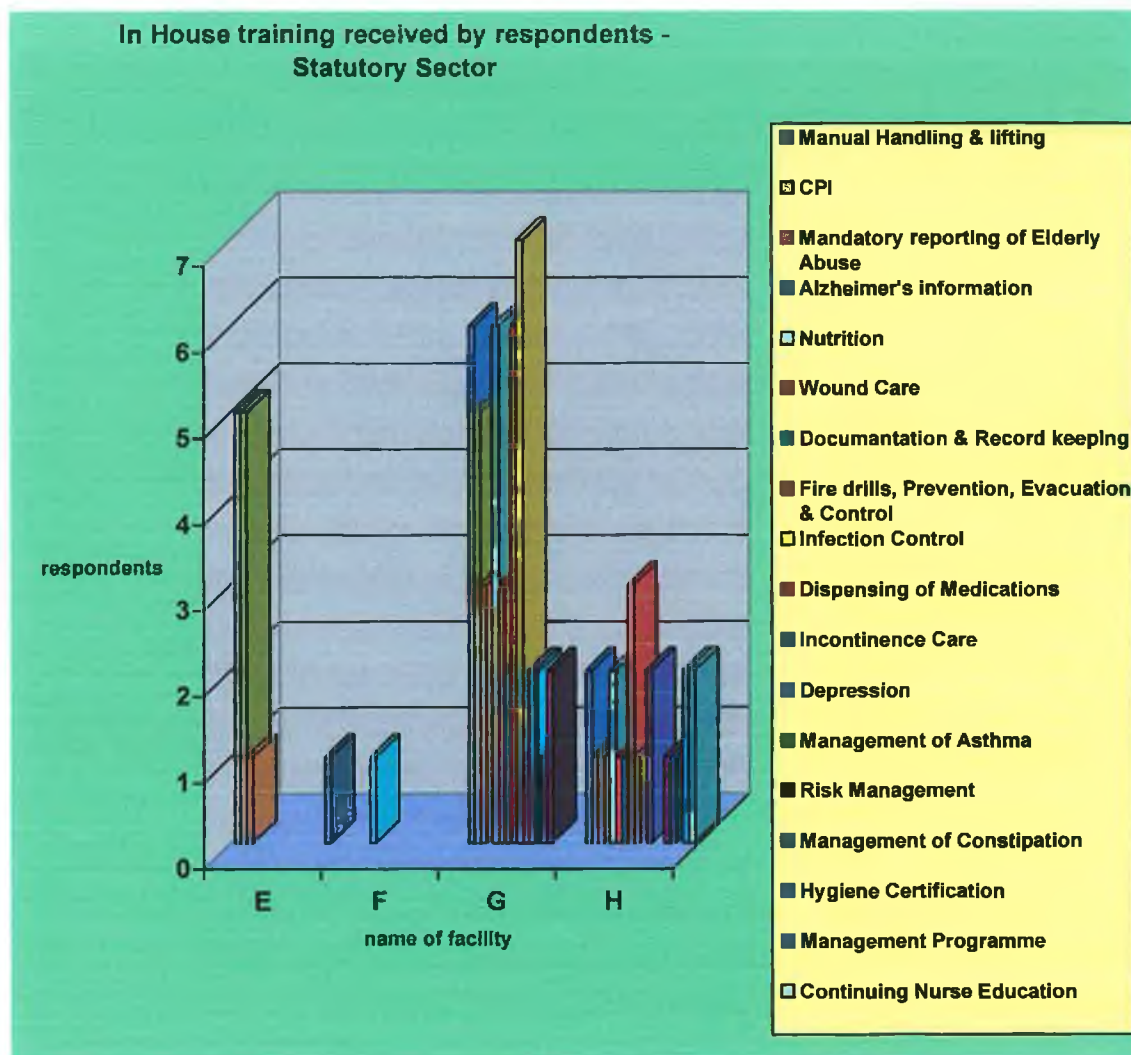
Nursing homes B and C appear to offer quite a similar level of training to its staff members with the exception of Care Assistants in both facilities who do not appear to have received training of any kind. The author feels that the level of training which is offered to existing staff members should be updated so that all care facilities within the private sector could provide a similar level of training for its staff.

Nursing home D, offers a reasonably high level of training to all its members of staff, however the author feels that this training should be restructured towards the empowerment of older persons and should include all members of staff from nursing staff to domestic and support staff as all members must be kept updated as to the benefits of empowerment and the role that they play in empowering older persons in their care.

The author feels that the training that is offered to respondents in the voluntary and statutory sector should be geared towards the concept of empowerment and what empowerment entails for staff and residents/patients alike. In addition to this the author feels that all members of staff regardless of their role within the organisation should receive this training as they are equally important in the empowering process.

The author wishes to note the lack of training which is offered to respondents in the voluntary sector who do not appear to have received any training in nursing

homes B and C. Care assistants should receive training which is appropriate to their role within the organisation and also in relation to empowerment.



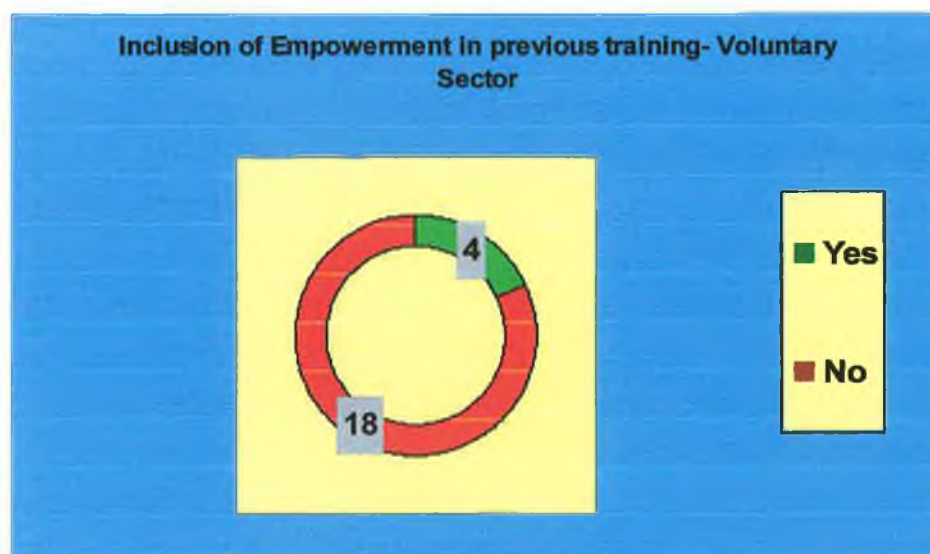
Graph 13

In terms of respondents from the statutory sector, the author found that a greater range of training was presented to staff. The training which was offered comprised of a stronger medical base when compared to the training which respondents in the voluntary sector received. Ideally an equal amount and level of training should be offered to members of staff in both the voluntary and

statutory sectors. As previously indicated this training should be sufficient and appropriate for each person's role within the organisation, as well as encapsulating the concept of empowerment and the benefits of its incorporation into service provision for older people.

The author found that there was lack of standardisation in relation to the range of training which staff could avail of within both the voluntary and statutory sectors. An example of this is where a different broad range of training opportunities is provided to staff within the same sectors, either statutory or voluntary sectors. The author believes that some standardisation should exist in relation to both the level of training which respondents can avail of and the type of training which they have the opportunity of engaging in.

6.2.6 Inclusion of Empowerment in previous training

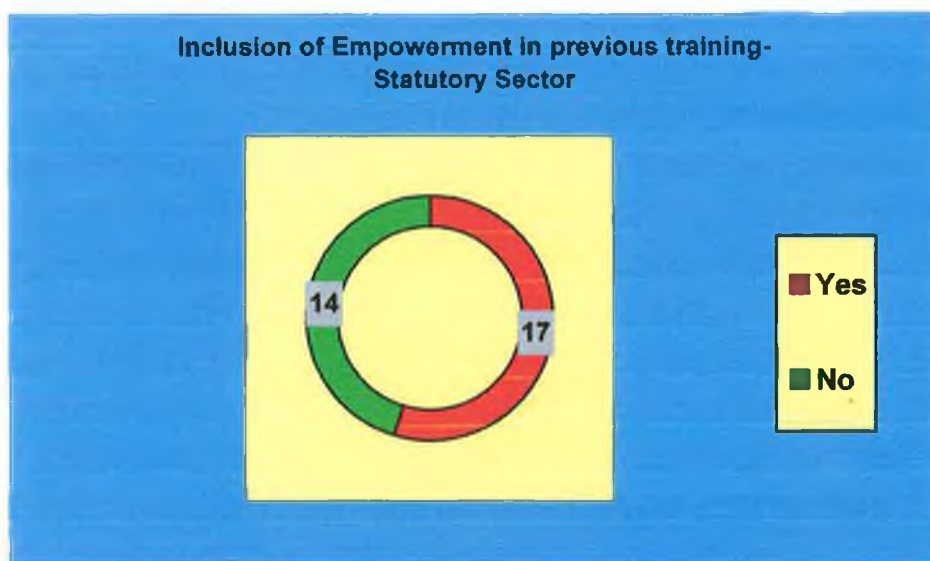


Graph 14

Voluntary Sector

Overall from graph 15, it can be identified that out of twenty two respondents, only four respondents believed that empowerment had been previously covered in their training.

Statutory Sector



Graph 15

Some of the respondents who felt that empowerment had been incorporated in their previous training went on to explain where and when it had been introduced into their training. One respondent stated that it had been incorporated as part of a management course which they took part in and had not been covered in the original training which they received while training as a Nurse. One respondent stated that empowerment had been incorporated in their studies while studying for their diploma in Nursing (ACCS). Another

respondent stated that it had been incorporated in their training while they were a student nurse. This respondent went on to say that they had received no training in relation to empowerment as a qualified nurse due to increased pressure which they attributed to “working with colleagues who are neither competent or often times are unwilling to take responsibility. They need to be hand- fed”.

One of these respondents in response to this question inquired “What do you mean by Empowerment?”

Overall, the author identified that a higher percentage of respondents from the statutory sector felt that empowerment had previously been incorporated in their training. This can be ascertained from the results as only four respondents from the voluntary sector felt that empowerment had been incorporated in their previous training while seventeen respondents from the statutory sector also felt that empowerment had been incorporated in their previous training.

6.3 Section 3 Job Satisfaction

Question 9 asked respondents if they enjoyed working with older persons. All twenty two respondents from the voluntary sector replied yes, while one respondent freely declared “I love it”. Similarly all thirty one respondents from the statutory sector stated that they enjoyed working with older persons.

The author asked this question in the hope of ascertaining whether respondents enjoyed working with older people or whether they were quite happy but preferred to work in a different setting, e.g. with children, etc. From the results gathered it is very clear that the respondents who participated in the study are very contented working in the care services for older people. These results are also borne in the following section.

6.3.1 Most Rewarding Aspect of Working with Older People

Voluntary Sector

Some respondents from the voluntary sector did not reply to this question, despite their earlier positive statements regarding their love of working with older people. The most rewarding aspects of working with older persons as deemed by respondents in the voluntary sector can be classified into four distinct categories:

1. The personality and character of each individual resident / patient.

Some respondents felt that the “different characters” which they came into contact with was very rewarding for them. Others felt that developing a bond with residents and families alike also complimented the efforts of staff. Some respondents felt that “older persons are funny” and due to this they are very nice and rewarding to work with.

2. Helping and supporting older persons.

Under this category respondents listed “the feeling of giving emotional and physical relief to people who are elderly and vulnerable” as a very rewarding aspect for them. Other respondents felt that it was very “rewarding work to help older people with different things” and in the “helping of older persons who cannot help themselves”. Another respondent felt that it was very important for them “to see older people smile, knowing that they are happy and that I did something during my day at work to make them happy and comfortable”.

3. Talking and listening to older people.

Respondents felt that “talking to older people and helping them to cope with their daily needs” was important and rewarding for them. In addition to this respondents felt that it was very important to listen to older people especially to “their stories of olden times and their younger years”.

4. Helping them to feel at home in their care setting.

Respondents placed a very high emphasis on assisting older persons to feel comfortable and at home in a different setting than they had previously been accustomed to. In order for older persons to feel at home it was therefore necessary to “create a warm and homely atmosphere” and to “make them feel at home”. Other respondents felt that it was very rewarding for them when “people are happy and contented in the nursing home and treat it as

their own home” as well as “seeing them settle down and enjoy life in the nursing home”.

The overall perspective from the Care Assistants, on the most powerful motivator in working with the elderly was the ability to provide companionship for the older person. In terms of the Nursing staff seeing the older person recover from illness and aiding in this process was the most powerful motivator for them.

Statutory Sector

The most rewarding aspects as deemed by respondents in the statutory sector can be classified as follows:

1. **Helping patients on a daily basis.**

Respondents felt rewarded when they were “helping patients with their needs” especially when they “could see the look of satisfaction and happiness on their faces” when they did things for them. Respondents were rewarded when they were “helping older people in any way possible” and when “they were of assistance to them in their daily living”. Respondents were happy when “assisting older people with activities of daily living that they are no longer able to manage themselves”.

2. **Spending time with and listening to older people.**

Respondents whose responses came under this category felt that it was both very rewarding and important to spend time with and listen to older people

and in helping to make them happy. Some respondents felt that “having time to spend with patients without watching the clock” and “listening to their stories” was very rewarding. Other respondents felt that “making their lives more satisfying and happier” also had similar effects for them.

3. Helping older people to feel at home.

Some respondents felt that “seeing them comfortable and happy in an environment away from their own home” was very rewarding. Other respondents felt that when “older persons are no longer able to live at home” it was very rewarding to “help them in every way to make their life happy and comfortable”.

4. The wealth of knowledge which older people possess.

Many respondents spoke of the “wealth of knowledge which older people possess” and the “wisdom which they have gained from a variety of life experiences”. In addition to this one respondent felt that “older people are great teachers as they have qualified from the university of life” and in this way they loved working with them and gaining a wealth of knowledge and stories from them.

In the statutory sector, three central themes ran through the responses which were provided by respondents. These include seeing older people happy and content and having the ability to make them comfortable. The final theme can

be classified into the responses provided by nursing staff – to provide each person with a high quality of nursing care, and care assistants – to assist and help older people to the best of their abilities.

6.3.2 Most Difficult Aspect of Working with Older People

The findings which resulted from this question are a combination of the personalities, illness, sadness and physical inabilities found among older persons in the care of others.

Voluntary Sector

Difficult aspects listed by respondents in the voluntary sector included:

1. Illness among residents

The illnesses included “deterioration in physical and mental conditions”

– Strokes, Alzheimer’s disease, etc.

2. Communication problems which resulted when patients had a stroke.

The inability which members of staff had in communicating with residents who were ill or confused was also listed as a difficult aspect by respondents.

3. Death of older people.

Respondents felt that the death of a resident was particularly upsetting especially when the attachments which they had formed with them were broken. In addition to this some respondents felt that caring for an older person after they passed away was very difficult.

4. Time constraints.

Respondents felt very restricted in terms of the amount of quality time which they could spend with residents- talking and listening to them.

5. Loneliness among the elderly.

Respondents felt that the loneliness which older people felt was often heightened when all their family members were deceased.

6. Sadness among staff members.

This occurred when residents passed away, when older people left and returned home and also when they saw residents disturbed or upset about something which was beyond their control or capabilities.

Some respondents provided quite negative replies to this question.

One respondent found that older persons can be 'difficult, grumpy and inconsiderate at times' while another felt that they can be "manipulative and aggressive at times". One respondent spoke of the sheer commitment which can be required of one, while another spoke of the physical limitations with regard to some residents. One respondent spoke of the struggle which they felt when dealing with a large number of residents and the difficulties which they had to meet their requirements.

Statutory Sector

The difficult aspects as listed by respondents in the statutory sector can be categorised as follows:

1. Staff shortages

This included not having enough staff to complete designated tasks and to spend 'quality time' with residents.

2. Quality time

Many respondents felt that time constraints were imposed upon them due to a heavy workload and a rigid routine within care facilities. Therefore a difficult aspect of working with older people was the "lack of time to meet the needs of everyone" and "not having enough time to talk to them" or "to spend with them on an individual basis".

3. Exhaustion

Some respondents spoke of the "physical and psychological exhaustion" which they often experienced as the "job can be heavy and takes a lot of patience".

4. Incontinence

Some respondents found this very difficult to deal with on a daily basis including all the associated tasks which must be completed as a result of a

resident's incontinence, such as "changing wet and soiled clothes- washing the older person".

5. Lack of physical movement.

Some respondents found it very difficult when residents were greatly restricted in movement by their physical abilities. "Lifting some older persons" was also listed as being a difficult aspect for some respondents.

6. Communication difficulties.

Some respondents found it very difficult to communicate with residents /patients when they were ill. Respondents also felt that it was often difficult to find enough time to dedicate to communicating with residents.

7. Staff members who are unwilling to deliver a quality service.

8. High dependency levels of some older people.

Respondents felt that the dependency level of some patients was difficult in terms of the amount of time which they required. Some respondents found it difficult that "while older persons physical needs are met, their emotional needs may not be".

9. Time constraints relating to encouraging older people to have individualised interests and activities.

10. Providing a safe environment while allowing independent mobility and maintaining an acceptable level of hygiene.

11. Forgetfulness among older persons and the poor self image which they possess.

12. Aggression among the elderly.

Only one respondent provided a negative aspect of working with older people, namely the aggression which they can often demonstrate to other residents and members of staff.

The author has drawn certain parallels between the views of Nursing staff and that of Care staff within the voluntary and statutory sectors, in terms of the most difficult aspects that they specified.

The Nursing staff in general found that deterioration in physical and mental well-being and the effects that illnesses had on other family members were the most difficult aspects for them. The most difficult aspects for Care staff were found to be the death of the resident, not having enough time to talk with them and difficulties they found in working with them on a day to day basis, e.g. in terms of communicating with severe stroke patients.

6.4 Section 4 Practice and Policy within the organisation relating to Empowerment

Question 12 investigated whether employees understood what the term empowerment means.

Voluntary Sector

Out of a possible twenty two respondents, fifteen replied yes that they understood what empowerment meant while six answered no to the question.

The author feels that Nursing home A, C and D demonstrate quite a high level of knowledge with regard to empowerment, with one only respondent in A and D answering no to the question. The author does not however accept the existing level of knowledge that prevails with regard to empowerment in Nursing Home B. The respondents within this facility particularly the four members of nursing staff should possess a good level of understanding in relation to the concept of empowerment. The author wishes to note the lack of knowledge and understanding of empowerment within Nursing Home B from both Nursing and Care staff sectors.

Statutory Sector

Overall out of a possible thirty one respondents, twenty eight believed that they understood what empowerment entailed while four felt that did not fully comprehend the concept or its implications in practice.

In terms of the number of respondents who believed that they understood what empowerment entailed, over double the number of respondents from the statutory sector compared to the voluntary sector conceded that they held an understanding of empowerment. The author therefore concludes that a greater perceptual knowledge is held by respondents in the statutory sector.

6.4.1 Empowerment explained by respondents

The second part of the question asked the respondent to give an explanation of what they understood by empowerment. In the first part of this question, the results which were obtained from respondents in the voluntary sector established that fifteen respondents out of a possible twenty two understood what the concept of empowerment implied. However only thirteen out of this fifteen went on to explain what the term implied. Two respondents did not reply to this question, even though they had previously agreed that they understood what the term implied. Therefore thirteen respondents out of a possible twenty two responded to this part of the question. Five respondents out of thirteen felt that empowerment was related to **‘encouraging, promoting, giving, allowing and enabling older persons to help themselves and make their own choices’**.

Voluntary Sector

The responses which were offered by respondents in the voluntary sector can be categorised as follows:

1. Decision making

Respondents felt that empowerment implied that older people should be afforded with the “ability and control to make their own decisions” so that they would be “enabled to have more control, power and authority” over their lives and life situation.

2. Independence

Respondents felt that older persons should be enabled to become independent in as many ways as possible, e.g. “providing information on their illness or needs, thus allowing them to have full impact on their care planning”. Respondents felt that empowerment reflected their efforts in “giving, allowing and fostering independence” so that “older persons are more in control of their needs on a daily basis”.

3. Choices

Respondents felt that empowerment was related to giving and providing choices for residents / patients. These choices were inclusive of all the integral elements of daily life – choices related to when to get up, go to bed, what to eat, when to eat, etc. “Choices with regard to the activities of daily living”.

4. Empowerment of staff

Respondents felt that an integral element of empowerment was the empowerment of staff and the impact which staff had in creating an appropriate environment in which empowerment could occur. For some respondents empowerment meant “power coming from a person in authority

to change/alter/improve a situation, in conjunction with team members” and for others it implied the “general relationship within your job with patients, manager and other colleagues”.

5. Respect for older people

An important element of empowerment according to respondents is the respect which staff members must pass on to older persons their care. This includes “respecting their wishes and opinions” as well as each individual person.

It is interesting to note that three broad categories can be drawn from the replies of respondents with regard to empowerment. These are the **provision of choices, independence and the empowerment of staff.**

The author feels that the fact that the respondents could explain what they believed empowerment to consist of strengthened their perception of the concept and their understanding of its implications. In the absence of some degree of understanding of empowerment, it would be very difficult to initiate and incorporate empowerment within existing service provision.

Statutory Sector

Results which were obtained from the first part of question twelve established that twenty seven respondents out of a possible thirty one respondents from the statutory sector understood what empowerment entailed. However only twenty

five went on to explain their understanding of what the concept implied.

Similarly two respondents did not explain what they felt empowerment was even though they had previously stated that they understood what the term implied.

Some responses put forward by respondents from the statutory sector are as follows;

- *“To authorize, give power to, to make able-to trust, support and encourage the patient to be as independent as possible”.*
- *“Providing holistic care for all”.*
- *“I understand it is giving the patient a choice of for example, going to bed or a choice of what time they would like their meals”.*
- *“Being part of a team”.*
- *“Having and making choices, decisions, independence, and the use of their own initiative to influence their care”.*
- *“Empowerment comes under the heading of their ‘scope of practice’ and that it would maximize an individual’s ability to function.*
- *“Everyone has the right within reason, to make decisions about their own destiny provided their actions are socially acceptable and does not compromise their own or others health and safety”.*
- *“Ageing and older people will be empowered to make choices that will promote their health and social well-being”.*
- *“Giving power to somebody”.*

- *“To enable old people to make choices, to nurture independence and to raise their self esteem”.*
- *“Empowerment means giving the individual person, the power/choice to make their own decisions, i.e. on their choice of care to remain in their own home or to reside in a nursing home, having the freedom of choice where and whenever possible”.*
- *“To nurture independence, to support older people to continue living in their own community for as long as possible. To be able to make choices that will promote health and well-being. The need for self-esteem, to feel useful and competent”.*
- *“Allowing the patient to have and make an impact on their care, being a good listener to the patient and relatives”.*

Other respondents looked at empowerment from a staffing point of view, such as:

- *“Encouraging staff through motivation to deliver better care by involving the patient and giving them choices”.*
- *“To supply adequate education, training and knowledge and then to step back and support staff (from the side lines) in achieving what they set out to achieve”.*

Other respondents felt that empowerment implied giving people choices, to do what they like to do for themselves, to make their own decisions and to allow them to participate in what they most enjoy, giving them dignity and respect.

In general from the responses provided from respondents in the statutory sector, five categories can be drawn as follows:

1. Allowing and encouraging the patient to have an impact on the care which they receive.
2. Nurturing the level of independence of patients and raising their self esteem.
3. Providing choices and making decisions.
4. Motivating and empowering staff.
5. Provision of holistic care.

Analysis of the responses provided by respondents in both sectors identifies that **respondents from the statutory sector provided in depth replies which incorporated the role which staff had to play regarding the incorporation of empowerment in practice. Respondents from the voluntary sector provided general responses with a primary focus upon the empowerment of residents as opposed to staff.**

The author feels that the respondents from both sectors possess good knowledge of the components which comprise empowerment. The main differences between the responses from respondents from both the voluntary and statutory sectors lie in the base which their knowledge of empowerment originates. The author concludes therefore that respondents from the statutory

sector possess a broader knowledge of empowerment from the viewpoint of both patients and staff.

6.4.2 Most important elements of the empowering approach

Question 13 identified what respondents felt were the most important elements of the empowering approach for older persons in their care. A choice of twelve options was presented on the questionnaire, the most appropriate of which was to be determined by the respondents.

Voluntary Sector

Nine respondents ticked all the options presented while the remaining ten respondents were a little more selective. Table 5A sets out the top five most important elements of an empowering approach as deemed by respondents in each nursing home. Overall it can be seen that respondents in nursing homes A, C and D appear to have chosen the same options generally, while the options of respondents in nursing home B are somewhat different.

From the table it can be identified that the most important element of an empowering approach as deemed by respondents in A, C and D is providing older people with choices and ensuring their continual independence. In nursing home B the most important element of an empowering approach is allowing older people to do what they enjoy as long as this fits into the daily routine.

Top 5 most important elements of the empowering approach- Voluntary

Sector

	A	B	C	D
1	Giving Older people choices / Allowing them to be independent	Allowing them to do what they enjoy as long as they fit into the daily routine	Giving Older people choices / Allowing them to be independent	Allowing them to be independent/ Giving older people choices
2	Healthy Environment with good communication	Ensuring that they receive good care, dignity & respect	Giving them help and support when required	Allowing them to do things on their own initiative
3	Ensuring that they receive good care, dignity and respect	Giving Older people choices	Ensuring that they receive good care, dignity and respect	Ensuring that they receive good care, dignity and respect
4	Giving them individual tasks and responsibilities	Providing a healthy environment with good communication	Providing a healthy environment with good communication	Giving them individual tasks and responsibilities
5	Allowing older people to have his/her own possessions around them	Giving help and support when required	Ensuring that all older people are given a high degree of privacy.	Giving help and support when required

Table 5A

The least important elements to the empowering approach among respondents in the voluntary sector were deemed to be:

Least important elements as deemed by respondents – Voluntary Sector

Advising older persons on the best course of action.
Allowing elderly people to have his/her own possessions around them
Ensuring that all elderly people are given a high degree of privacy
Allowing them freedom to develop friendships and relationships

Table 5B

All of these elements are equally important to an empowering approach as they foster independence and the opportunity to have their wishes considered. These are good foundations on which other empowering components are laid, e.g. ensuring that they receive good care, dignity and respect. The elements of the empowering approach can be directly related to the charter of rights for people receiving care as stated by Bell (1993). This charter sets out the rights of those who receive care, particularly older persons. The charter is included in the appendix

The first right as set out by this charter is ‘the right to privacy and confidentiality’ however the corresponding element ‘ensuring a high degree of privacy’ is one of the least important elements as deemed by staff. Similarly the freedom to develop friendships and relationships is another element of the empowering approach which has been afforded little importance by respondents

in the various nursing homes. It is set out in the charter as 'the right to have access to friends and relatives and to be given assistance to see them, if necessary.

Statutory Sector

Seven respondents from the statutory sector ticked all the options presented on the questionnaire. However the nineteen other respondents who replied to this question were a little more selective in their particular choices.

Table 5C across, identifies the top five most important elements as deemed by respondents from the various care facilities in the statutory sector. Analysis of the table illustrates the differing options as provided by respondents in each facility. In this sector it is difficult to identify a pattern of similar responses in similar facilities however it is clear that respondents although they have presented similar options as those in the voluntary sector, they have ranked them differently.

Top 5 most important elements of the empowering approach-

Statutory Sector

	E	F	G	H
1	Providing a healthy environment with good communication	Giving older people choices	Giving older people choices	Ensuring that they receive good care, dignity & respect
2	Ensuring that they receive good care, dignity & respect /	Allowing them to be independent	Ensuring that they receive good care, dignity and respect	Ensuring that all older people are given a high degree of privacy
3	Allowing them to be independent	Giving them individual tasks & responsibilities	Allowing them to be independent	Healthy environment with good communication
4	Giving older people choices	Allowing them to do things on their own initiative	Ensuring that all older people receive a high degree of privacy	Giving help and support when required
5	Allowing them to do things on their own initiative /Allowing older people to have their own possessions	Ensuring that they receive good care, dignity and respect	Healthy environment with good communication	Allowing them to be independent

Table 5C

Choices

In the voluntary sector for example, respondents rated highly the attributes of the provision of choice and independence for residents. Choices were deemed to be the most important element of an empowering approach in two out of the four care facilities in the statutory sector.

Having One's Own Possessions around them

Respondents from one nursing home and one care facility felt that it was important that older people have their own possessions around them.

Good Care, Dignity and Respect

In contrast respondents from the statutory sector rated highly the attributes of the provision of good care, dignity and respect compared to the importance which respondents accorded to it in the voluntary sector.

Independence

Respondents from the statutory sector accorded less importance to ensuring that older people maintain their independence than the voluntary sector who felt it was a very important element of an empowering approach.

Presence of a Healthy Environment with Good Communication

Respondents from three facilities in the voluntary and statutory sectors felt that the presence of a healthy environment with good communication between staff and older people was important.

Provision of Individual Tasks and Responsibilities

Respondents from two Nursing homes in the voluntary sector accorded importance to providing older people with individual tasks and responsibilities compared to the respondents from one facility in the statutory sector.

Giving Older People Help and Support

Respondents from three nursing homes in the voluntary sector felt that giving older people help and support when required was important while respondents from only one facility in the statutory sector felt this to be the case.

Allowing Older People to do things on their own initiative

In contrast respondents from two facilities in the statutory sector felt that allowing older people to do things on their own initiative was important, while respondents from only one nursing home felt this to be the case.

Ensuring that Older People are given a high degree of privacy

Respondents from two care facilities accorded importance to the value of ensuring that older people are given a high degree of privacy, whereas respondents from only one nursing home in the voluntary sector felt this to be the case.

The author feels that the results of the data presented indicate that a greater emphasis is placed on older people and their care within the voluntary sector. This can be identified from the options which were presented in table 5A which illustrate that overall importance is accorded to the provision of choices, independence, good care, help and support when required, dignity and respect.

Table 5C illustrates the differing options provided by respondents in the statutory sector. The author feels that while similar options have been accorded importance from respondents in the statutory sector, the options provided demonstrate an equally good emphasis on older people and their care. However despite this, respondents appear to place much greater emphasis on the environment in their facilities. This is due to the fact that they place great importance to the **presence of a healthy environment with good communication, as well as privacy, and allowing older people to do things on their own initiative.**

The least important elements of the empowering approach as deemed by respondents from the statutory sector in order of importance are as follows;

Least important elements as deemed by respondents – Statutory Sector

Allowing them freedom to develop friendships and relationships.
Giving older persons individual tasks and responsibilities.
Allowing them to do what they enjoy as long as they fit into the daily routine.
Advising them on the best course of action.
Ensuring that all elderly people are given a high degree of privacy.
Allowing them to do things on their own initiative.
Allowing elderly people to have his/her own possessions around them

Table 5D

The above table illustrates that respondents in the statutory sector place very little importance to allowing older people the freedom to develop friendships and relationships. Similarly in the voluntary sector this is also deemed to be an unimportant element of empowerment.

The author feels that this is a great pity as friendships and relationships are extremely important to everyone particularly in old age. Many older people have seen so many of their friends pass away and as a result they feel lonely and isolated. This should not be the case when older people enter a facility due

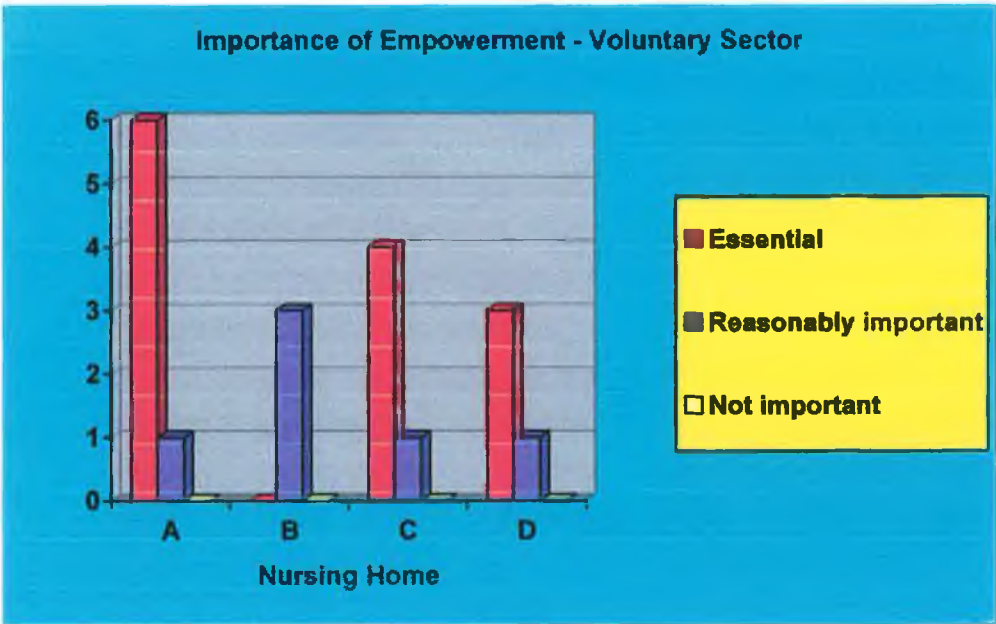
to the requirement of receiving care. A greater emphasis should be placed on the development of older people so that they can empower themselves to make decisions, live life as they wish and be happy with the quality of their circumstances.

6.4.3 Importance of Empowerment

Question 14 asked respondents to rate the importance of empowerment on a scale of 1-3, with 1 being essential, 2 reasonably important and 3 not important.

Voluntary Sector

Graph 16 below, illustrates the rating which respondents from each nursing home placed upon the importance of empowerment.



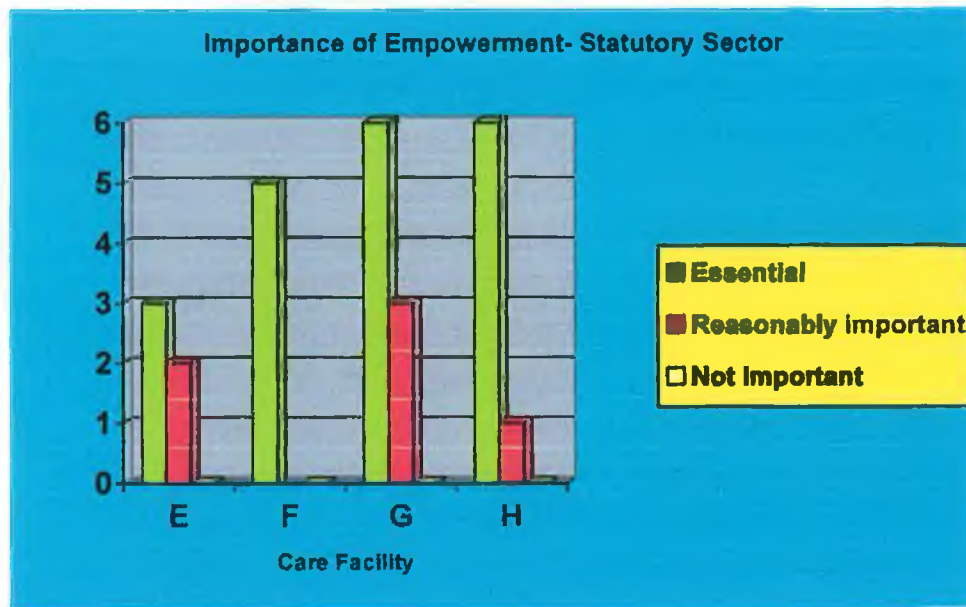
Graph 16

Overall, thirteen respondents from the voluntary sector felt that empowerment was essential in the care services for older persons. Six respondents felt that empowerment was reasonably important in the care services for older persons.

The author feels that quite a reasonable response was obtained from respondents considering that only fifteen respondents originally felt that they understood what the concept of empowerment entailed. Thirteen respondents from this fifteen went on to explain their perception of the concept. Those respondents who offered an explanation as to what they understood empowerment to entail, held the belief that empowerment was essential in the care services for older persons. The six respondents who felt that empowerment was reasonably important had originally acknowledged their lack of precise knowledge with regard to empowerment. The author feels that the fact that such respondents felt that a concept which they did not adhere to, was reasonably important as opposed to 'not important', is quite positive and demonstrates a willingness to adopt principles and concepts into an existing base of knowledge.

Statutory Sector

Graph 17 on the next page illustrates the rating which respondents from the statutory sector accorded to the importance of empowerment in their opinion.



Graph 17

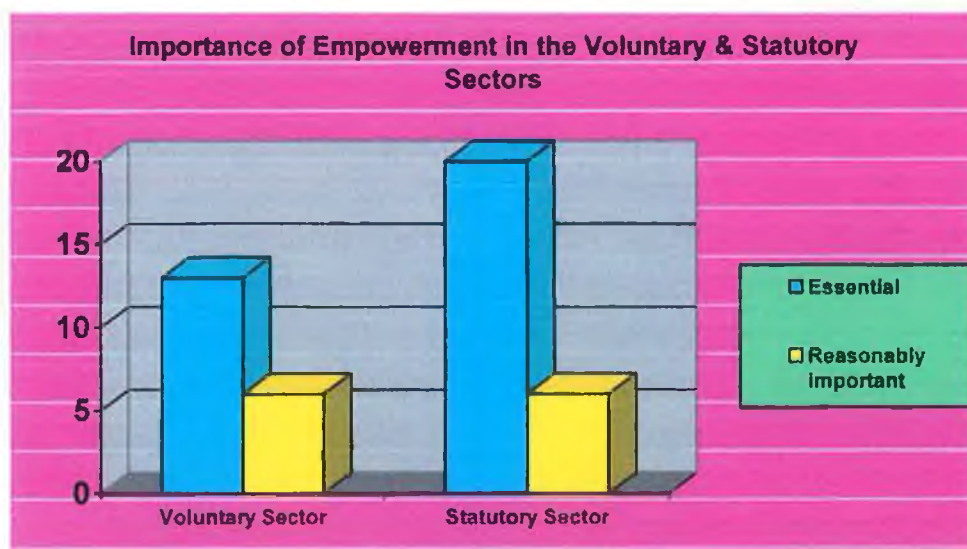
Overall, twenty respondents from the statutory sector felt that empowerment was essential in the care services for older persons. Six respondents felt that empowerment was reasonably important.

The author feels that quite a reasonable response was obtained from respondents as initially twenty seven respondents stated that they understood what empowerment entailed. Twenty five respondents went on to explain what empowerment implied and twenty of these respondents believed that empowerment was essential in the care services for older persons. Only six respondents felt that it was reasonably important.

No respondent from either the voluntary or statutory sectors felt that empowerment was un-important.

Graph 18 below, illustrates the importance which respondents from the voluntary and statutory sector, accorded to empowerment and its practice in the care services for older people.

From the graph, it can be identified that an equal number of respondents from both the voluntary and statutory sector felt that empowerment was reasonably important, i.e. six respondents. Quite a high number of respondents from both sectors felt that empowerment was essential in the care services for older people. However a **higher number of respondents from the statutory sector felt that empowerment is essential, i.e. twenty respondents as opposed to thirteen respondents from the voluntary sector.**



Graph 18

6.4.4 Beneficial aspects of Empowerment

Question 15 specified how each respondent believed empowerment would benefit older people in their care.

Voluntary Sector

The beneficial aspects as listed by respondents in the voluntary sector can be categorised as follows:

- Fostering and maintaining independence.
- Provision of choices.
- Prevention of institutionalisation of both residents and staff.
- Residents could feel at home in a “home from home environment”.
- Older people would have an enhanced sense of control and ownership of their own lives, daily activities, thoughts and wishes.
- Care services would not be solely run by routines and rigid time schedules.
- Older people would have an enhanced sense of being worth while.
- Older persons could remain physically and mentally alert.
- Older people would be encouraged to sustain their dignity, independence, free will and their right to chose what’s best for them.

One respondent felt that empowerment could only benefit those with good mental faculties. This respondent was saddened that a large majority of their

residents were compromised with regard to empowerment due to decreased psychological capabilities and associated problems.

In Nursing Home B, all five respondents failed to complete this question.

The beneficial aspects which the respondents from the voluntary sector provided illustrate how respondents felt empowerment could benefit older people from an enhanced level of self control, dignity, independence, choices and maintaining physical and psychological awareness. Two of the benefits presented included benefits for staff and residents, i.e. preventing institutionalisation and improvement of the care services.

Statutory Sector

The beneficial aspects of empowerment for older people as listed by respondents in the statutory sector can be categorised as follows:

- Expression of opinions and views.
- Increased Independence
- Increased self fulfilment and self worth.
- Increased confidence in the services provided for older people.
- Sense of achievement derived from empowering oneself.
- Possessing control and a sense of ownership of the life situation which they find themselves in.
- Ensuring that dignity and respect are maintained.

- Identification of barriers and strategies to overcome barriers.
- Freedom of choice in so far as is reasonably practicable.
- Enhanced levels of privacy.
- Enhanced communication.
- Happiness and contentment as a result of a sense of control over their life and an improved sense of value and worth.
- Enhancement of patient centred and quality holistic care.
- Option to play an active part in decision making, as opposed to a passive role whereby the older person is a passive participant of the care that they receive and the decisions which are made on their behalf.
- Older people would feel less intimidated in a care setting.

Two respondents felt that empowerment could not really benefit the patients in one care facility as it is an Alzheimer's / Dementia unit and as a result the staff need to guide and direct the older persons which reside in the facility. One of the respondents also spoke of the communication difficulties associated with patients who had Alzheimer's. One respondent felt that a positive aspect to empowerment would be that patients could have control over the life situation which they find themselves in.

Two respondents reiterated the importance of empowerment and how they tried to encourage it as much as possible within the particular care facility. They were both in agreement as to the existence of the beneficial aspects of

empowerment; however they did not explain what they felt any of these aspects might be.

The author feels that the beneficial aspects as listed by respondents in the statutory sector comprise of all the possible elements regarding older people which could possibly be enhanced. **The beneficial aspects are comprehensive and cover a wide range of aspects from increased self worth and self esteem, communication, privacy, sense of ownership and an active role in decision making.** Some of the aspects listed by respondents acknowledge the difficulties which older people may encounter when entering care, e.g. intimidation, dependence, etc. Overall respondents feel that empowerment will be beneficial to older people in the enhancement of the level of quality, patient centred, holistic care that they receive.

The author found that some of the beneficial aspects which respondents listed were common to both sectors. These include:

- Independence.
- Provision of choices.
- Sense of ownership and control over their life and the circumstances which they find themselves in.
- Sense of being worthwhile, self fulfilment and self worth.

These four elements as listed which are common to both sectors are highly achievable and obtainable for older people by empowering practices. Even at a very basic level, if empowerment resulted in these beneficial aspects being conveyed to residents / patients in care, it would be an extremely positive foundation on which to build future care services to attain self efficacy and empowerment for older people.

6.5 Section 5 Factors facilitating Empowerment

Examples of the Empowerment of Older People

Question 16 asked each respondent to provide an example of where older persons are empowered within the Nursing Home or Care setting.

Voluntary Sector

The examples which were provided by respondents in Nursing Home A, included-;

- Choosing their outfits every morning and choosing their own clothes.
- Choice of diet- what foods they like to eat.
- Choice of what they want to do.
- Choice of when to get up.
- Choice of whether they want to do recreational activities or otherwise.
- Choice of whether they would like to eat in the dining room or in the privacy of their own rooms.
- Allowing them to bring their own possessions into their own rooms.

The author feels that the examples provided were excellent in terms of providing choice and independence for older persons. Things that are often taken for granted by one living in the community, such as meal times or choice of food can often be determined by routine and convenience in a Nursing Home. The examples provided prove that choices particularly those in relation to meal times, or food preferences are not determined by routine and convenience. These examples also bear witness to the evolving changes that are taking place in the care of older persons. These can be compared with similar provisions that were provided within similar settings less than twenty years ago. Changes for the better are therefore gradually evolving.

The respondents in Nursing Home B did not provide any examples of where older persons are empowered.

Examples of empowerment were provided by three respondents in Nursing Home C. They included choices with regard to when and what day they shower, choice of staying in bed when tired, choices in relation to what they eat and that residents are encouraged where possible to be independent in activities of daily living.

The respondents in Nursing home D, offered examples with regard to where a residents sits, choosing what to wear, freedom to go to bed when tired and the time at which they do this. Only three respondents replied to this question and

one respondent provided an example of where a resident can be disempowered in the wearing of incontinence wear whereby their dignity is removed or taken away to a certain extent in the wearing of such.

The author feels that the examples of empowerment for older people as provided by respondents are particularly good in nursing home A. The examples bear witness to the increased level of choices which residents are provided with, encouraging their independence and sense of self worth.

The examples provided by the respondents in nursing homes C and D again encapsulate the element of choice which residents are provided with and how they are encouraged to be independent. However the author feels that the respondents concerned could have facilitated additional examples of empowerment.

As no examples of empowerment were provided by the respondents in nursing home B, it is difficult to ascertain whether empowerment takes place within this organisation. Even the very basic choices which are provided to residents on a daily basis could have been listed such as choice of when to get up, go to bed, etc. It is therefore important to ask whether empowerment takes place within this nursing home?

Statutory Sector

Five respondents in care facility E provided examples of empowerment. These included;

- Daily Diversion Therapy.
- Choice of bedtimes and mealtimes and whether these are indeed suitable for each individual patient.
- Allowing some patients to be creative.

The author feels that the examples provided by respondents in this facility are what any person could reasonably expect when their care is in the hands of others. A lot of the respondents in this facility provided similar responses.

Only one respondent provided an example of empowerment in care facility F. These were in relation to the existence of flexible bed times as some clients had kept late hours prior to admission. Meal times were determined by the wishes of the patient to eat.

In care facility G, six respondents provided examples of empowerment. These included;

- The granting of requests made by patients with regard to staying in bed for a day or having a siesta after dinner.
- Patients have the choice whether to go to Diversion Therapy, Mass or Bingo.

- Patients have a choice with regard to Menu's- some choice with regard to diet.
- Encouragement by staff to complete one's own hygiene requirements.
- Provided with the opportunity to vote.
- Can choose what they wear.
- Can choose to lie down for a rest when they wish.
- Can choose to join in activities or not
- Choose to stay in bed longer if they wish.

The examples provided by respondents in care facility H are as follows;

- Patients regularly refuse to undergo further investigations or surgical interventions.
- If a patient wishes to return to his / her own home, they are given all possible assistance to do so safely.
- By promoting independence in all aspects of patients activities and daily living.
- Encouragement in so far as is achievable for patients to attend to their own personal hygiene and dressing.
- Going to the toilet and having a shower.
- Encouraging patients to help themselves by diversion therapy and use of the SONAS programme.
- Providing patients with choices in relation to rest periods, meal choices, and independence where possible.

The author feels that greater levels of empowering examples have been provided by respondents in the statutory sector. The examples provided by respondents in care facilities G and H are particularly good, in terms of encouraging independence, providing choices and respecting the wishes of patients while meeting their needs.

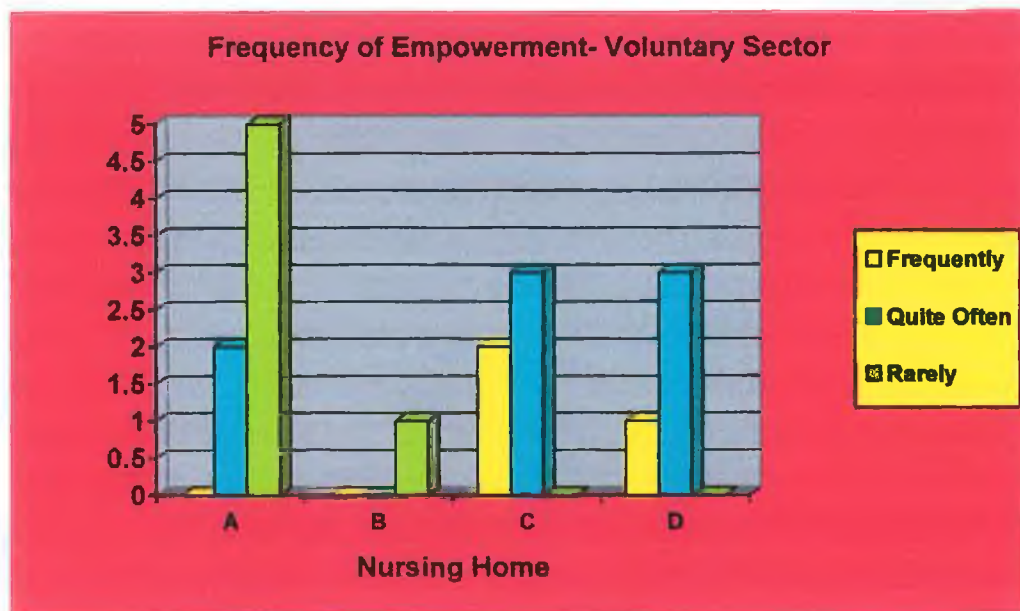
The examples of empowerment provided by respondents in care facilities E and F are quite basic, as the author feels that they are what any person could reasonably expect while in care, e.g. flexible bedtimes and choice of meals. The only exception to this is an example provided by a respondent from care facility E, namely daily diversion therapy. This is a daily activity in most facilities in the statutory sector whereby patients are encouraged to participate in activities such as baking, card games, art, etc. The author believes that this therapeutic means is very important to older people in care as it creates a diversion in the daily monotonous routine. In addition to this it shortens the day for patients and gets them involved in doing thing together as a group.

Overall, the examples provided by respondents from the voluntary and statutory sectors are quite similar. The main difference lies in the activities which patients in the statutory sector appear to engage in and which are tailored to their interests and capabilities. These include SONAS, daily diversion therapy and Bingo.

6.5.1 Frequency of Empowerment

Question 17 asked respondents to rate how frequently they felt that examples of empowerment occurred within the Nursing Home on a scale of 1-3: 1 representing 'frequently, 2 representing 'quite often', and 3 representing 'rarely'.

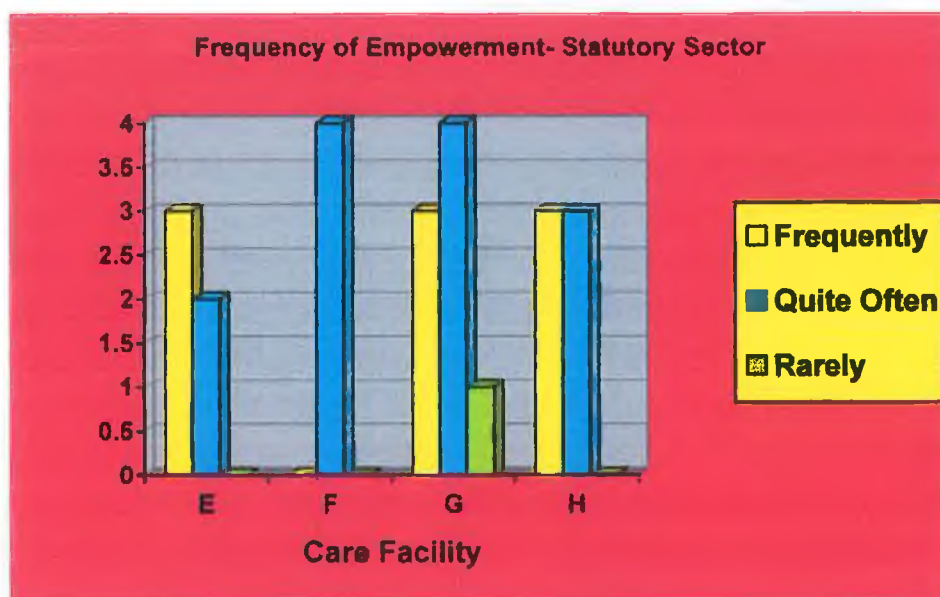
Voluntary Sector



Graph 19

Graph 19 above, illustrates the number of respondents from each nursing home in the voluntary sector who felt that empowerment occurred frequently, quite often or rarely. Overall in the voluntary sector, **three respondents felt that empowerment occurred on a frequent basis, six felt that it occurred quite often and six believed that it took place on rare occasions.**

Statutory Sector



Graph 20

Graph 20 above illustrates the number of respondents who felt that empowerment occurred frequently, quite often or rarely. Overall in the statutory sector, **nine respondents felt that empowerment occurred on a frequent basis, thirteen felt that it occurred quite often while one respondent felt that it occurred rarely.**

Comparing the results derived from respondents from both the voluntary and statutory sector, it can be identified that three times the number of respondents from the statutory sector compared to the voluntary sector felt that empowerment occurred frequently. A higher number of respondents from the statutory sector felt that empowerment occurred quite often, while a higher

number of respondents from the voluntary sector felt that empowerment occurred rarely.

In the voluntary sector respondents from only two nursing homes felt that empowerment occurred on frequent occasions. Similarly respondents from two nursing homes felt that empowerment occurred rarely. A percentage of respondents from three of the nursing homes studied felt that empowerment occurred quite often.

In the statutory sector an equal number of respondents from three care facilities felt that empowerment occurred frequently. Some respondents from all four care facilities studied felt that empowerment occurred quite often, while only one respondent from one care facility felt that empowerment occurred rarely.

Analysis of the results indicates that respondents from the statutory sector felt that empowerment occurred more frequently than their colleagues in the voluntary sector. In addition to this a greater number of respondents from the statutory sector also felt that empowerment occurred quite often. In contrast an equal number of respondents from the voluntary sector felt that empowerment occurred both quite often and rarely. Only three respondents felt that it occurred frequently.

Graphs 19 and 20 illustrate the frequency which each respondent felt that their particular organisation engaged in empowerment. The author feels that the results are very interesting. Graph 19 indicates that empowerment occurs frequently to quite often in nursing homes C and D. In terms of nursing home A respondents feel that empowerment occurs quite often to rarely, while respondents in nursing home B believe that empowerment only occurs on rare occasions.

Graph 20 represents a more positive picture in terms of the frequency of empowerment. Respondents from care facilities E, G and H, feel that empowerment occurs frequently to quite often, while respondents from care facility F believe that empowerment occurs quite often. Therefore the author concludes that respondents from the statutory sector are more positive in their outlook regarding the occurrence of empowerment as only one respondent felt that empowerment occurred on rare occasions.

6.6 Section 6 Barriers to Empowerment

The last section of the questionnaire addresses and investigates the perception of staff in relation to the barriers to empowerment. Question 18 asked respondents if they could think of any barriers to an empowering model of service provision.

Voluntary sector

In nursing home A, time and lack of staff from both nursing and caring sectors were perceived as being the main barriers. In addition to this the following five factors were perceived as being barriers to a lesser extent. These are:

- **Bad practices**, which staff believed entailed doing everything for the resident- rushing the routine.
- **Those who work solely by the routines of the day** and who, in effect do not allow older people to make their own decisions and choices were seen as being a barrier to the process of empowerment.
- **The attitudes of staff and management** were perceived as being limitations and challenges to the process of empowerment.
- The final barrier as perceived by respondents was the overall **lack of appropriate recreational activities** as respondents felt those that were currently in place to be childish and totally unsuitable for those that they are aimed at. The point was further discussed that these activities serve no purpose but to make the days seem longer and more monotonous for residents

In **Nursing Home B**, One respondent felt that residents who had senile dementia and Alzheimer's could not be empowered. Another respondent felt that **staff shortages** were the greatest barrier to the provision of empowerment.

The factors which were perceived as being barriers to empowerment in

Nursing Home C are as follows:

- **Rigid routine** which was in place within their particular nursing home acted as a barrier.
- **Lack of flexibility among staff to move from a ritualistic approach of care to a more individual needs approach** was a barrier.
- **Time and lack of staff can hinder the development of a patient centred approach / empowering approach.**
- The process of empowerment “can become disturbed by some residents when they constantly get their own way. They are then inclined to run the Nursing Home- one resident can pick up on the habits of another”.

In **Nursing Home D**, the following are the responses which respondents provided:

- No evident barriers to the process of empowerment.
- **Caring for older persons was time consuming**, particularly when a resident was totally dependent on members of staff to take care of them.
- When older persons are admitted or transferred to the Nursing Home when they are very ill, they require a lot of care and attention and as a result other residents may not receive the same level of attention that they previously did.

In general it can be ascertained from the responses which respondents provided that the barriers which exist within facilities in the voluntary sector in order of importance are as follows:

1. **Time factor / Lack of staff.**
2. **Attitude of staff / rigid routine.**
3. **Safety / Bad practices / Attitudes of management / Lack of appropriate recreational activities / Difficulties associated with Alzheimer's patients / Dependency of resident / Personality of resident.**

Respondents from the voluntary sector felt that the overall main barriers to empowerment were lack of time and lack of staff. These two factors are common barriers within a busy setting such as caring for older people. Lack of staff also means that the existing members of staff are drained of their resources in meeting the needs of residents. Therefore additional members of staff have the ability to solve both of the inadequacies, i.e. lack of staff and time.

Lack of Staff

Staffing problems are directly related to the amount of quality time which residents receive and the amount of time which members of staff have to meet the needs of other residents. Management must therefore seek additional

members of efficient, competent and professional staff to meet the inherent staffing shortfalls and to allow existing members of staff additional time to complete daily tasks, needs of residents and cope with the heavy workload which they deal with.

Lack of time

Lack of time can be tackled by effective time management strategies where the time which is available in the day is managed efficiently.

Attitudes of Staff

The attitudes of staff and the rigid routine which exists in nursing homes has been identified as a secondary barrier. If the primary barriers, namely lack of time and staff were addressed, then they would also benefit the attitudes of staff and the routine in existence. New members of staff can bring a lot to existing staff teams- new ideas, ways of working, enhanced levels of communication, etc. Additional staff coupled with training and education has the ability to tackle the attitudes of staff and alter them, hopefully for the better.

Rigid Routine

A routine becomes rigid due to a number of factors – lack of time, lack of resources, lack of staff, inflexible ways of working, attitudes of staff and management. If the strategies as listed were addressed, as well as the adoption

of a quality, person centred, holistic model of care, then the routine would be greatly altered.

Some of the barriers which were listed are very difficult to alter such as the dependency and personality of residents. It is therefore paramount to focus on the supports and resources which are required to alleviate these barriers rather than trying to change the personality of a resident, for example.

The additional barriers which were listed can be tackled by both staff and management addressing the problems which exist and working together to develop practical, achievable strategies to overcome them.

Statutory Sector

In care facility E the main barriers which respondents presented were as follows:

- **Staff shortages.**
- **Lack of time**
- **The rigid routine** that exists within the facility.
- **Lack of training and education** in relation to empowerment.
- **Goals not set** with the knowledge and cooperation of residents.
- **Poor communication** skills among staff.

In care facility F the main barriers which respondents provided were;

- Dependency levels of the patients
- Older members of staff
- Difficulties associated with working with Alzheimer's patients.

In care facility G the main barriers provided by respondents were:

- Time.
- Staff shortages.
- Lack of knowledge into the concepts of the approach.
- General disinterest among staff.
- Institutionalisation.
- Lack of flexibility among staff. This factor also included the old fashioned ideas which staff held, such as "it has always been done this way" etc.

In care facility H the main barriers were:

- Staff shortages
- Heavy workload which existed within the facility.
- Low staffing levels which existed at night time disempowered patients by removing their choice to stay out of bed as long as they might have liked to.
- Heavy workload which had to be undertaken on a daily basis.
- Lack of time, lack of resources and facilities.

- The attitudes of some staff members.

One respondent did not list any barriers but instead focused on two strategies which they thought might improve their present situation. The respondent felt that voluntary help was needed and that more activities and outings which were tailored to the liking and needs of the patients might also be useful.

Overall it can be ascertained from the responses provided by respondents that the barriers which exist within the statutory sector in order of importance are as follows:

- 1. Staff shortages**
- 2. Time**
- 3. Heavy workload in facilities**
- 4. Lack of resources and facilities / Attitudes of staff / Older members of staff / rigid routine.**
- 5. Lack of training & education / Dependency of patient / Alzheimer's patients / Lack of knowledge & interest in the concept.**

Staff Shortages

The main barrier as listed above is staff shortages. The only strategy to combat this barrier is to employ additional members of staff. Addressing this barrier will also tackle the lack of time which is the next barrier deemed by

respondents. Additional staff will mean that the staff shortages which exist in the statutory sector will be addressed as well as the lack of time and the heavy workload which staff must deal with on a daily basis.

A lot of the additional barriers which respondents from the statutory sector listed are co-dependent on one another. **This means that three overall strategies – additional staff, training and education for all staff and an environment of openness to new ideas have the ability to tackle all of the barriers listed.** The provision of additional staff would go a long way in addressing some of the barriers listed as well as alleviating other staff members of some tasks and responsibilities.

The author believes that both staff and management should come together, to work as a team, to address the barriers and to develop strategies to combat them so that empowerment can be incorporated into service provision for the benefit of all.

Barriers common to both sectors

The factors which are common to both sectors are *time and the lack of staff* which serve as barriers to the process of empowerment. Staff shortages are however more prevalent in the statutory sector as they are presented as the main barrier by respondents.

Tackling time as a barrier

Time is a factor which can be difficult to ameliorate as it is determined by many additional factors such as dependency of patients, levels of staff on any one particular shift and the number of patients in each facility. There are possibly only two ways in which the barrier of time can be conquered. The first is if management and members of staff focus on the time which is available in any one working day and identify how it is utilised – could the time which is available be managed more effectively? The second method is to employ additional members of staff so that other staff members are relieved of some of their tasks and responsibilities.

Tackling staff shortages as a barrier

Staff shortages which are so apparent from the high responses of respondents in the statutory sector can only be addressed by recruiting and employing efficient, competent and skilled staff members.

Heavy Workload

The existence of a heavy workload is a barrier in the statutory sector which does not feature as a challenge in the voluntary sector. This is possibly due to the fact that patients in care facilities in the statutory sector possess a higher dependency level than those in nursing homes in the voluntary sector.

Factors which are unique to each sector

Respondents from the voluntary sector provided some factors which did not feature within the responses of those in the statutory sector. These include issues related to safety, bad practices which rush routines, absence of appropriate recreational activities, and the dominant personalities of some residents.

Similarly in the statutory sector respondents provided some factors which limited the extent of empowerment and did not feature within the responses of those in the voluntary sector. These include older members of staff who have become institutionalised and possess old fashioned ideas regarding care and its delivery to older people. Lack of knowledge and interest relating to empowerment is another additional factor as well as the lack of facilities and resources.

Analysis of the data illustrates that each nursing home and care facility are both similar and different in terms of the barriers which limit the extent of their empowering approaches. Some barriers are common to both as previously discussed, but as **all facilities are unique they also possess different factors which challenge and limit the process of empowerment.**

6.6.1 Main barrier to Empowerment

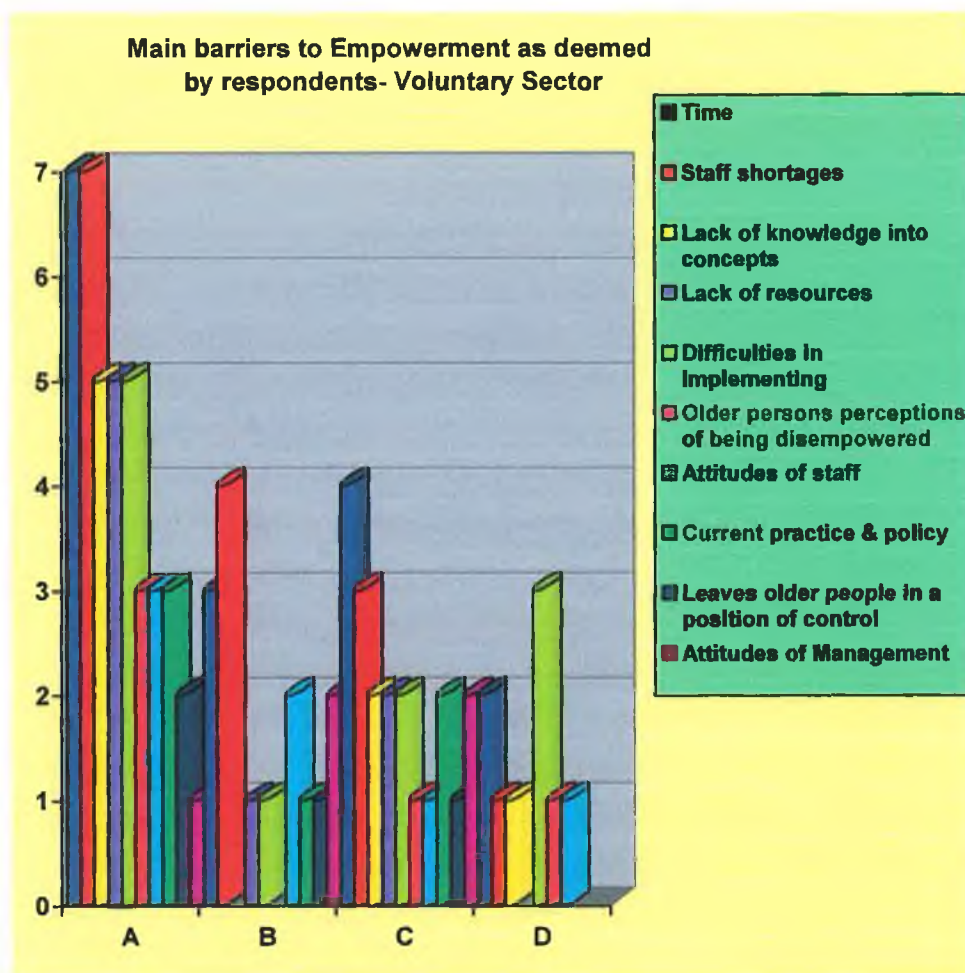
Question 19 served the purpose of getting the respondents to list what they felt was the main barrier to empowerment in the Nursing Home or Care Facility in question.

A choice of ten categories was selected by the author to provide each respondent with some options regarding possible factors which may or may not impinge on the process of empowerment. This question is different from the previous question, where respondents were asked if they felt that any barriers existed within their particular organisation. The respondents were therefore free to suggest any factors which they felt acted as barriers to the process of empowerment.

Table 6A across identifies the main barriers as deemed by respondents in the voluntary sector. Graph 21 provides a graphical illustration of the data so that the main barriers can be easily identified.

Main barrier as deemed by respondents in the Voluntary Sector

Barrier	A	B	C	D
Time factor	7	3	4	2
Staff shortages	7	4	3	2
Lack of knowledge into concepts	5		2	2
Lack of resources	5	1	2	
Difficulties in implementing	5	1	2	3
Older peoples perceptions of being disempowered	3		1	2
Attitudes of staff	3	2	1	2
Current practice & policy	3	1	2	
Leaves older people in position of control.	2	1	1	
Attitudes of Management	1	2	2	



Graph 21

Voluntary Sector

The results are related in their order of importance in Nursing home A, as follows:

1. Time / Staff shortages
2. Lack of knowledge into concepts / Lack of resources / Difficulties related to implementation.
3. Older people's own perceptions of being disempowered / Attitudes of staff / Current practice and policy within each organisation.

4. Leaving older people in a position of control over what goes on within the nursing home.
5. Attitudes of management.

Lack of time and staff shortages were deemed to be the main barriers to empowerment. Time is very difficult to re-allocate, particularly in a busy environment, which often exists in a Nursing Home.

Staff shortages can be overcome by additional members of staff introduced onto a staff team. Additional staffing levels would ensure that each resident is afforded extra time with staff, being helped by staff and would leave more time for an empowering approach. This barrier could be overcome through the employment of additional staff. Achieving this goal may also alleviate the shortage of time or at least increase the level of time available to individual residents.

Lack of knowledge into the concept of empowerment could quite easily be overcome by additional training for staff, specific to empowering practice and models of intervention.

The greatest barrier to an empowering approach as agreed by Lupton and Nixon (1992) is that of professional resistance, i.e. through the attitudes of staff members and management. This position is not however borne out by the

results obtained from the perceptions of staff. Only one respondent felt that the attitudes of management were a barrier, while three respondents felt that the attitudes of staff members served as a barrier to an empowering approach.

In **Nursing Home B** the barriers in order of importance as deemed by respondents are as follows:

1. Staff shortages
2. Time factor
3. Attitudes of staff / Attitudes of management
4. Leaves older people in a position of control over what goes on within the nursing home / Difficulties related to the implementation of the approach / Lack of resources / Current practice and policy within the organisation.

In **Nursing Home C** the barriers as deemed by respondents in order of importance are as follows:

1. Time factor
2. Staff shortages
3. Attitudes of management / Lack of resources / Current practice and policy / Lack of knowledge into the concepts of the approach / Difficulties in implementation.

4. Attitudes of staff / older people's own perceptions of being disempowered / leaving older people in a position of control over what goes on within the nursing home.

In **Nursing Home D** the barriers in order of importance as deemed by respondents are as follows:

1. Difficulties associated with the implementation of empowering practices
2. Time / Lack of knowledge into the concepts of the approach / staff shortages /attitudes of staff / older people's own perceptions of being disempowered

In general the **top five most important barriers as deemed by respondents in the voluntary sector** are as follows:

1. **Time Factor / Staff shortages**
2. **Difficulties in implementation**
3. **Lack of knowledge into the concepts of the approach**
4. **Lack of resources / Attitudes of staff**
5. **Older people's own perceptions of being disempowered / current practice and policy within the organisation.**

Statutory Sector

In Care Facility E the results obtained are as follows in order of importance:

1. Staff shortages.
2. Time factor and lack of knowledge into the concepts of the approach were both deemed as the second barrier.
3. Current practice and policy of the organization was the third barrier.
4. Difficulties in implementation of the approach were the fourth barrier.
5. The fifth barrier was deemed to be the circumstance where older people are in a position of control over what goes on within the Care Facility.

In Care Facility F, the barriers as deemed by respondents in order of importance are as follows:

1. Difficulties in implementing the approach.
2. Lack of knowledge into the concepts of the approach / Current practice and policy of the organisation.
3. Older person's own perceptions of being disempowered.
4. Attitudes of staff.
5. Leaves older persons in a position of control over what goes on within the Care Facility.

In **Care Facility G** the barriers as deemed by respondents, in order of importance are as follows:

1. Staff shortages.
2. Time factor.
3. Lack of knowledge into the concepts of the approach.
4. Difficulties in the implementation of the approach / Attitudes of staff.
5. Leaves older person's in a position of control over what goes on within the Nursing Home or Care Facility / Older person's own self perceptions of being disempowered.

Lastly in **Care Facility H**, the barriers as proposed by respondents, in order of importance are as follows:

1. Time factor.
2. Lack of knowledge into the concepts of the approach.
3. Staff shortages.
4. Lack of resources.
5. Difficulties in implementing the approach / Attitudes of staff.

To summarise the top five barriers as deemed by respondents in the statutory sector are as follows:

1. **Time / Staff shortages**
2. **Lack of knowledge into the concepts of the approach**
3. **Difficulties in implementation**
4. **Current practice and policy within the organisation / Attitudes of staff**
5. **Leaves older people in a position of control over what goes on within the nursing home/ care facility.**

Overall the author found that respondents from both the voluntary and statutory sectors selected the same options, with some exceptions. Respondents from both sectors selected the same main barrier, namely *time / staff shortages*. This indicates that both sectors have the same primary barriers and need to adopt appropriate measures to address them.

The options which respondents selected for the 2nd and 3rd barriers are also the same, apart from the order in which they were selected. Respondents from both sectors selected the same 4th barrier- attitudes of staff and in addition also selected the barrier of 'current practice and policy within the organisation' for either the 4th / 5th barrier. Overall respondents from the voluntary sector selected six barriers which respondents from the statutory sector also selected.

The author concludes that both sectors appear to possess similar barriers limiting the process of empowerment. The main barriers which are common to both and which have been reflected in the results of this question and the previous question are:

- **Lack of time.**
- **Lack of staff / Staff Shortages.**

In addition to these barriers, the results of both questions have highlighted the lack of training and education as well as the attitudes of staff as barriers to a lesser extent.

The author feels that it is therefore necessary for both the voluntary and statutory sectors to reflect on the causes of these barriers and act to address and eliminate them. Empowerment cannot be utilised or effectively incorporated into practice without these barriers first being addressed and tackled.

6.6.2 Overcoming the barriers to Empowerment

Question 20 asked respondents if they felt that the barriers to empowerment within their particular organisations could be overcome.

Voluntary Sector

Overall in the voluntary sector, eleven respondents felt that the barriers which existed could be overcome while five respondents felt otherwise. Respondents from nursing home B did not offer a reply to this question.

Statutory Sector

Overall in the statutory sector, twenty five respondents felt that the barriers which existed could be overcome while just two respondents felt that the barriers which existed could not be overcome.

In general it can therefore be identified that a **greater number of respondents from the statutory sector felt that the barriers which existed could be overcome, compared with respondents from the voluntary sector.** In addition to this a greater number of respondents from the voluntary sector compared to the respondents from the statutory sector felt that the barriers which existed could not be overcome.

The author therefore feels that respondents from the statutory sector are more positive regarding the possibility of overcoming the barriers which exist. The results indicate that they are more than twice as likely to view empowerment challenges to empowerment and strategies to combat the barriers to empowerment in a positive way.

6.6.3 Strategies to overcome the challenges to Empowerment

Question 21 asked each respondent how they felt that the barriers to an empowering approach could be overcome.

Voluntary Sector

Respondents from nursing home A felt that three main strategies within the organisation would help to overcome the barriers which existed. They felt that the following strategies could overcome the challenges to empowerment:

- **Additional staff** would ameliorate the situation, particularly if a person was employed to come in for recreation times, e.g. between the hours of 2-8 pm.
- **Staff training and education with regard to gaining knowledge of what the concept was and how it could be implemented** would also help.
- **Increased communication** would benefit the overall process of empowerment.

Strategies for residents

In terms of strategies related to the residents in each facility, respondents felt that the following would be helpful:

- **Education for residents in relation to empowerment** was important. This was so that in the setting of goals and objectives residents would possess the knowledge to realise what they wanted and the choices which they could make for themselves.
- Respondents felt that **if residents were afforded more responsibility and given tasks to complete**, this would improve the process of empowerment considerably.

- Respondents also felt that **providing residents with sufficient time and choices would benefit the process of empowerment.**
- Respondents believed that **trail runs** with selected residents might be a good idea.
- In addition, it was also proposed that **a number of residents should be allocated to a member of staff, so that this person would work directly with the older persons who were allocated to them.** This person would be directly responsible for discussing their needs with them, spending time with them, etc.

Recreational Activities

In terms of the recreational activities which were provided for each resident, respondents believed that **incorporating a greater level of recreational activities which were aimed at older persons would greatly enhance the daily lives of residents and would be empowering.** Activities which are aimed at the older person and within their range of interests would increase the level of empowerment, such as painting, having a garden, writing, crafts and card games like bridge, to mention but a few.

Layout of the Organisation

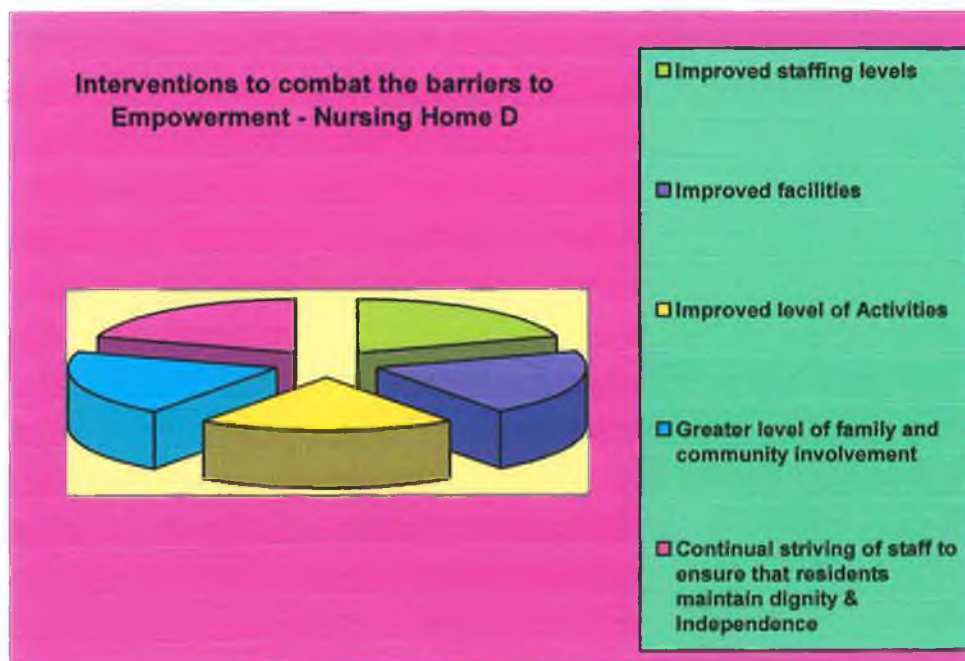
To conclude respondents believed that the current layout of the day room was disempowering for residents, as they sat there day after day staring at four walls as opposed to having their chairs situated in small groups.

All respondents felt that at the moment it would take a lot of time and effort on the part of all grades of staff to empower their residents.

In **Nursing Home B**, no strategies were offered by the respondents who completed questionnaires with regard to overcoming any barriers which may exist in relation to the process of empowerment.

In **Nursing Home C** respondents offered the following strategies:

- **Educating staff and management** was thought to be essential to overcoming barriers.
- **Increasing the bed capacity for residents** would help.



Graph 22

In **Nursing Home D** the following strategies were provided by respondents as are shown on graph 22:

- **Improved staffing levels.**
- **Improved level of activities.**
- **Improved areas** to accommodate smaller numbers.
- **A greater level of family and community involvement.**
- Continual striving on behalf of all members of staff was necessary to ensure that residents maintained their independence and dignity to the highest possible degree.

The strategies which respondents from the voluntary sector provided are directly related to the barriers which they previously indicated. Some additional strategies have also been provided to ensure that all possible barriers and factors are eliminated.

The strategies are more than capable of overcoming the barriers which respondents believe exist, with dedication and commitment from all involved.

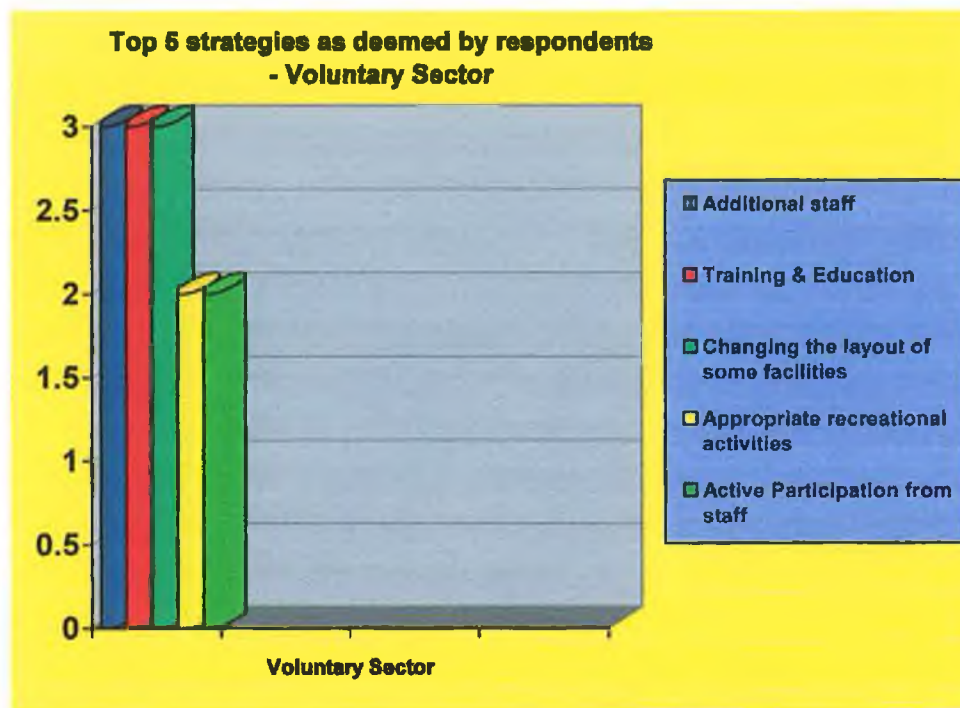
Table 7A across provides an overview of the range of strategies which respondents felt could overcome the barriers which exist in relation to empowerment.

Strategies to overcome the challenges to empowerment as deemed by respondents –

Voluntary Sector

Strategies	A	B	C	D
Additional staff	2			1
Training & Education	2		1	
Education for Residents	1			
Tasks & responsibilities for Residents	1			
Recreational Activities aimed at Older People	1			1
Quality time to be afforded to residents	1			
Enhanced Communication	1			
Trials & assessments	1			
Changing the layout of some facilities	1		1	1
Active Participation from staff	1			1
Greater level of family & community involvement				1

Table 7A



Graph 23

The above graph identifies the top five strategies which were deemed by respondents in the voluntary sector. Additional staff, training and education and changing the layout of some facilities were all viewed as being equally important. Appropriate recreational activities and the active participation for all members and grades of staff were identified as strategies which might also be beneficial to a lesser extent.

Additional Staff

Additional staff appears to be a very straight forward strategy but employing extra staff is dependent on numerous factors such as having the resources to do so, ability to source competent staff etc. However this factor also alleviates

other factors such as the active participation of staff and the training and education of staff. Additional staff ensures that other staff have additional time to give of their time to those in their care, to attend courses and training days and to actively participate in empowering methods of service provision.

Training and Education

Training and education is required for all members of staff despite their particular roles in courses related to their work and in relation to empowerment and what it entails.

Changing the layout of some facilities

Changing the layout of some facilities should be carried out so that all available space is put to good purpose, for accommodation, recreation, rest areas etc.

Planning of nursing homes is therefore very important to ensure that all available space is utilised for maximum user friendliness and comfort.

Appropriate recreational activities

Appropriate recreational activities are paramount for the self esteem, and social interaction of residents as too often older people can be found sitting side by side to each other gazing across the room or out the window at greener pastures.

Recreational activities which are specifically aimed at older people are very beneficial and different activities and events should occur each day in order to shorten and encourage each resident to interact with staff and other residents.

Strategies to overcome the challenges to Empowerment as deemed by respondents -

Statutory Sector

Strategies	E	F	G	H
Additional Staff	2		2	1
Education & training for staff	4	2	1	2
Good Communication	1			1
Assessment, Planning & Review process	1			
Multi-disciplinary approach	1			
Changes in the daily routine	1			
Active participation by both Staff & Patients		2		
Rotation of staff			1	
Empowering staff first			1	
Receiving feedback from patients				1
Work as a team to overcome any barriers which may exist				1
Allow patients to make their own decisions and make them aware of their options			1	2

Table 7B

Statutory Sector

The following are strategies which have been provided by respondents in **Care Facility E**, to overcome the barriers to empowerment:

- In relation to staff respondents believed that if the facility provided **additional members of staff**, this would ameliorate the situation.
- Some respondents felt that **re-rostering of off-duty staff** would also help.
- Respondents also believed that **members of staff need to be re-educated and trained**. This includes sending staff on additional courses and by regularly briefing them with regard to the current situation of each patient.
- In order for regular briefings to be effective respondents felt that **good communication was essential between all grades of staff and that the flow of communication between staff and patients should be strengthened and continued**.
- Respondents additionally spoke of the Assessment; Planning and Review process which they felt should be incorporated and introduced on a gradual basis. As a result of this ward meetings with all grades of staff should also take place.
- Respondents stated that a **Multi-disciplinary approach** was essential in order to incorporate an empowering model of service provision into each care facility.

- Finally respondents felt that **changes should be introduced into the daily routine and that staff should be apportioned with additional duties.**

In **Care Facility F** respondents provided strategies which they felt should be adopted to overcome barriers which existed. They are as follows:

- **Education** and senior members of staff and management should lead by example- little by little.
- **Active participation by staff and patients.**
- Positive empowerment when encouraged can only lead to confusion among those with Alzheimer's and to a lesser extent it can help older persons to make an informed decision. However this decision may be solely based on previous habits.

In **Care facility G** respondents' offered what they felt were strategies to overcome the barriers to empowerment within their particular Care Facility.

- **Additional members of staff** were required to allow for the process of empowerment to be incorporated into daily life in the facility.
- In addition to this respondents felt that **staff should be given training into the concept of empowerment.** As improving the level of understanding among all members of staff would in turn improve attitudes regarding the concept.

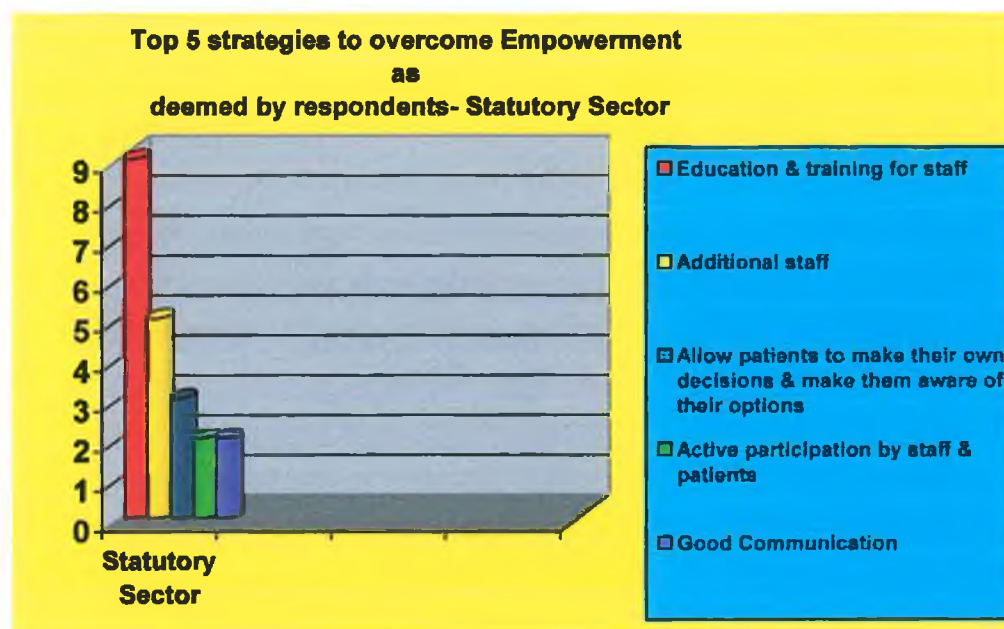
- **Older people should be encouraged to empower themselves** and be empowered by others as respondents felt that they often give in too easily, allowing others to do things for them.
- Another respondent felt that **staff should be empowered first**. They should be sufficiently educated and informed regarding an empowering approach to caring for elderly patients. In this way this respondent holds the view that the concept and approach to care may “eventually catch on” so that the patients in their care may enjoy such an approach to care.
- **Staff should be rotated** between the male and female wards every six weeks. This would be beneficial to older persons as they would have to try to remember new faces- new approaches are good for patients too. In addition to this point, this respondent felt that male Care Assistants should not wash or deal with female patients intimately. Instead they can encourage female patients to eat and socialize and in a way to act as a father figure. This respondent stated that they had previous experience of such a strategy and it worked very well.

In **Care Facility H** the following strategies were provided by respondents which could be adopted to overcome the barriers to empowerment in their particular care facility:

- **Provision of appropriate education and in-service training with regard to empowerment and its implications in practice.**

- In addition some respondents felt that it was important to **identify and address the attitudes of staff and to work through any issues which concerned them.**
- **Working as a team** was perceived as being a very important strategy to overcome any barriers which existed and to carry out the suggestions as proposed in the health strategy.
- **Importance of receiving feedback from patients with regard to their thoughts and feelings in relation to the level of care which they receive.**
- **Listening to their suggestions is essential** to improve delivery of care.
- **Importance of spending quality time with patients** on an individual one to one basis.
- **Sufficient staff** are required to be on duty at all times to carry out the daily tasks which present and in order to afford residents with ‘quality time’.
- **Importance of allowing patients to make their own decisions** on certain aspects of their life style while in residential settings.
- In addition to this respondents felt that while it is acceptable to provide choices for patients it is also **important to make each individual aware of the options available to them and if necessary to advise them on the best course of action.**

The author felt that a broad range of strategies were offered by respondents from the statutory sector. Similarly, to the respondents from the voluntary sector, the strategies were directly related to the barriers which they had previously noted.



Graph 24

Graph 24 above graphically illustrates the top five strategies which respondents in the statutory sector felt could help to overcome the barriers which exist to limit the extent of empowerment. Respondents felt that training and education for staff in relation to the concept of empowerment and what it entails was the most important strategy to overcome any challenges to the process of empowerment. In addition to training and education for staff, respondents felt that additional staff would ameliorate the situation. In the voluntary sector,

respondents accorded these two strategies with equal importance as that of their colleagues in the statutory sector.

Both sectors possessed a balanced level of respondents who felt that active participation was required from all members of staff. The author feels that this is a very positive result as respondents from both sectors appear to have an equal regard of the input that is required from staff. The author feels that the fact that staff are aware of the work which is required and must be continuously initiated is a very positive factor which can then be built upon with additional training and education for staff specific to the concept and its practice.

Good Communication

Good communication is vital to care and its delivery to older people. It is important that good channels of communication are forged and flow between patients and staff and between all members of staff and management so that everyone has a say, is listened to and has their wishes considered.

Allowing Older People to make their own choices

The final strategy proposed by respondents in the statutory sector is that older people should be allowed to make their own decisions. In addition to this that staff and family members intervene to ensure that they are aware of the options that are open to them. It is a fundamental right that everyone should be able to

make their own decisions particularly in later years. It is therefore important that members of staff are continuously reminded that this is the case despite other issues which may concern them such as safety concerns, best interests of the resident, etc.

Overall, it can be seen that quite similar responses were presented by respondents in the voluntary and statutory sector, with the exceptions of two different responses from each. Different responses give credence to the fact that both sectors possess similarities and also differences in the strategies which may need to be incorporated to ensure that an empowering model of service provision is viably integrated into the facilities which care for older people.

6.6.4 Additional Comments from respondents

Question 22, the last question on the questionnaire afforded respondents the opportunity to offer any additional comments which they wished to express.

Voluntary Sector

Only three respondents provided an additional comment in **Nursing Home A**.

One respondent reiterated the fact that training is needed for staff with regard to empowerment and its implications. One respondent felt that empowerment was essential but believed that it was often overlooked, while another respondent stated that they would like to know more about empowerment.

In **Nursing Home B**, none of the respondents provided any additional comments.

In **Nursing Home C**, two respondents provided additional comments. One respondent felt that there was either a lot of work or nothing to be done at night. Another respondent felt that it was very difficult to carry out additional tasks or activities with the older persons as they are very set in their ways.

In **Nursing Home D**, two respondents offered additional comments. One respondent wished to point out that the nursing home in which they worked was an enjoyable place in which to work in terms of the existence of a good level of communication and the use of their own discretion encouraged to the highest extent possible. They did however feel that increased pay levels would be welcome to all members of staff. The second respondent stated that they encouraged all residents to carry out the activities of daily life to the best extent possible. However they were also aware that this was not always possible due to the level of illness which was experienced by older persons.

Statutory Sector

In **Care Facility E**, only one respondent offered an additional comment. This respondent felt that all patients can be empowered- not just those who are ambulant. However they believed that all grades of staff need to be empowered so that they can transfer this onto those in their care.

No respondents in Care Facility F offered any additional comments.

In **Care Facility G**, three respondents presented additional comments. One respondent felt that the facility was doing well as it was only a new facility. This respondent lamented that due to the constraints of time they were unable to talk to them and to hear about their lives and their loved ones as much as they would have liked to. In addition this respondent felt that more outings were essential to cater for the social interaction skills of older persons in care. The respondent gave an example of an outing- attending the fine local theatre which they have a short journey away from the facility.

Another respondent felt that staff members need to utilize and manage their time to a higher degree in order to provide a better level of quality care.

The last respondent reiterated some of the points that they previously made as follows:

- Lack of staff.
- High dependency levels of patients in units
- Working to schedules very often means that members of staff are rushing to meet deadlines so sufficient time is not given to allow for independence and choice.
- Time is a big factor in this facility.
- Allowing patients additional time would improve their independence, self confidence and overall well being.

6.7 Conclusions to be drawn from analysis of Quantitative data.

Analysis of the data derived from the qualitative interviews illustrates the many similarities and differences which exist within the different nursing homes in the voluntary sector and care facilities in the statutory sector.

The quantitative element of the data sought to gain general information from each respondent regarding each facility and more specific areas which were based on the perceptions and perspectives of the respondents.

Response rate

As previously indicated a higher rate of response was attained in the statutory sector 77.5% compared to the voluntary sector at 55%. The author attributes two factors to the fact that a higher response rate was achieved in the statutory sector. Firstly care facilities in the statutory sector are affiliated to the North Eastern Health Board and secondly the fact that clearance had to be sought from a person responsible for all facilities.

In the voluntary sector, however the response from each nursing home depends on the importance that is attributed to the completion of the questionnaires by the person who took part in the qualitative element of the study and the motivation of staff to complete and return the data in question.

Personal Details – Age & Gender

All respondents from nursing homes in the voluntary sector were females.

Twenty respondents out of twenty two stated their age. Nursing home A appears to employ the youngest respondents in the study which may be attributed to the fact that it is a relatively new facility.

Thirty respondents from the statutory sector were females while only one was a male respondent. Nineteen respondents out of thirty one stated their ages.

Similarly to the voluntary sector one facility appeared to employ younger respondents than the other three facilities- care facility G. This is also possibly due to the fact that this facility is relatively new.

Staff Qualifications

The various qualifications of the respondents who took part in the study are set out in graphs 4 and 5. From analysis of the graphs it can be seen that in the voluntary sector those who responded were as follows:

- Staff Nurse 11
- Care Assistant 9
- Manager 0
- Chef 2

In the statutory sector those who responded were as follows:

- Staff Nurse 16
- Care Assistant 10
- Manager 2
- Chef 3

It can therefore be concluded that a higher proportion of nurses responded to the study from both the voluntary and statutory sector than any other collective number of support staff.

Positions held by respondents

In the voluntary sector all positions held by respondents correlated exactly to the results obtained in the previous question in relation to the qualifications and training of staff.

In the statutory sector it was found that some respondents held different positions than their previous training would have indicated such as holding a managerial position after completing training as a nurse. The differences lie in the additional courses which staff engaged in to elevate them to their current positions.

Length of service

In the voluntary sector, it can be seen that nursing home A respondents who worked for relatively short periods of time, nineteen months. In contrast, respondents in nursing home D for the longest periods of time. Respondents from nursing home employed for relatively long periods of time followed by respondents from nursing home B who had also worked for quite a long number of years.

In the statutory sector, it can be seen that care facility G possesses respondents who worked for relatively short periods of time, the shortest period being two months and the longest being two years. Care facility F possessed respondents who worked for varying periods of time, the longest being six and a half years and the shortest being seven months. In care facility E respondents had worked for relatively short periods of time the shortest being a year and the longest being three years. Care facility H possessed a respondent who had worked there for the longest period of time – ten years, compared to the other three facilities.

Overall it can be identified that respondents in the voluntary sector worked for a greater numbers of years when compared to their colleagues in the statutory sector. The longest period of time worked by a respondent in the voluntary sector was seventeen years.

Previous experience in similar settings

Graphs 6 and 7 illustrates whether respondents had indeed worked in previous similar settings. In the voluntary sector, from a total of twenty two respondents, thirteen had previously worked in similar settings and eight respondents had not previously worked in similar settings.

In the statutory sector, from a total of thirty one respondents, twenty seven had previously worked in similar settings and four had not. Therefore over double the amount of respondents in the statutory sector had worked in similar settings compared to respondents in the voluntary sector. In terms of respondents who had not previously worked in similar settings, double the amount of respondents in the voluntary sector had not worked in similar settings compared to respondents in the statutory sector. Overall it can be seen that a higher proportion of respondents from the statutory sector had previously worked in similar settings compared to their colleagues in the voluntary sector.

In terms of the lengths of time in which respondents had worked in similar settings as illustrated by graphs 8 and 9, it can be seen that the periods of time in which respondents worked in previous employment were much greater among respondents from the statutory sector compared to those from the voluntary sector. A high percentage of respondents from the statutory sector had previously worked in similar settings for more than fifteen years and not exceeding thirty five years. In contrast respondents from the voluntary sector

have worked for shorter periods of time, such as one to three years. Only one respondent had worked for a period of more than nine years.

The author has concluded therefore that respondents from the statutory sector possess an overall greater level of experience of working with older people due to the periods of time in which they worked in similar settings. Respondents from the voluntary sector in contrast have worked for longer periods of time in the same nursing home and shorter periods of time in previous similar settings. While it is very positive that respondents from the voluntary sector have worked there for longer periods of time than those in the statutory sector, it is possible that a greater level of experience is developed when one experiences numerous similar settings as opposed to remaining static in one facility.

Another factor may also have some bearing on these results, namely that staff have a tendency to remain in a facility when they are happy with their job, their role within the organisation, management of the organisation and the level of care that is provided to older people. It is therefore difficult to ascertain the best approach and the most assured level of experience which staff can possess in either sector.

In – house training received

Graphs 10 and 11 illustrate the level of additional in house training received in both sectors. In the voluntary sector, from a total of twenty two respondents,

sixteen respondents received additional in-house training and six respondents did not receive any such training. In the statutory sector, from a total of thirty one respondents, twenty three received additional in-house training while eight respondents did not receive any such training.

In the voluntary sector, the author found that care assistants from nursing homes B, C and D had failed to receive any training despite working in these facilities for long periods of time. In addition to this a nurse who had been employed for twelve years had not received training of any kind. In nursing homes A and D good levels of training opportunities are presented to staff as all respondents had received in – house training in nursing home A and only one respondent from nursing home D had not received additional training. The training opportunities which are presented to staff in nursing homes B and C were much lower than that of A and D.

In the statutory sector, the author found that good levels of training opportunities exist in care facilities G and H while the levels of training which were offered to respondents in facilities E and F were much less than that of G and H.

Training received by respondents

Graphs 12 and 13 illustrate the in-house training which respondents received in both sectors.

In the voluntary sector as previously identified nursing homes A and D provide a reasonably high level of training to the respondents who took part in the study. The author feels however that the training which is provided to staff members should also be geared towards the concept of empowerment and what it entails for both staff and residents. In addition to this all members of staff should receive this training as they are equally important in the empowering process.

The author feels that nursing homes B and C offer a similar level of training to its staff members with the absence of care assistants who do not appear to receive training of any kind in either facility. The author believes that the levels of training which is offered to care assistants in these facilities is unacceptable as all members of staff should receive training which is appropriate to their roles in the organisation and also in regard to empowerment. Ideally the author feels that all facilities in the private sector should provide similar levels of training and education to its staff members.

In the statutory sector, the author found that a greater range of training was presented to staff. The range of training offered possessed a stronger medical base when compared to the training which respondents in the voluntary sector received. Graph 13 identifies that facilities G and H offer a great range and level of training to their members of staff. Despite this fact however care facility G did not provide any training for the care assistants employed at the

facility that completed questionnaires. Training should be provided to all members of staff which is appropriate to their role within the organisation and also with regard to the concept of empowerment and what it entails for both staff and patients.

Care facilities E and F offer quite a low level and range of training opportunities to their staff as graph 13 identifies. The author believes that all facilities should offer a similar level and range of training and education to their staff particularly since all facilities are under the auspices of the North Eastern Health Board. As previously mentioned this training should be sufficient and appropriate for each person's role within the organisation and should also encapsulate the concept of empowerment and the benefits of its incorporation with service provision for older people.

Overall the author found there to be a lack of standardisation within both the voluntary and statutory sectors with regard to the level and type of training which respondents could avail of.

Inclusion of empowerment in previous training

Graphs 14 and 15 illustrate the number of respondents from the voluntary and statutory sector who felt that empowerment had been included in their previous training. In the voluntary sector, only four respondents out of a possible twenty two felt that empowerment had been incorporated in their previous training. In

the statutory sector, seventeen respondents out of a possible thirty one respondents felt that empowerment had previously been incorporated in their training. It can therefore be ascertained that a higher percentage of respondents from the statutory sector felt that empowerment had previously been incorporated in their training.

Job Satisfaction

Collectively all respondents from both sectors stated that they enjoyed working with older people.

Most rewarding aspect of working with older persons

In the voluntary sector, the overall perspective from care assistants as to the most rewarding aspect for them was their ability to provide companionship to older people. In terms of the nursing staff seeing the older person recover from illness and being able to assist in this process was the most powerful motivator for them.

In the statutory sector, three central themes ran through the responses which were provided by respondents. These include seeing older people happy and having the ability to make them comfortable. The final theme can be differentiated into the responses provided by nursing staff which is to provide each person with quality nursing care and the response provided by care assistants which is to assist and help and older person in any way that they can.

Most difficult aspect of working with older people

The most difficult aspects which respondents listed were a combination of the varying personalities, illnesses, sadness and physical inabilities which they found among older persons.

In general nursing staff found that deterioration in physical and mental well-being and the effects which illnesses had on other family members were the most difficult aspects for them.

The most difficult aspects for care staff were found to be the death of the resident, not having enough time to talk with them and the difficulties which they found in working with them on a day to day basis.

Understanding of Empowerment

In the voluntary sector, fifteen respondents out of a possible twenty two respondents believed that they understood what empowerment entailed.

In the statutory sector, twenty seven respondents out of a possible thirty one respondents believed that they understood what empowerment entailed.

One nursing home in the voluntary sector does not appear to possess any knowledge with regard to empowerment. Overall it can be identified that a greater perceptual knowledge can be found among respondents in the statutory sector.

Empowerment explained by respondents

The author believes that the fact that respondents could explain what they meant by empowerment strengthened their perception of the concept. However had respondents simply declared that they understood what empowerment implied in the absence of an ensuing explanation one might assume that respondents answered yes for the sake of doing so, i.e. without any precise or general knowledge of the concept.

In the voluntary sector thirteen respondents out of the fifteen who previously stated that they understood what empowerment entailed went on to provide an explanation. Three broad categories can be drawn from the responses received. These are choices for older people, that people should be enabled to have authority and control over their own lives and in the care that is delivered to them. In addition to these the empowerment of staff was a common theme. In the statutory sector, twenty seven respondents out of a possible thirty one respondents stated that they understood what empowerment entailed. A further twenty five respondents went on to explain their understanding of what the concept implied. Some respondents felt that empowerment involved the older person being valued, having power and responsibility and being involved in decisions and authority. Other respondents felt that empowerment involved choices, decisions, independence and the use of their own initiative to influence their care. Other respondents felt that empowerment implied giving older

people choices, to do what they liked to do for themselves and to allow them to participate in what they enjoy most, giving them dignity and respect.

From analysis of the responses provided it can be seen that respondents in the statutory sector provided more elaborate replies which also included the role which staff had to play in the incorporation of empowerment in practice.

Respondents from the voluntary sector offered straight forward replies with a more honed focus upon the empowerment of residents as opposed to staff. The author feels that a good level of knowledge in relation to empowerment exists within both sectors but the level of understanding which respondents possess in the statutory sector has a broader base than that of the respondents in the voluntary sector. The results which were gained as a result of the analysis of qualitative data also collaborates the previous point made by the author. The author found that respondents from the statutory sector possessed a diverse conception of what empowerment entailed. As a whole it was found that their perception of the concept of empowerment had a broader base which acknowledged the wider aspects of the term from the viewpoint of patients and staff.

Most important elements of the empowering approach

The top five most important elements as deemed by respondents in the voluntary sector are set out in table 5A. Overall it can be identified that

respondents in nursing homes A, C and D appear to have chosen the same options generally, while the responses from the respondents in nursing home B are somewhat different.

In the statutory sector, the author has found it difficult to identify a pattern among the different responses provided by respondents in different facilities. It is clear however that although respondents have presented similar options as those in the voluntary sector, they have ranked them differently.

The author feels that a greater overall emphasis is placed on older people and their care among the respondents from the voluntary sector as they placed a strong emphasis on the provision of choices, independence, good care, help and support when required and dignity and respect. The author feels that while similar options have been accorded importance from respondents in the statutory sector, the options provided accord a much greater emphasis on the overall environment in the facilities in the statutory sector such as a healthy environment with good communication, privacy and encouraging older people to do things on their own initiative.

Importance of Empowerment

In the voluntary sector thirteen respondents felt that empowerment was essential in the care services for older people. Six respondents felt that empowerment was reasonably important in the care services for older people.

In the statutory sector twenty respondents felt that empowerment was essential in the care services for older people. Similarly to the voluntary sector six respondents felt that empowerment was reasonably important in the provision of care for older people.

Graph 18 illustrates the importance of empowerment in the voluntary and statutory sectors. From the analysis of the data derived from the qualitative and quantitative elements of the study the author feels that respondents from the statutory sector held a greater perception of the importance of empowerment in the care of older people. This can be ascertained from the data derived from the qualitative element of the study which found that respondents in the statutory sector collectively held the view that empowerment was a working principle which could be incorporated into daily practice. In addition to this a higher proportion of respondents from the statutory sector, as above held the view that empowerment was essential in the care services for older people.

Beneficial aspects of empowerment

In the voluntary sector respondents spoke of the positive aspects which they hoped empowerment would bring. These aspects included a sense of worth, ownership of their lives and how they spent their days, comfortable 'home from home' feeling and helping each resident to remain physically and mentally alert.

In the statutory sector respondents felt that some beneficial aspects which empowerment could bring would include the enhancement of patient centred care, options to make decisions as opposed to decisions being made for them and enabling patients to live as independently and with as much self-fulfilment as possible.

Examples of the empowerment of older people

The author feels that good examples are provided by the respondents in the voluntary sector, particularly by respondents in nursing home A. The examples bear witness to the evolving changes that are gradually taking place in the care of older people.

The examples of empowerment provided by respondents in the statutory sector include the various choices which are open to patients such as choice of bedtimes and mealtimes. Greater levels of examples were provided by the respondents in care facility G and H. The main difference between the responses of respondents in the statutory sector compared to the voluntary sector is the options which patients have e.g. diversional therapy, bingo, SONAS programme etc.

Frequency of Empowerment

In the voluntary sector, three respondents felt that empowerment occurred on a frequent basis.

Six respondents felt that it occurred quite often and six respondents believed that it took place on rare occasions.

In the statutory sector, nine respondents felt that empowerment occurred on a frequent basis, thirteen felt that it occurred quite often while one respondent felt that it rarely occurred.

Overall it can be ascertained that a greater number of respondents from both sectors felt that empowerment occurred quite often as opposed to frequently. Three times the amount of respondents from the statutory sector felt that empowerment occurred frequently when compared to the views of respondents from the voluntary sector. In addition to this six times the number of respondents in the voluntary sector felt that empowerment occurred rarely compared to the views of respondents in the statutory sector.

Barriers to Empowerment

The barriers which exist within nursing homes in the voluntary sector in order of importance are as follows:

- 1) Time factor / Lack of staff.
- 2) Attitude of staff / rigid routine.
- 3) Safety issues / bad practices / attitudes of management / lack of appropriate recreational activities / difficulties associated with Alzheimer's patients / dependency of resident / personality of resident.

Information collected from the qualitative element of the study showed that those interviewed from the voluntary sector felt that the levels of staff which existed were inadequate. In addition to this other issues were raised such as the safety of residents, ability of residents and the heavy workload which had to be borne in nursing homes. Only two issues which were raised in the qualitative element of the study were addressed above in the quantitative results, namely staff shortages and safety concerns.

The barriers which exist within the statutory sector in order of importance are as follows:

- 1) Staff shortages.
- 2) Time.
- 3) Heavy workload in facilities.
- 4) Lack of resources and facilities / attitudes of staff / older members of staff / rigid routine.
- 5) Lack of training and education / dependency of patient / patients with Alzheimer's disease / lack of knowledge and interest into the concept.

The results which were gained through the qualitative element of the study found that those who were interviewed from the statutory sector felt that the barriers which existed included:

- 1) Staff shortages.
- 2) Institutionalisation of staff.
- 3) General difficulties in relation to staff such as laziness.
- 4) Training and re-training of care staff.
- 5) Dominant personalities and their effect on other staff members.
- 6) Time limitations.
- 7) Inflexible routine.
- 8) Heavy workload.

It is interesting to note that a greater number of barriers can be identified as being similar from analysis of the results from both the qualitative and quantitative elements of the study. These are staff shortages, institutionalisation of staff, time limitations, and heavy workload in facilities, lack of training & education, institutionalisation of staff, dominant personalities and the attitudes of older members of staff.

The author found that each nursing home and care facility is both similar and different in terms of the barriers which challenge the extent of their empowering approaches. Some barriers are common to both sectors but as all facilities are unique they also possess different factors which challenge and limit the process of empowerment.

Main barrier to Empowerment

The author presented this question in the analysis of data displaying the top five most important barriers as deemed by respondents in both the voluntary and statutory sector. However the main barriers as deemed by the respondents in the voluntary sector are the limitations which time can impinge on the daily work practices and shortages of all grades of staff. Similarly in the statutory sector respondents deemed the same two previous factors as being the overall main barriers within their organisations – time / staff shortages.

Overcoming the barriers to Empowerment

In the voluntary sector, eleven respondents felt that the barriers which existed to limit the process of empowerment could be overcome; four respondents felt that the barriers could not be overcome.

In the statutory sector twenty two respondents felt that the barriers which existed to challenge empowering processes could be overcome while only two respondents felt that the barriers which existed could not be overcome.

It can therefore be ascertained that respondents in the statutory sector are more than twice as likely to view empowerment, challenges to empowerment and strategies to combat the barriers to empowerment in a positive way. Only half the number of respondents from the voluntary sector who originally took part in the study felt that the barriers which existed to challenge the process of

empowerment could be overcome. This is a very disappointing result when compared to the number of respondents who positively replied from the statutory sector.

Strategies to overcome the challenges to empowerment

Graph 23 identifies the top five strategies which respondents in the voluntary sector felt that could help to overcome the challenges to empowerment. These are as follows:

- Additional staff.
- Training and Education.
- Changing the layout of some facilities.
- Appropriate recreational activities.
- Active participation from staff.

Strategies which respondents from the voluntary sector felt would overcome the barriers to empowerment as part of the qualitative element of the study included:

- In-house training & study days.
- Appropriate staffing levels.
- Ensuring environs are safe.
- Encouragement, support and praise for residents.
- Stressing the importance of empowerment to all.
- Increased time to be afforded to residents to discuss their needs.

When one focuses upon the different strategies which have been proposed by respondents who took part in the quantitative and qualitative elements of the study from the voluntary sector it can be quite clearly seen that two factors are common to both, namely **appropriate staffing levels and training and education for staff in relation to the concept of empowerment and its implications for service provision**. There are similarities between the factors which are additionally provided, such as ensuring environs are safe which may be initiated by changing the layout of some facilities. The results suggest that management and staff collectively hold both similar and differing perceptions with regard to empowerment and the strategies which need to be initiated for the incorporation of empowering practices into service provision

In contrast respondents from the statutory sector felt that the following strategies could help to overcome the barriers to empowerment:

- Education and training for staff.
- Additional staff.
- Allowing patients to make their own decisions and make them aware of their options.
- Active participation by staff and patients.
- Good levels of communication.

Strategies derived from the qualitative element of the study which respondents from the statutory sector felt would help to overcome the barriers which exist to limit the extent of empowerment include:

- Education and training for staff.
- Increased staffing levels.
- Enhanced communication.
- Maintaining an appropriate focus as to why members of staff are there.
- Identification of personal strengths and weaknesses.
- Obtaining trained professional, efficient and competent members of staff.
- Provision of quality time to residents.
- Being up-skilled.

Analysis of the strategies which were proposed by respondents from the statutory sector as part of the qualitative and quantitative elements of the study identify that there are four factors which are common to both. These are the education and training of staff, additional staff, enhanced communication levels and the active participation which is required from staff and patients alike.

These results make it difficult to ascertain whether those who were interviewed from the statutory sector are more aware of the strategies which need to be initiated to combat any barriers which may exist to challenge the process of empowerment. The fact that these same strategies have also been provided by

respondents during the quantitative element of the study suggests that both staff and management hold a similar perceptual base of empowerment and the strategies which are required to ensure its incorporation as a working principle in service provision for older people.

Overall the results suggest that good levels of communication exist between management and staff. In addition to this they demonstrate the same pattern of thought and ability to select appropriate and effective interventions to combat the barriers to empowerment within their organisations.

Additional comments from respondents

The author wishes to take a very brief look at the additional comments which respondents in both sectors expressed when they were afforded the opportunity of doing so.

Only eight respondents from the voluntary sector offered additional comments. Respondents from nursing home B did not offer any additional information or comments. As these comments have already been presented the author wishes only to put forward the general topics which respondents accorded importance to. The comments put forward by respondents in the voluntary sector are as follows:

- The need for training for staff with regard to empowerment and its implications.
- Empowerment is essential but often overlooked.
- Respondents wished to know more about empowerment.
- Difficulties associated with carrying out additional tasks with older people as they are “very set in their ways”.
- The levels of work to be carried out during night time hours- either a lot or very little.
- Increased pay levels would be welcome.
- Encouragement is required so that all residents carry out the activities of daily life to the best extent possible however awareness is also required as to the levels of illness which is experienced by older people.

Only half the amount of respondents in the statutory sector compared to the voluntary sector offered additional comments. The comments which they put forward are as follows:

- All patients can be empowered – not just those who are ambulant. However all grades of staff need to be empowered so that they can transfer this care and knowledge of empowerment onto those in their care.
- Constraints of time which impinged on the ability of staff to talk and listen to residents as much as they would have liked to.

- Additional outings were essential to cater for the social interaction requirements of older people in care.
- Staff members need to utilize and manage their time to a higher degree in order to provide a better level of quality care.
- Lack of adequate staffing levels.
- High dependency levels of patients in facilities.
- Time is at a premium and allowing patients additional time would improve their independence, self confidence and overall well being.
- Working to schedules often means that members of staff are rushing to meet deadlines.

Recommendations

&

Conclusions

7.0 Conclusions and Recommendations

This chapter sets out to address and highlight the objectives with which the author wished to achieve the overall aim of the study. The aim of the study was to make comparisons between the voluntary and statutory services for older people in County Cavan, with particular reference to the levels of understanding and the application of the concept of empowerment within existing service provision for older people.

Objective 1

The first objective to achieve the aim of the study was to identify the overall levels of knowledge and the awareness of management and members of staff in relation to the concept of empowerment, in each organisation which participated in the research. The author utilised qualitative and quantitative methodology for the study. The author hoped that in combining these two elements that a greater level and depth of knowledge and awareness from both management and staff could be achieved.

The author found that a greater level of knowledge and awareness was evident among respondents from the statutory sector as opposed to the voluntary sector. This can be ascertained from the data collected as a result of the quantitative and qualitative elements utilised in the study. The author

concluded that a greater knowledge and awareness of empowerment was held by respondents in the statutory due to the findings as follows:

The qualitative data identified that **all respondents from the statutory sector collectively hold the view that empowerment is a working principle as opposed to an abstract concept.** In contrast respondents from three out of the four nursing homes in the voluntary sector felt that empowerment is a principle which can be incorporated into the daily routine. Respondents from one nursing home believed empowerment to be a concept as opposed to a working principle. Despite these findings, **respondents from both sectors believed empowerment to be a practice which needs to be continuously worked at and which required the active participation of all grades of staff.**

In addition to this, the author feels that the empowering practices which members of management perceive to occur within their particular nursing homes and care facilities identify to a lesser extent the levels of knowledge and the awareness which management and staff hold with regard to empowerment. To this end it can be identified from the **responses provided by respondents in the voluntary sector that the element of choice is a central theme. The elements of independence, encouragement, and assistance where necessary were also accorded importance among the practices of empowerment provided.**

Respondents from the statutory sector were concerned with and focused upon the practice of empowerment from a staffing point of view, i.e. empowerment of staff, boosting the morale of staff, according tasks and responsibilities to staff, etc. Respondents from one facility within the statutory sector focused upon the empowerment of its residents and the practice of enabling them to have choices and to make decisions.

In terms of the results collected from the quantitative element of the study regarding the level of knowledge and the awareness which management and staff demonstrated, the following can be identified:

- The author found that a **higher proportion of respondents from the statutory sector felt that empowerment had previously been incorporated in their training.**
- When respondents were asked whether they understood the concept of empowerment, fifteen respondents from the voluntary sector agreed that they understood the term, while twenty seven respondents from the statutory sector agreed that they too understood the term. These figures when converted to a percentage can be presented as follows:

Voluntary sector.....68%

Statutory sector.....87%

- The respondents from the voluntary and statutory sectors who went on to explain their level of understanding of the concept of empowerment can be presented as follows:

Voluntary sector.....59%

Statutory sector.....80%

- The importance which respondents attribute to the concept of empowerment also provides one with an insight of the levels of knowledge and awareness of empowerment in existence among management and members of staff. The data collected identifies that **59% of respondents from the voluntary sector believed empowerment to be an essential element which should be incorporated into service provision for older people. However a higher percentage of respondents 64.5% from the statutory sector also believed empowerment to be an essential element.** In terms of the respondents who felt empowerment to be reasonably important, the results can be presented as follows:

Voluntary sector.....27%

Statutory sector.....19%

It is therefore apparent that **respondents from the statutory sector place a greater overall emphasis on empowerment as an important and essential practice in service provision for older people.**

Objective 2

The second objective with which the author hoped to fulfil the aim of the study was to investigate the perceptions of management and staff in relation to the

levels of empowerment which exist within each organisation that participated in the study. The author set out to identify the perceptions of management through the qualitative element of the study and it was hoped that this element would yield in-depth quality data regarding the perceptual base which managerial members held. In terms of the perceptions which staff held regarding empowerment, the author hoped to collate this data through quantitative measures namely, questionnaires.

The author felt that the perceptions of empowerment held by the qualitative respondents in the voluntary and statutory sector were very interesting.

Respondents from the voluntary sector perceived empowerment as a concept deeply steeped in the elements of decision making, freedom of choice, transfer of powers, dignity and independence for the resident in an environment of holistic care. Respondents from the statutory sector possessed a more diverse conception of what empowerment entailed. As a whole their perceptions of the concept encompassed a broader base of knowledge which acknowledged the wider aspects of the concept pertaining to the viewpoint of both patients and staff.

The perceptions of managerial members of staff can also be identified from their perception of who initiates and practices empowerment on a daily basis. The author found it difficult to identify a clear pattern from the responses put forward by the respondents in the voluntary sector as all four responses were

different. A somewhat clearer pattern emerged in the statutory sector as over half of the respondents from the facilities researched placed an emphasis on the attributes of working as a team and the contributions which each member of a staff team can offer. Only one respondent felt that empowerment could be solely attributed to the efforts of nursing staff.

The perceptions of staff were identified within the quantitative element of the study. As previously mentioned, a higher percentage of respondents from the statutory sector presented various statements of understanding with regard to empowerment when compared to respondents from the voluntary sector. In addition, the **explanations put forward by respondents from the statutory sector with regard to empowerment, were found to be more inclusive and concise.**

The perceptions of staff can also be derived from the most important elements which respondents deemed as being important. **Respondents from the voluntary sector place a greater emphasis on the care of older people while respondents from the statutory sector place an emphasis on the environment which is created in facilities in the statutory sector as well as the care of older people. The author ascertained that respondents from the statutory sector place a greater overall emphasis on the environment in facilities such as the morale and empowerment of staff, team work, staffing levels, multidisciplinary approaches and good communication.**

A greater number of respondents from both the voluntary and statutory sector found that empowerment occurred quite often as opposed to frequently. In addition to this **three times the amount of respondents from the statutory sector felt that empowerment occurred frequently when compared to the views of respondents from the voluntary sector.**

Perceptions of empowerment may be additionally founded from the training which respondents received prior to employment and while in employment. The training which respondents received prior to employment encompassed training and education in relation to the positions they now hold. **In terms of the training which respondents from both sectors received while in their current positions, the author found that a greater range of training was offered to staff in the statutory sector compared to respondents in the voluntary sector.** Respondents from the voluntary sector received training with regard to general care of older people, fire safety, manual handling and lifting. However despite a greater range of training opportunities being presented to respondents in the statutory sector, the author feels that **all training which is provided is deficient regarding information on empowerment and the implications and benefits for its incorporation into service provision.**

In addition to this, the length of service which respondents had completed prior to holding their current position and during their current position was also viewed as being an important factor by the author, in determining the

perceptions of staff. The author found that **respondents from the voluntary sector had worked for a greater number of years in their current positions when compared to respondents from the statutory sector.** In terms of the length of time which respondents worked in previous similar settings, the author found that **twice the number of respondents from the statutory sector as opposed to the voluntary sector had previously worked in similar settings.** Therefore it can be concluded that a higher proportion of respondents from the statutory sector had previously worked in similar settings. In addition to this a greater number of respondents from the voluntary sector had worked in their current positions for longer periods of time.

The author feels that **respondents from the voluntary and statutory sectors appear to possess an even balance in terms of the experience which they received to colour their feelings and perceptions of empowerment.**

Respondents from the statutory sector have gained a range of different experiences derived from working in their current positions and also while working in various previous similar settings. On the other hand, respondents from the voluntary sector have worked for longer periods of time within their current positions so they have gained a vast knowledge and understanding of the delivery of care and work practices in those settings. However they possess less experience of various previous similar settings when compared to respondents in the statutory sector. It is therefore difficult to argue which

respondents possess the greatest knowledge as both appear to have gained an equal balance of good experience and knowledge.

Overall, the author feels that **respondents from the statutory sector possess a greater perceptual base of knowledge in relation to the concept of empowerment and its existence within each particular organisation.**

Objective 3

The third objective which the author set out to achieve the aim of the study was to identify and investigate the barriers which existed within each nursing home and care facility.

From the data which resulted from the qualitative element of the study the following barriers were identified by respondents within the voluntary sector. These include staffing levels, safety of residents, the ability of residents and the heavy workload which is borne by staff and management on a daily basis. Respondents from the statutory sector were concerned with the following factors, staff shortages, and institutionalisation of staff, general difficulties related to staff such as laziness, training of care staff, dominant personalities and how they affect others, time limitations, inflexible routine, and the heavy workload which is borne by respondents on a daily basis. Therefore **the most prevalent issue which can be identified from the results from both the**

voluntary and statutory sectors are current staffing levels and staff shortages.

Overall the author found that **lack of time and staff shortages were deemed to be the most prevalent barriers by all nursing homes and care facilities by respondents who took part in the quantitative element of the study.** In addition to this some factors were common to both sectors as being barriers to a lesser extent. These include the attitudes of staff, routines which are of a fixed and rigid nature, dependency levels of the resident and the difficulties associated with working with Alzheimer's patients. Each nursing home and care facility had their own distinct barriers which they felt were important to their particular setting and care practices.

In the voluntary sector the additional barriers which were found to be prevalent among the various nursing homes include issues related to safety, bad practices carried out by staff members who rush empowering practices, attitudes of management, lack of appropriate recreational activities and the various and often difficult personalities of residents.

In the statutory sector the additional barriers deemed to be factors which limited the process of empowerment among the various care facilities included the heavy workload borne by staff members on a daily basis, lack of resources and facilities, the institutionalisation of older members of staff, lack of training and

education in relation to empowerment and lack of knowledge and interest into the concept.

Similar responses can be identified as being provided by respondents who took part in both elements of the study. **Staff shortages were identified as the main barrier by respondents who took part in the qualitative element of the study, while staff shortages and lack of time were identified as being the main barriers by respondents who took part in the quantitative element of the study.**

Objective 4

The fourth objective which the author set out to achieve the overall aim of the study was to identify the factors which facilitate the inclusion of empowerment in service provision for older people. The author hoped to develop a profile of facilitative factors from the related responses from respondents in the voluntary and statutory sector.

In terms of the respondents who took part in the qualitative element of the study, the author established that the factors offered by both sectors focused on the abilities of staff, their strengths and weaknesses, teamwork, motivation, openness to new ideas, etc. Residents were only briefly mentioned by the respondents from both sectors with factors such as listening to residents, provision of a homely environment and the prioritisation of the needs of

residents at all times. **The author found that the statutory sector placed a greater central emphasis on staff, issues related to staff and the subsequent importance of empowering staff before attempting to initiate the empowerment of residents.**

In terms of the results resulting from the quantitative element of the study, the author attributed two questions under the factors which facilitate the inclusion of empowerment. These two questions are the frequency of empowering practices and the examples provided by respondents of circumstances where they feel older people are empowered. As previously mentioned, three times the number of respondents from the statutory sector felt that empowerment occurred frequently when compared to the views of respondents in the voluntary sector. A greater number of respondents from both sectors felt that empowerment occurred quite often as opposed to frequently.

A central theme which ran through the responses of respondents from both sectors with regard to examples of empowerment was the element of choice. This element spans from choosing one's clothes, foods which they like to eat, when to get up and go to bed, whether they wish to do recreational activities, where they would like to eat- in the dining room or in the privacy of their own rooms, whether they would like to have a shower or a bath, etc. The examples provided by respondents in the voluntary sector show that choices particularly

those in relation to meal times or food preferences are not determined by routine and convenience.

The examples provided by respondents in the statutory sector included daily diversion therapy, Mass or bingo- these are options which did not appear to be offered to residents in the voluntary sector. The author feels that an equal balance can be found among respondents who responded to the particular question from both sectors in relation to the examples that they provided of empowerment. However the author is very disappointed that the respondents from nursing home B did not provide any examples of where older people are empowered within their organisation. In addition to this the author feels that while two care facilities in the statutory sector provided some examples of empowerment, the examples which they provided were what any person could reasonably expect, such as the choices regarding bedtimes and mealtimes.

Objective 5

The author had a fifth defined objective with which she hoped to achieve the overall aim of the study – to compare and contrast the approaches to empowering practice as observed in the voluntary and statutory organisations which cooperated and participated in the study.

From the outset of the study, the author adopted a comparative focus in terms of each organisation, its members of staff and management and the sector to which

it was accorded. The author therefore concludes that the main findings which can be derived from the research are as follows:

- **A higher rate of response was yielded from the statutory sector at 77.5%, while in the voluntary sector the response rate was 55%.**
- **Twenty two respondents replied from the voluntary sector and all these respondents were females. Thirty one respondents replied from the statutory sector, thirty of these were females while one was a male respondent.**
- **The majority of respondents from the voluntary sector are aged between 30 and 60 + years, while only three respondents in total were aged between 20 and 30 years. The majority of respondents from the statutory sector were aged between 40 and 60 + years; two respondents were aged between 30 and 40 years while two respondents were aged between 20 and 30 years. It can therefore be identified that a higher percentage of respondents from the statutory sector are aged 40 and over compared to respondents from the voluntary sector.**
- **The services which both nursing homes and care facilities offered to their residents were both quite similar and different. Some services were**

common to both sectors such as **24hr nursing care, Chiropody and the availability of a doctor.**

- **Nursing homes researched from the voluntary sector have greater capacities to cater for larger numbers of residents when compared to the care facilities which participated in the study.**
- **Levels of nursing staff were found to be greater in the statutory sector compared to the levels of care and support staff which were employed. In contrast the levels of care staff in employment are higher in nursing homes in the voluntary sector compared to the subsequent nursing staff levels.**
- **All members of staff and management who were employed in each nursing home / care facility held positions in the area in which they previously received training.**
- **A higher proportion of nurses responded to the study from both nursing homes and care facilities within the voluntary and statutory sector. In addition to this a higher proportion of nursing and care staff responded to the study from the statutory sector.**

- **Respondents from the voluntary sector worked for longer periods of time in their current positions** compared to those in the statutory sector- the shortest period being 5 months and the longest being 17 years. **Respondents from the statutory sector worked for shorter periods of time**, the shortest period being 2 months and the longest being 10 years.
- **59% of respondents from the voluntary sector had previously worked in similar settings while a higher percentage of respondents from the statutory sector 87% had similarly worked in related settings.**
- **A high percentage of respondents from the voluntary sector who had worked in previous similar settings had worked there for shorter periods of time**, such as one to three years. Only one respondent had worked for a period of more than nine years. **In contrast respondents from the statutory sector had worked for longer periods of time** such as more than fifteen years but not exceeding thirty five years.
- In terms of the additional in-house training which respondents received- **72% of respondents from the voluntary sector received training**

while 74% of respondents from the statutory sector received training.

- Training received by respondents in the voluntary sector included general care of older persons, fire safety and manual handling and lifting. Training opportunities which were offered to respondents from the statutory sector included a greater range of training with a medical base. **Neither sector offers training which is related to the concept of empowerment or its implications for inclusion in service provision.**
- **Good training opportunities were instituted by half of the nursing homes and care facilities who took part in the study.**
- When respondents were asked whether empowerment had ever been incorporated into their previous training, 18% of respondents from the voluntary sector felt that it had while 54% of respondents from the statutory sector stated that empowerment had been covered in their training. **Therefore a higher percentage of respondents from the statutory sector felt that empowerment had previously been incorporated in their training.**
- **All respondents from both the voluntary and statutory sectors stated that they enjoyed working with older people in their care.**

- In the voluntary sector the most rewarding aspect for care assistants was their ability to provide companionship to older people while nursing staff felt that seeing an older person recover from illness and being able to assist in this process was the most rewarding aspect for them. In the statutory sector respondents felt rewarded in their work when they felt that they possessed the ability to enable the happiness and comfort of older persons. Nursing staff felt that being able to provide quality nursing care to older people was rewarding for them while care staff felt rewarded when they were able to assist and help an older person in any way that they could.
- In terms of the most difficult aspects of working with older people, **nursing staff in general found that the deterioration in physical and psychological well-being of an older person and the effects which various illnesses had on other family members were the most difficult aspects for them. The most difficult aspects for care staff were identified as being the death of the resident, not having enough quality time for each resident and the difficulties which they encountered while working with them on a day to day basis. Some negative replies which were offered can be attributed to respondents in the voluntary sector who felt that among other things older persons can be ‘difficult, grumpy, manipulative, aggressive and inconsiderate at times’.**

- **In terms of whether respondents understood what the term empowerment meant, 68% of respondents from the voluntary sector believed that they did, while 87% of respondents from the statutory sector also believed that they understood what empowerment meant.**
- **59% of respondents from the voluntary sector went on to define what they understood by empowerment while 80% of respondents from the statutory sector provided an explanation of what they believed empowerment to entail.** The fact that respondents could explain what they felt empowerment consisted of, strengthened their perception of the concept.
- **Respondents from the voluntary sector placed a strong emphasis on older people and their care among the most important elements of empowerment which they selected.** They placed a particular focus on the provision of choices, independence, good care, help and support when required, dignity and respect. **Respondents from the statutory sector chose similar options but they accorded a much greater emphasis on the overall environment which exists in facilities in the statutory sector as opposed to older persons and their care.**

- In terms of the importance which respondents accorded to empowerment, **59% of respondents from the voluntary sector felt that empowerment was essential, while 64.5% of respondents from the statutory sector equally felt that empowerment was essential.** In terms of respondents who felt that empowerment was reasonably important, **27% of respondents from the voluntary sector and 19% from the statutory sector believed empowerment to be reasonably important.**
- **Respondents from the voluntary sector perceived empowerment to be a concept deeply steeped in the elements of decision making, freedom of choice, transferral of powers, dignity and independence for the resident in an environment of holistic care. In contrast respondents from the statutory sector possessed a diverse conception of what empowerment entailed as their perception had a broader base which acknowledged the wider aspects of empowerment which took into account the environment of care and the perspectives of staff and patients alike.**
- Beneficial aspects of empowerment listed by respondents in the voluntary sector include a sense of worth, ownership of their lives and how older people spent their days, comfortable ‘home from home’ feeling and helping each resident to remain physically and

psychologically alert. The beneficial aspects which were listed by respondents from the statutory sector include the enhancement of patient centred care, options to make decisions as opposed to decisions being made for them and enabling patients to live as independently and with as much self-fulfilment as possible.

- **One nursing home and one care facility felt that empowerment was initiated and practiced solely by nursing staff.**
- **Two nursing homes and two care facilities felt that empowerment was initiated and practiced by nursing and care staff.**
- **One nursing home felt that empowerment was undertaken by care staff while one care facility felt that empowerment was initially undertaken by management and then it filtered down to nursing and care staff.**
- **Three nursing homes out of the four researched in the voluntary sector believed empowerment to be a working principle which can be incorporated into daily practice. In contrast all respondents from the statutory sector collectively held the view that empowerment is a working principle as opposed to an abstract concept.**

- **All respondents stressed the importance of active participation and the continuous endeavours required by all members and grades of staff.**
- Many good examples were related and provided by respondents particularly in the voluntary sector. They bear witness to the evolving changes that are gradually taking place in the care of older people. **The examples provided from respondents in both sectors illustrate the efforts which are initiated by staff members to empower those in their care from the basic choices of the clothes they wear, food they eat to choices in relation to participating in recreational activities such as SONAS, Diversion Therapy and Bingo.**
- **A large number of respondents from both the voluntary and statutory sector felt that empowerment occurred quite often as opposed to frequently.** Three times the number of respondents from the statutory sector as opposed to the voluntary sector felt that empowerment occurred frequently. Six times the number of respondents from the voluntary sector as opposed to the statutory sector felt that empowerment occurred rarely.
- The main barriers which respondents deemed as important from the qualitative element of the study was the **level of staff which each**

nursing home and care facility possessed and subsequent staff shortages.

- **The greatest barriers to an empowering approach as deemed by respondents who took part in the quantitative element of the study were the lack of staff and time.**

- **The barriers provided by respondents which are common results deriving from both the qualitative and quantitative elements of the study are as follows:**
 - ◆ **Staff shortages**
 - ◆ **Time limitations**
 - ◆ **Heavy workload in facilities**
 - ◆ **Lack of training and education specific to empowerment**
 - ◆ **Institutionalisation of staff**
 - ◆ **Dominant personalities and their effect on other staff**
 - ◆ **Attitudes of older members of staff**

- **50% of respondents from the voluntary sector felt that the barriers which existed could be overcome in the future while 70% of respondents from the statutory sector believed that barriers could be overcome in the future which currently challenged the process of empowerment.**

- The strategies and interventions which respondents from the voluntary sector felt would be most effective in overcoming the barriers to empowerment and which were common to both elements of the study, are **appropriate staffing levels and training and education for staff in relation to the concept of empowerment and its implications for incorporation into existing service provision for older people.**
- The strategies and interventions which respondents from the statutory sector felt would be most effective in overcoming the barriers to empowerment and which were common to both elements of the study include **education and training for staff in relation to the concept of empowerment, appropriate staffing levels, enhanced communication levels and the active participation which is required from staff and patients alike.**
- In terms of the responses which were provided by management and staff from the voluntary sector, it appears that they hold both **similar and differing perceptions regarding empowerment and the strategies required for the incorporation of empowering practices into service provision. In contrast management and staff from the statutory sector appear to display like patterns of thought and similar abilities in selecting appropriate and effective interventions to combat the barriers to empowerment within their organisations.**

- The factors which respondents in the voluntary sector believe facilitate the inclusion of empowerment are different to those which respondents from the statutory sector proposed. **The factors offered by both sectors overall focused on the abilities of staff, their strengths and weaknesses, teamwork, motivation and openness to new ideas, etc.** Some factors were common to both sectors such as good communication, keeping up to date with current practices, trust and respect, good management and leadership.

Objective 5

The final objective with which the author set out to achieve the overall aim of the study was to make recommendations in the light of findings found with regard to the adoption of the principles and practice of empowerment in residential services for older people.

Overall the author feels that a greater perceptual knowledge of empowerment, the factors which facilitate it and the barriers which restrict its incorporation are held by respondents in the statutory sector.

This can clearly be identified by the findings of the study where respondents from the statutory sector possessed a greater understanding of empowerment:

- ⇒ In terms of its importance in service provision.
- ⇒ The beneficial aspects of empowerment for older people.

⇒ Explanations which they provided to define their perceptions regarding empowerment.

The author feels that both sectors possess a good knowledge of empowerment, although they may not attribute their knowledge to the term empowerment. As one respondent stated “many members of staff may not view their working practices as empowering or in any way related to empowerment”. However this does not mean that these staff members are not initiating and practicing empowerment on a daily basis. **The author feels that an even greater level of empowerment could be initiated through adoption of empowering principles into the existing knowledge base of each individual member of staff, working in each organisation despite the role which they play.**

It is therefore vital that all members of staff receive training and education which is appropriate to their particular role within an organisation and which is also aimed at increasing the perceptions of staff to the possibilities, benefits and advances, which can be initiated and incorporated, into the existing level of service provision for older people.

All staff must receive training-nursing, care and support staff alike, as education broadens the mind, particularly in circumstances where staff members have been working in the same organisation for long numbers of

years. Some respondents particularly in the statutory sector spoke of the institutionalisation of staff as opposed to residents. They believed that the longer a person worked in a particular organisation, the more institutionalised they became. Eventually these members of staff reached a stage where they felt that they possessed a reasonably good knowledge in relation to caring for older people and that they did not require additional training or education. However regardless of the length of service which members of staff engage in, every day should be a new learning experience. Each new working day should represent a challenge to members of staff and management to partake, to listen, to engage, to contemplate and to overcome any difficulties which may arise during the course of the day. Therefore all staff and members of management should be flexible and open to new challenges, experiences and perspectives offered by colleagues, older people and their family and relations.

Training should be provided to all staff and management so that they are up to date with current practices and practical advances in the delivery of care to older persons. Some training courses are essential in terms of their completion such as manual handling and lifting, hoist training and fire safety. All staff must undertake these courses as they are compulsory in the delivery of general care to older people.

However apart from the general care of older persons, do staff receive training regarding the overall wellbeing of older people in their care- physically,

psychologically, emotionally and spiritually? The majority of training opportunities which are offered to the respondents from both sectors do not include any other aspects apart from the physical dimension of the care of older people. Everyone has certain needs which must be regularly met; this state does not alter when a person becomes older.

An older person may be physically deteriorating in terms of their bodily functioning and appearance; despite this all other dimensions are possibly still intact and require nurturing from those who are caring for them. It is quite often the case that older people are neglected in the ways in which they need reassurance and care the most. This is currently referred to as holistic care which encompasses the whole person. Many factors limit the practice of empowerment and holistic care which respondents previously noted as barriers.

Recommendations for future service provision

The author feels that for empowerment to be incorporated in existing service provision many changes must be introduced into all organisations. These include:

- **The employment of competent, efficient and trained professional staff to alleviate the shortages which are experienced by organisations in both sectors.** A ratio of care should exist and be practiced within all organisations. In addition to this sufficient staffing levels should be in existence particularly during night time hours. No

member of staff should be allowed to work on their own during night time hours despite the number of residents which they cater for.

- **As previously mentioned training and education should be provided to all staff and this training should not be dependent on the role which they play in the organisation. Staff should also be encouraged to participate in training courses and to present the knowledge which they gained to their fellow workers in their return.**
- **Facilities for older people must be appropriate for their purpose. All environs should be safe and free from obstructions and potential risks such as wet, slippery floors. Facilities should be constructed in way in which the comfort, quality and care of older people are enhanced.**
- **All nursing homes and care facilities should incorporate appropriate recreational activities for older people, which are aimed at their interests and suitable for their abilities. In addition to this the author believes that all older people who are not incapacitated should be brought on day trips and outings so that they can enjoy their current life circumstances to the fullest extent possible.**

- All older people should be involved and be active participants in their own care planning and the delivery of the care which they receive. Their wishes should always be taken into account and they should be afforded with as many opportunities for choices as is possible.
- Good communication is vital for all aspects of the care of older people. This means that **good channels and processes of communication should exist between management and staff, staff member's alike, staff and residents, management and residents, support staff and residents and between all residents.** Family involvement and communication should take place and be encouraged between family members, staff and management. Listening is also an important element to the process of empowerment.
- Active participation from staff and residents had been deemed as a very important strategy to overcome any barriers to empowerment by respondents from both sectors. **Residents must want to empower themselves and staff must be appropriately trained, possess awareness and the ability to create situations and an environment which facilitates empowerment.**

- Respondents from the statutory sector placed a central importance on the empowerment of staff before older people can be empowered. **The author feels that it is very important that staff members are facilitated to empower themselves, feel valued and that they are have a very important part to play in empowering older people in their care.** The empowerment of staff is not something which can be expected to occur over a short period but it will however occur if as Randolph (1995) in his article ‘Navigating the journey to empowerment’ stated the three keys to empowerment exist. These are sharing information, communicating a vision and teamwork. If staff members are empowered first they will then be more proactive and possess an adequate knowledge of empowerment so that it can then be passed and transferred to those in their care.
- **The author believes that a greater level of family and community involvement should take place and be encouraged by all organisations so that older people are afforded as much ‘quality’ time as possible.**
- **All members of staff within each organisation should work together as a team so that their strengths and abilities are maximised and their weaknesses are reduced.**

- **Nursing and care staff alike should be empowered to adopt a holistic person centred approach which is not reliant on a medical model based approach. A medical based approach is essential for those who are ill but a person – centred approach has the ability to empower.**
- **Finally the author believes that it is the responsibility of all management teams in nursing homes and care facilities to overcome and tackle the barriers which prevent the incorporation of an empowering model of service provision into their organisations. As a result the level of knowledge which pertains among management, staff of all grades and older people will be raised so that an empowering model of service provision can become a reality as opposed to an unattainable goal.**

Empowerment can be identified to possess many different aspects from the review of literature which the author undertook. The literature review addressed the achievement of empowerment on personal, psychological, societal and environmental levels. It can be said that it is possible to change the attitudes of management, staff and older people by first shaping their behaviours, however the true benefits of empowerment can not be seen unless people first perceive themselves as being empowered.

Parker and Price's study in 1994 of the relationship between empowered managers and empowered workers identified that employees' feelings of empowerment correlated positively with their perceptions of their managers as being empowered and in control as well as with managerial support. **Therefore management must be empowered to create an environment whereby staff can empower themselves. In turn, nursing, care and support staff must also create an open and friendly environment whereby residents feel at ease to voice their problems, to be assertive and to feel empowered.**

Empowerment is present in two dimensions – in each person's psyche and in the environment which others have created or they themselves have created. Empowerment occurs throughout the course of one's life and it is possible to be empowered every day of our lives. This does not alter as we grow older. As Heumann et al (2001) state, society as a whole must embrace the values and commit to the planning, research and the use of resources towards the goal of empowerment of all people. In addition the authors believe that we as a society continue to embrace our fears of ageing, to see ageing as pathology rather than a natural and fulfilling completion of life. Therefore the approaches which we attribute to ageing are predominantly focused on the extension of life and not the quality of living in later years.

Empowerment is a complex process and the definition which Gibson (1991) offered identifies that empowerment is a process whereby individuals are

involved to take an active part in the process by recognising, promoting and enhancing their abilities to meet their own needs. In essence, the achievement of empowerment requires both clients and professionals to become jointly involved to ultimately ameliorate their apparent positions- so that both groups are enabled to work together to maximise their circumstances and quality of life.

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Appendices

Charter of rights for those receiving care

- The right to privacy and confidentiality.
- The right to be listened to and have wishes considered.
- The right to be respected and not to be demeaned.
- The right to have freedom of movement and of not being restricted, e.g. being kept in a locked room or home.
- The right to be allowed to take risks.
- The right not to be discriminated against for any reason, e.g. race, age, religion, colour, disability, sexual orientation, physical and financial circumstances and gender.
- The right to personal choice, according to individual preferences whenever and wherever possible.
- The right to be addressed in the way each individual chooses and prefers, and to have ones personal first name used only on freely given consent.
- The right to have access to preferred religious leaders.
- The right to eat and drink according to own preferences, only being advised by appropriate people on the advantages and disadvantages of certain foods and of the dangers of excessive smoking and alcohol consumption.
- The right to make ones own decisions which may conflict with others, e.g. professionals and /or with the family view.
- The right to have access to friends and relatives and to be given assistance to see them, if necessary.
- The right to have a pet if able to care for and look after it.
- The right not to be coerced to participate in activities against ones will
- The right to say no.

Questionnaire

Section 1

Personal Details

1. What age are you ?
2. Are you male _____ or female _____

Section 2

History of employment and training

3. Did you train as a ;
- | | |
|--------------------|-------|
| Manager | _____ |
| Nurse | _____ |
| Care Assistant | _____ |
| Social Care Worker | _____ |
| Chef | _____ |
| Other | _____ |
- If other please specify _____

4. What position do you hold within this Nursing Home ?

5. How long have you been working in this Nursing Home ?

6.(a) Have you previously worked in a similar setting ?

Yes ____ / No ____

(b) If yes, how long did you work there ?

7.(a) Have you received any additional “in –house” training since the commencement of your employment in this Nursing Home ?

Yes ____ / No ____

(b) If yes, what kind of training did you receive ?

8. Was Empowerment ever incorporated in your training ?

Section 3

Job Satisfaction

9. Do you enjoy working with older persons ?
10. What do you find to be the most rewarding aspect of working with older people ?
11. What do you find to be the most difficult aspect of working with older people ?

Section 4

Practice and policy within the organization

12. (a) Do you understand what the term Empowerment means ?

Yes _____ / No _____

- (b) If yes, what do you understand by the term ?

13. What do you feel are the most important elements of the Empowering approach for older persons in your care ? (Please rate from 1-10)
 1 being the most important and 10 being the least important

- Giving elderly people choices. _____
- Giving them individual tasks and responsibilities. _____
- Allowing them to be independent. _____
- Ensuring that they receive good care, dignity and respect. _____
- Allowing them to do things on their own initiative. _____
- Giving them help and support when required. _____
- Advising them on the best course of action. _____
- Allowing them to do what they enjoy as long as they fit into the daily routine. _____
- Allowing them freedom to develop friendships and relationships. _____
- Ensuring that all elderly people are given a high degree of privacy. _____
- Allowing elderly people to have his/her own possessions around them. _____
- Providing a healthy environment with good communication between staff and elderly people. _____

14. How important do you think Empowerment is in the services for elderly people ? (Rate on a scale of 1-3)

1	2	3
essential	reasonably important	not important

15. How do you think Empowerment would benefit older persons in this Nursing Home ?

Section 5

Factors Facilitating Empowerment

16. Can you give an example of where older persons within this Nursing Home are Empowered ?

17. How frequently do you see examples of Empowerment occurring in this Nursing Home ?

1
frequently

2
quite often

3
rarely

Section 6

Barriers to Empowerment

18. Can you think of any barriers to an Empowering approach in this Nursing home ?

19. What do you feel is the main barrier to Empowerment in this Nursing Home ? (Please rate from 1-10) 1 being the main barrier, 2 , 3 etc...

- Lack of knowledge into the concepts of the approach. _____
- Current practice and policy of the organization. _____
- Time factor. _____
- Difficulties in implementing the approach. _____
- Lack of resources. _____
- Staff shortages. _____
- Attitudes of Management. _____
- Leaves older persons in a position of control over what goes on within the Nursing Home _____
- Attitudes of staff. _____
- Elderly people's own self perceptions of being dis-empowered. _____

20. Do you feel that barriers to Empowerment can be over come ?

Yes ____ / No ____

21. How can they be over come ?

22. Any other comments you would like to make , with regard to empowering practice, practice and policy within this Nursing Home or in general ?

Thank you for taking the time to complete this questionnaire and for your co-operation with this research.