

**Entering the Twilight Zone: Exploring the experience of
older people as they transition their living accommodation**

**A Thesis submitted in partial fulfilment of the requirements for the
degree of Master of Health Sciences**

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Abstract

Older people have a greater array of choices for retirement living than any other generation before them. Deciding on where to live is a major dilemma for them. What are the factors that contribute to this making this life-changing decision? How do older people cope with the transition to new accommodation?

This research considers the experience of older people who have made the shift to a retirement complex. It also contemplates their attitudes and perceptions and those of older people who may, at some point in their lives, have this decision taken from them and find they are directed into care. The focus of the research was to hear and record the 'voice' of a purposeful sample of older people by exploring their experience of shifting into one of four levels at retirement complexes; villa, serviced apartment, resthome or hospital. The research also delved into the attitudes towards a potential shift of those who remain in their family home.

Thirty-five participants, ranging in age from 66 to 95-years were located into three groups according to their living situation. They were interviewed using an unstructured interview process and information from these interviews was categorised into sixteen themes. The data were sifted through, in order to discover similarities and differences between participants and groups. Findings were then compared with available literature to offer further endorsement or to proffer an alternative perspective to the existing information. These findings also indicate areas where further research could be carried out to gain a more holistic oversight in order to reduce the stress for older people moving from their family home.

Chapter 1

Introduction

When I am of retiring age, Statistics New Zealand (2012) projects that I will be in the middle sector of retiring Baby Boomers and that I will be part of the over 52,000 New Zealanders reaching this milestone in 2021. Together we will form part of the over 800,000 retirees and make up 17% of the country's population. By 2026 we will, for the first time in this country's history, out-number those aged 0 – 14ys (Statistics New Zealand, 2010).

Many of us Baby Boomers are experiencing a snapshot of what life may hold for us as we move through our retirement years, when we look at our surviving parent's who are aged between their mid-70s and well into their 90s. Our concern for our parents and their contentment with life as older citizens is partly enmeshed with our concern for what life as a retiree may hold for us. We are well aware that the citizens in New Zealand are living longer. Is this increase in life span causing celebration or anxiety among older people? If the answer is; that older people are becoming more anxious about how they live and for how long, we must address their anxiety.

This research will focus on one aspect of the lives of older people; that of transitioning their accommodation when they are over 70 years old. For older people, this is possibly the single most significant event after the loss of a life-time partner, in their retirement years. There have been many studies that focus on the needs of the older citizens; as perceived by health care professionals and family members. Fewer studies focus on hearing what older people have to say about their needs and more

specifically how they transition their accommodation as they continue to meet their physical and cognitive needs.

This study used qualitative methodology by adopting a phenomenological focus on the phenomena of the perceptions of a group of older people who have transitioned their accommodation and a group of older people anticipating this shift. In order to 'hear the voice of the elderly' a narrative approach was employed. As the researcher I have used unstructured interviews to solicit the experience of the older people. As a 'naive enquirer' I asked open ended questions with some prompts to engage the participants in telling their story.

It is intended that this research will contribute to a growing trend of 'hearing the voice' of the group that are being researched and allowing their 'voice' to be heard above the roar of those that research and work with them. Older people have a lifetime of experience and they are willing to share from their plethora of experience, their gained wisdom about their needs and how these can be met.

Literature Review

Global Perspectives

New Zealand and the rest of the world are about to reach an historical landmark where those over 65 years of age will exceed the number of children aged five years and under. It is estimated this cross-over will occur around 2016 when both the number of older people and those under five years old will reach around nine percent of the global population (Kinsella & Phillips, 2005; National Institute of Health, 2011). In the 40 years from 2010 to 2050 it is estimated that the world's population of those aged sixty-five and older will triple to one and a half billion, increasing from approximately 8% to 16% of the world population. By 2030 it is likely to be around 13% (National Institute on Aging, 2007). In the early 1960s, when the majority of those fitting the Baby Boomer demography were born, they formed just under 15% of the global population whilst those 65 years of age and over were a fraction over 5% of the total world population.

With lower birth rates comes a significant change in the structure of families. Compared to children in previous generations, many future children will have fewer siblings, or none at all (Statistics New Zealand, 2007). They also have an increased likelihood of knowing their grandparents and great-grandparents. If these children are the progeny of Baby Boomers and live in Western countries, the extended families they live in are likely to mirror the changes in their societies such as delayed childbearing until parents are in their thirties and forties, single parent families, divorce, reconstituted families with or without children, elective childless adults and couples, and adults that choose to remain single (Kinsella & Phillips, 2005; National Institute on Aging, 2007).

Globally, the numbers of those considered the 'oldest old' (80 plus years) are projected to increase significantly to total approximately 7.5% of the world population by 2020, more than double the number at the turn of the millennium (Kinsella & Phillips, 2005). This is the most rapidly growing age group in the world (National Institute of Health, 2011). At 70 million in 2000, this number is expected to be 5 times that by 2050 (United Nations, 2002). It should also be noted that those in the 'extreme old age' category (centenarians) will continue to increase considerably; in more developed countries their numbers have doubled each decade since 1950. For females who live in countries with a low mortality rate, the chances of living to be 100 years old has increased from one in 20 million in early human history to one in 50 people now (National Institute on Aging, 2007).

Decreased Mortality Rate

Early in the Twentieth Century, the most common causes of death were transmissible diseases which largely threatened the mortality of the young. One hundred years later, now in the early years of the Twenty First Century, many of these diseases have been reduced or eradicated due to increased sanitation, improved standard of living conditions, improved nutrition levels, better knowledge of illness and its combatants, and disease prevention, as well as global immunisation programmes. "This represents the triumph of public health, medical advancement, and economic development over disease and injury, which have constrained human life expectancy for thousands of years." (National Institute on Aging, 2007, p. 4) However, in recent times there has been a considerable rise in non-transmissible diseases, which represent the increased affluence of many societies, including chronic and terminal conditions as cancer, heart disease and diabetes. The decline

in fertility, a rise in longevity and the change from transmissible to non-transmissible diseases has added considerably to the rapid change in demographics in the global population (National Institute of Health, 2011; National Institute on Aging, 2007).

Changing Structure of Families

In recent years, changing constitution of families coupled with increased longevity and increased independence of older people has led to a revolution in living arrangements for older people. There has been an escalation in the numbers of elderly and the number of older people moving into residential care, living with their spouse or partner or on their own. At the same time, there has been a marked decline in older people living with their children (Kinsella & Phillips, 2005). Medical treatments and the sustaining and prolonging of life for those with the foremost Twenty-First Century non-transmissible diseases (i.e., cancer, diabetes, heart disease and stroke) are costly to a nation in a variety of ways (Kinsella & Phillips, 2005; National Institute of Health, 2011; National Institute on Aging, 2007). The costs of medical treatment, specialist care and day-to-day care giving escalate particularly when the patient is elderly and care is no longer able to be provided by family members as it once was. There is an expectation in many developed countries, including New Zealand, that the state will assume responsibility for fully or partially funding the treatment, care, and often accommodation of the older person if their condition is severe and they have limited funds.

New Zealand in a Global Community

In recent years, as the world population has begun to noticeably age, there has been increasing focus on the needs of the older people. In New Zealand the number of older people will continue to rise rapidly until 2026 when the last of the

Baby Boomers have reached the age of 65 years. This will equate to 20% of the country's population. The parents of this demographic are the first generation to extensively use retirement complexes (Kinsella & Phillips, 2005).

The current older population, largely those born around the end of the First World War (1918) up until the end of the Second World War (1945), are a growing group. Better living conditions, an enhanced standard of health, and the medical expertise to sustain life following serious illness (that in previous generations would have guaranteed death) have all resulted in an increased lifespan. The relatively new-found-ability to prolong life has not come without consequences (Baltes & Smith, 2003). There is an increased need for specialised services such as medical, assessment, care, and accommodation. Coupled with these there has also been the need to seriously consider what successful ageing means for older people (Blazer, 2006). In fact, providing goods and services for older citizens has become a booming industry in most Western countries; many companies providing such goods and services have become multi-million dollar industries. Whereas in the past families tended to care for their aging relatives they now frequently don't have the time, energy or inclination to do this (Kinsella & Phillips, 2006). Many older people are also keen to maintain their independence and prefer to make decisions about their needs rather than relying on their children or younger relatives to take the responsibility of maintaining and caring for them (Kinsella & Phillips, 2006).

The New Zealand 1996 Census (Prosser, 1998) showed the following division of living arrangements for older people who responded: 54% lived with their partner or spouse, 10% lived with their children, approximately 30% lived alone, while 6.3% lived with people to whom they were not related. This latter figure included those that lived in such places as hospitals and residential care. Of these, just under 5% lived

in residential care. 25% of all those aged 85-years and over lived in residential care. More than half of the residents in care facilities were 85-years or older. Those people over 85-years living at home were the most likely group of older people to have need of assistance to carry out everyday tasks. These tasks were usually carried out by family members and friends (Prosser, 1998).

The New Zealand Government Statistician (Bascand, 2012), notes that the total population of the country will be in the vicinity of six million by 2006. At the same time there will be a rapid change in population age structure which is likely to occur in the next 50 years. The median age reflects this. In 1951, the mean age was 29. By 2001-12 it had reached 37 and is expected to continue to rise to 41 by 2036. By 2061, it is expected to have reached 44. Accordingly, the number of older citizens will continue to increase from 9% in 1951 (Davey, de Joux, Nana, & Arcus, 2004), to 14% in 2011. The projection for 2031 is 22% (New Zealand Ministry of Health, 2002), and the expectation is that it will reach 26% by 2061 (Bascand, 2012). The percentage of elderly who are over 85-years old will double from 12.5% in 2012 to between 25% and 26% in 2051 (Bascand, 2012; Koopman-Boyden & van der Pas, 2009; Koopman-Boyden & Waldegrave, 2009; New Zealand Ministry of Health, 2002).

Impact of the Baby Boomers

Much of the rise can be attributed to the Baby Boomers who, as a cohort, double the number of people aged over 65 group in the 20 year span between 2011 and 2031 as they reach retirement age. Again, this group almost doubles those aged over 85-years between 2031 and 2051 as they enter and become the 'oldest-old' category of the population (Bascand, 2012). The longevity trend in New Zealand

reflects the rest of the developed world and for similar reasons - increased sanitation and enhanced public health programmes (including anti-smoking campaigns and associated legislation).

Global Plan of Action

At the Second World Assembly on Ageing in Madrid in 2002, representatives from United Nations (UN) governments not only reaffirmed the philosophy and proposals for achievement that arose from the 1982 UN's International Plan of Action on Aging and the 1991 United Nations Principles for Older Persons. They also adopted the Political Declaration and the Madrid International Plan of Action on Aging. The Political Declaration containing 19 Articles, coupled with the Madrid International Plan of Action on Ageing, was designed to build a society for all ages (United Nations, 2002). It recognised the global phenomenon of a rapidly rising older population, not only among more developed countries but even more so among developing nations. The Madrid International Plan of Action on Aging was endorsed by in excess of 159 countries of which New Zealand was one. This plan noted that it was the responsibility of individual governments to implement the wide-ranging recommendations. To do so, they would need to engage both government and non-government organisations to assess how the plan could become part of their own national framework to address ageing and the concerns of that nation's older persons (United Nations, 2002).

New Zealand's Plan of Action

In 2002, the New Zealand Ministry of Health (MoH) released the Health of Older People Strategy: Health Sector Action to 2010 to Support Positive Ageing (New Zealand Ministry of Health, 2002). With the arrival of the new millennium came

a flurry of health strategies for the country including the overarching strategies of Positive Ageing Strategy Action Plan for 2001/02, and the New Zealand Health Strategy 2002, New Zealand Disability Strategy 2001. The population-based strategies were key actions derived from the overarching strategies. These were He Korowai Oranga Maori Health Strategy Discussion Document 2001, Health of Older People Strategy 2002, and Pacific Health and Disability Action Plan 2002 (New Zealand Ministry of Health, 2002). To implement these strategies, the following service-based strategies were developed; Primary Health Care Strategy, Mental Health Strategy and the New Zealand Palliative Care Strategy. As would be expected, these were often inter-related and helped to inform other strategies, including the New Zealand Injury Prevention Strategy 2003.

The Health of Older People Strategy (New Zealand Ministry of Health, 2002) was developed through drawing on expertise from within the country and internationally as well as consulting international policies, including the United Nations Principles for Older Persons 1991, the fore-runner of the Madrid International Plan of Action on Ageing, 2002 (United Nations, 2002). The vision of the MoH strategy was stated as “Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes” (Ministry of Health, 2002). In order to implement the MoH’s Health of Older People Strategy, the District Health Boards (DHBs) were expected to develop their own strategies to meet the needs of the older people in their community prior to 2010. The flow on effect was that as these strategies were put into action, they necessitated delivery changes from service providers and those working within the health sector (New Zealand Ministry of Health, 2002).

Heartland Strategy

The research for this thesis was situated in the city of Christchurch which falls within the Canterbury District Health Board (CDHB) area. Therefore, information pertinent to older people living within the CDHB environs was reviewed. In 2006, the CDHB published their Healthy Ageing Strategy: Older People's Health Service Strategy 2006-2010 (Canterbury District Health Board, 2006). This document was composed in collaboration with community groups and individuals through submissions and with expertise from within the health sector within the framework of the Health of the Older People Strategy (New Zealand Ministry of Health, 2002). It should be noted that prior to the publication of this strategy, the CDHB had already formulated its "LinkAGE – Leading Integration for the Elderly" project (2002-2004). This paper outlined the strategies for implementing the Ministry of Health's Health of Older People's Strategy 2001 (Canterbury District Health Board, 2006).

Canterbury is identified by the MoH as an area within the country as having a higher proportion of older people within its population (Canterbury District Health Board, 2006; New Zealand Ministry of Health, 2002). A DHB with an older population has the task of not only endeavouring to develop strategies to meet the needs of its older citizens but also manage the added pressure of funding a larger segment of the population requiring more expenditure to have those needs met (New Zealand Ministry of Health, 2002). As people age, the estimated cost per capita for health and disability support services rapidly rises from age 60-years (New Zealand Ministry of Health, 2002). Those over 85-years tend to be the largest users of the support services provided for health and disability (Davey et al., 2004). It is expected that

citizens aged over 85-years in Canterbury will double in the 10 years from 2006 when the strategy was presented (Canterbury District Health Board, 2006).

The CDHB needed to take into account the needs of its older members in the community and its commitment to the maintenance and improvement of older citizen's health at the same time as keeping within its own fiscal restraints. It had identified the provision of service in Older People's Health as one of its priority five key strategic areas (Canterbury District Health Board, 2006). There is an acknowledgement by the CDHB that in the last decade the health of older people has improved but alongside this improvement comes other health issues for older people. The health and support services of the CDHB will have the pressure of providing services for additional numbers of people needing continuing care, people with chronic conditions such as cardiopulmonary diseases, strokes, dementia and other issues related to people living longer (Canterbury District Health Board, 2006). Despite these budgetary constraints, the "Underlying Principles for Developing Services" include such 'key principles' (Canterbury District Health Board, 2006, p. 7) as: older person-centered, ageing in place, participation and collaboration, partnership with Māori, and involvement of all groups, preventative, best use of resources, building capacity in non-institutional services, integrated planning and delivery, holistic model, attention to rural needs, flexible funding, and evidence-based. (Canterbury District Health Board, 2006, p. 8). The 36-page document proceeds with more explicit statements as to how services will be delivered to older people of their region in a way that will meet the needs of the elderly and the fiscal constraints of the board.

"The focus of the strategy is providing older people with community based services that allow them maintain [sic] their independence for as long as possible,

whilst acknowledging that older age often brings with it an additional need for support from a variety of health and related services.” (Canterbury District Health Board, 2006, p. 8).

Each year the CDHB, along with the 19 other DHBs in New Zealand, is required to produce an Annual Plan and a Statement of Intent. These are combined to outline the board’s planned path and identifies its “... key challenges, objectives and goals.” Both the Annual Plan and the Statement of Intent must fit with the New Zealand Ministry of Health’s national strategies and expectations that include working towards a sustainable health system to meet the challenges within the health sector both nationally and globally (Canterbury District Health Board, 2011b). The CDHB in its latest plan and strategy outlines the need for individuals to take increased care for their own health, individuals to maintain their health in their communities and at home, and complex care to be delivered appropriately and in time.

The implications to older people are that there will be greater focus and emphasis on providing education, support and services in order to maintain people in their own homes. For those needing complex care there will be access through the ‘Single Point of Entry’ system (Canterbury District Health Board, 2011b, p. 57) and a focus on reduction of hospital admissions, rehabilitation and support to return to their community or home rather than longer hospital stays. This is a trend regionally, nationally and internationally as the world faces the issues of an ageing society globally.

Wellbeing and Ageing

A combined and comprehensive study undertaken over six years conducted by both the Family Centre Social Policy Research Unit in Lower Hutt, Wellington, and the Population Studies Centre at the University of Waikato, in Hamilton, New Zealand, produced “Enhancing Wellbeing in an Ageing Society: 65 – 84 year old New Zealanders in 2007 (EWAS) (Koopman-Boyden & Waldegrave, 2009). The key findings in the EWAS research that related to older people and their living arrangements, ageing in place and wellbeing were derived from a sample of 1,680 participants aged 65-84 years old. Of these 46.6% were male and 53.3% were female (Koopman-Boyden & Waldegrave, 2009). Prior to this study in 2007, a wide-ranging report had been produced for the Centre for Housing Research Aotearoa/New Zealand (CHRANZ) focussing on the accommodation options for older people (Davey et al., 2004).

Davey’s (Davey et al., 2004) study revealed that because older women were more likely to be younger than their husbands and tended to live longer, they were also more likely than their male counterparts to live in a single-person household. Older men in a shared household were more likely to have a partner than were older women. For men, 75% aged 65-69years lived with a partner without children. When they reached 80-84years of age, 60% of them lived with a partner without children. However, women had a 61% chance of living with a partner without children when they were 65-69-years of age but by the time they were 80-84-years old they had only a 21% chance of this living arrangement. Approximately 56% of those 85-years or older lived on their own and of these, two-thirds were women (Davey et al., 2004; Koopman-Boyden & Waldegrave, 2009). If older people shared their household it

was more likely to be with their children. Males were more likely than females to be part of a couple if they lived in a shared household. Those with higher education who lived in shared households were more likely to live with those who were related or unrelated to them than were those with a lower education (although those with a lower education are more likely to live with their children) (Koopman-Boyden & Waldegrave, 2009). Conducting research into the accommodation needs of older people coupled with how these shifts can be made less stressful would enhance the wellbeing of those making a shift.

Health was the greatest single factor that impacted on whether or not a person remained in their own home as it influences the ability of older people to feel relaxed about continuing to live in their home (Koopman-Boyden & Waldegrave, 2009). Being mobile and being able to easily access transport and shopping facilities were a part of this. Other factors contributing to an older person staying in their own home include reasonable costs for housing, living near friends and family and living in a desirable area. Increased levels of wellbeing were felt by older people who lived with their partner as opposed to those living alone. Those living on their own are likely to be more isolated and lonely and find living more costly (Koopman-Boyden & Waldegrave, 2009). It is believed that living with a partner provides companionship, fulfils the need to care and be cared for, and the economics of pooling resources reduces the cost for both.

The EWAS study concluded that over 97% of older people wish to 'age in place' in their own home. Crucial factors that enable this to ensue are frequently dependant on their spouse or themselves maintaining good health, close accessibility to friends and family, residing in a pleasing location, accessible and available transportation, and affordable rent or maintenance (Koopman-Boyden &

Waldegrave, 2009). The CHRANZ report noted that 'ageing in place' called for a move from the more negative perception of growing older through medicalising ageing to 'positive ageing' that took into account lifestyle choices that include being involved and active (Davey et al., 2004). For a person to 'age in place' it has become increasingly important for the elderly, making it possible for them to remain in their own familiar community with the assistance of appropriate services and support (which may include the need to address the maintenance, renovation and adaptation of their housing). Some older people with significant assets may decide to leave their own home and live independently or semi-independently in a retirement complex (Davey et al., 2004; Koopman-Boyden & Waldegrave, 2009). For those in need of care and support of a high level, Davey et al (2004), advocates further investigation of 'sheltered' or 'intermediate' housing. This may include suitable unique plans or settings as well as meeting the care and support needs of older people "... which maximises their opportunities for autonomy and social contact." These, along with feeling secure, have been identified as important factors in the wellbeing of older people. Ideally, a variety of housing options will be available and affordable to meet the individual physical and socio-emotional requirements for older people (Davey et al., 2004).

Residential Care

In 2010, Grant Thornton (Grant Thornton, 2010) carried out an extensive review of aged residential care services in New Zealand. The review covered the residential care services of rest-home (57%), hospital (31%), dementia (8%), psychogeriatric (2%), and young physically disabled (2%). The review noted there had been an increasing demand for care services for older people since the

beginning of the millennium and that these had largely been absorbed by supportive services going to the homes of individuals requiring these. Grant Thornton (2010) maintains these are no longer sustainable and that by about 2015 home support services will no longer be able to cope with the demand. There will be an increasingly high demand for residential care, particularly that for beds in hospital and dementia facilities until around 2026. It is projected that the demand will increase between one-third and two-thirds of what it currently is and will largely be for the requirement for dementia beds.

Coupled with the increased estimated demand for between 12,000 and 20,000 additional beds there is also the need to update current facilities to fit the changing expectations of society and residents, residents' care needs and local building code regulations (Grant Thornton, 2010). In 2010, over half the beds in establishments were more than 20 years old with many of these over 50 years old. Twenty-five years is the expected life of a facility.

Facilities are now mostly business enterprises. Previously, residential facilities were run by not-for-profit, privately- owned organisations, such as religious groups, benevolent groups and trusts (Simpson & Cheney, 2007). There is an expectation that any business will aim to make a profit. Increasing share prices of publically-floated companies involved in providing accommodation and services for older people (Simpson & Cheney, 2007) would indicate that for many this is seen as a good investment. The most effective facilities are those with around 80 beds; many current facilities operate with 50 beds or less. The most costly services are those for rest-home and dementia care. Dementia care facilities have the greatest demand but the return is too low to continue to be sustained by investors. In recent years those offering new care facilities have targeted residents who are able to pay for some or

all of the services provided. Over one-third of facilities offering rest-home, hospital, or dementia care were located within retirement villages. This allows residents to have continuity of care (Grant Thornton, 2010) and possibly also allows the cost of the more expensive care facilities to be spread across the whole complex.

The Aged Residential Care Service Review (Grant Thornton, 2010), noted various possible changes to current services that included older people having more autonomy in selecting the services that meet their needs (which may include paying or part-paying for these services), the increased delivery of care services focussed on increasing wellbeing and reducing the likelihood of critical admissions to hospital, alternative affordable housing options for all that give choices for those less able to afford to purchase their accommodation (such as community-based housing) and changes that offer the opportunity for older people to provide help and support to each other (Grant Thornton, 2010). Koopman-Boyden and Waldegrave (2009) also recommended a variety of accommodation to meet the needs and finances of a greater cross-section of older people, home support and care services having increased resourcing to allow older citizens to stay within their community, and encouragement of continued participation within their community and with their peers.

Canterbury Earthquakes

It should be noted that the devastating earthquakes in the Canterbury region in 2010/2011 have had a serious impact on residential care facilities there. As a direct result of the earthquakes, over 600 beds were destroyed (Canterbury District Health Board, 2011c, 2012); and ten facilities providing residential care were required to close and had to evacuate their residents (Canterbury District Health

Board, 2011c). Just over 500 residents in residential care facilities were evacuated; approximately 10% of older people in care were evacuated from their care facility (Transition 2012; Heppenstall, in press). 60% of these were evacuated from the city by aeroplane or bus while the remaining 40% relocated within the city environs, a few to family, one to hospital and the remainder to other facilities (Canterbury District Health Board, 2011c; Heppenstall, in press).

The CDHB funded research to document how those who were evacuated, both within Canterbury and outside the region, had been affected by the relocation. Fifty older people who were relocated and 30 informal carers were interviewed (Canterbury District Health Board, 2011c). The older people were frightened in the immediate aftermath of the earthquake, unsure of what was happening and what was going to happen and worried about their lack of influence over these events. Nearly one third had continuing concerns with anxiety especially in association with the huge number of ongoing significant aftershocks. The majority of this group had not previously had a history of anxiety. Many of the evacuees were evacuated either late in the day or during the night and felt that there was a lack of communication about the shift with them or their family members. Most participants acknowledged that the situation was an extraordinary emergency and that it had been a difficult time for all involved. Many evacuees had developed good resilience and coping mechanisms, often through previous difficult experiences during their life. Evacuees applauded those in their new community for the welcome and acceptance they were given. Of the 298 older people who were moved from Christchurch, 129 elected to stay in their new home citing reasons such as being well-established in their new community, ongoing aftershocks in Christchurch, having family members close by, not wanting the distress of another move, and “not wanting to be a nuisance or

burden on family in Christchurch” (Canterbury District Health Board, 2011c). Of the 159 who were evacuated from Christchurch, 80 died and the remaining 79 returned to Christchurch as beds became available.

As a result of the earthquakes and the immediate loss of over 600 beds in subsidised residential care within Canterbury, the CDHB needed a plan to address the allocation of future vacant residential beds and for supported care of those who no longer fitted the criteria for being assigned a bed. As well, the CDHB was keen to repatriate back to their area those older people who had been evacuated and wanted to return to Christchurch (Canterbury District Health Board, 2011c). An interim plan was developed to cover the repatriation and new referrals while a more comprehensive plan that fitted with the CDHB’s more farsighted “Vision 2020” was being developed (Canterbury District Health Board, 2010). “Vision 2020” took into account the projected 35% increase in the region of those over 65-years by 2020 and included a focus on enhanced services that enabled older people to remain living in their own homes longer and, in some instances, reducing or eradicating the need for residential care (Canterbury District Health Board, 2010, 2011a). The CDHB’s Aged Residential Care (ARC): Physical Capacity Recovery Plan of June 2011 planned to provide for the 36.5% increase in the older aged population with an increase of 14.74% beds in the subsidised residential care sector. The discrepancy will be accommodated by better multidisciplinary assessment, rehabilitation, and support and care in conjunction with preventative programmes to enable people to remain in their homes (Canterbury District Health Board, 2011a). Those who have personal wealth will be able to make choices about the type and level of care they select if they are prepared to pay.

Canterbury District Health Board

There is an acknowledgement by the CDHB in the ARC plan that those with limited financial resources are likely to be housed in less-than-adequate housing. This is likely to have indirect adverse health consequences which, in turn, increase the rate of health deterioration. The corollary is that the need of health services for these older people increases and to a higher level. “This is not good for the individual, nor sensible from a whole of cost to the community perspective” (Canterbury District Health Board, 2011a, p. 23). The document refers to the Grant Thornton Review (2010) and reiterates the need for a greater diversity of special purpose housing options for older people, not only for those with lower incomes but also to give alternatives for those who wish to move from their own home, for a variety of reasons, and do not wish to move into, or are ineligible for, residential care (Canterbury District Health Board, 2011a; Grant Thornton, 2010). (Canterbury District Health Board, 2011a). Previously, the Christchurch City Council has been involved in public housing but as a result of the consequences of the earthquakes there may be a change in investment in this area as the Council focuses on rebuilding the city and its infrastructure (Canterbury District Health Board, 2011a).

For many years to come, the Canterbury area is likely to be used as a ‘blue-print’ for the rest of New Zealand as it grapples with the aftermath of the devastating earthquakes of 2010/2011. The earthquakes, coupled with the rapid increase of its older population, will provide opportunities for the region to redefine the connotation of housing for older people (Canterbury District Health Board, 2011a). These combined factors will give rise to a variety of options offered for older people that not only meet their diverse needs but also satisfies the budgetary constraints of local

bodies and government-funded organisations. “We demonstrated how easily we could develop new models and deliver break through innovations that the rest of the country can benefit from. In the space of hours we were organised and connected across Canterbury, in the space of days we had the whole system back on its feet and delivering free care to people in their communities” (Canterbury District Health Board, 2012, p.1). Further information about the experiences of the older people who lived through the earthquakes will help to develop a more holistic understanding of their issues in times of disaster.

The Third and Fourth Age

Much discussion has taken place on the topic of ‘successful ageing’ and what this means to both older people and other interested groups or individuals (Baltes & Smith, 2003; Blazer, 2006; Gilleard & Higgs, 2011; Mellor & Edelman, 1988; Neugarten, 1974; Smith, 2001b). In developed countries, the debate has increased with the rise in life expectancy. In 1974, Neugarten, considered the evolution of the life-cycle as the general population lived for increased periods of time. She noted that with the rising number of people aged over 55 years there seemed to be two distinct groups forming. The ‘young-old’ were largely those between 55 - 75 years while the ‘old-old’ were those aged over 75 years. Since the 1970’s, some 40 years ago, the life expectancy for those in their 80s has increased by at least a mean of eight years, approximately four years longer (Baltes & Smith, 2003). This increase in life-span has given rise to more recent researchers redefining these categories into the third and fourth age (Baltes & Smith, 2003; Gilleard & Higgs, 2010, 2011; Netuveli, Wiggins, Hildon, Montgomery, & Blane, 2006; Smith, 2001a). While it would seem they agree that there are two distinct categories they cannot concur on

definition. With the advent of the third and fourth age has come vigorous debate, not only about the boundary between these categories but also how each phase is defined. There is general agreement that the third age commences around the time of retirement, somewhere between 55 - 65 years old (Gilleard & Higgs, 2011; Netuveli et al., 2006; Smith, 2001a).

Definition of the commencement of the fourth age, or the 'old-old' category, falls into two main camps, one where the boundary is defined through population-based measures, and the other where the boundary is defined using person-based measures (Baltes & Smith, 2003; Netuveli et al., 2006; Neugarten, 1974; Smith, 2001a, 2001b). Researchers are in agreement that the boundary between the third and fourth age is somewhat fluid (Baltes & Smith, 2003; Gilleard & Higgs, 2010, 2011; Netuveli et al., 2006; Neugarten, 1974; Smith, 2001a) in the sense that it differs markedly between developed countries and developing countries where the lifespan varies considerably. Essentially, it is agreed that the third age is the time when retirees, having divested themselves from the responsibility of rearing children and earning an income to support themselves and their family, are able to indulge in leisure and freedom (Neugarten, 1974). Gilleard and Higgs (2011), refer to the third age as "ageing disgracefully" where today's retirees have interrupted the previously-accepted norms for older people of "abject old age" (p. 137). Instead, they argue, today's 'young-old' (or those in their third age) have risen to the challenge placed before their cohort - that of consumerism as laid down by marketing moguls. The third age is a burgeoning commercial area where retirees are encouraged to throw off the cloak of "enforced idleness and roleless existence" (Gilleard & Higgs, 2011) (p. 137) and take up the gauntlet of indulging in continuous entertainment activities and escapades that were previously unheard of for older people. Gilleard and Higgs

(2010) point out that this new generation of retirees were that same group of people who shaped the 1960's with a youth culture that emphasised freedom of choice, independence and an ability to express exactly what they wanted. This group is also the first cohort to have moved through the age of mass consumerism (Gilleard & Higgs, 2010).

The third age, with few health issues to impede individuals (Blazer, 2006), has become a time of almost over-enthusiastic refusal to acknowledge old age (Gilleard & Higgs, 2010) an age that epitomises optimistic aging Smith (2001b). Life in the fourth age, however, is no longer a jaunt of socialising and adventure but rather one where the physical and cognitive agility seeps away (Baltes and Smith (2003); Blazer (2006); Gilleard and Higgs (2010, 2011); Netuveli et al (2006); Neugarten (1974). Gilleard and Higgs (2010), refer to this stage of life as “terminal destination” (p. 123) whilst Smith (2001b) announces that “dysfunction and death” (p. 464) are the features of the age leading to “death-related” functioning (p. 465) or “terminal decline” (Smith, 2001a, p. 8). Laslett, entices third agers into the fourth age even more by defining the characteristic as dependence, decrepitude, and death (Laslett, 1996)

Since the mid-twentieth century, there has been a concerted study of older people and the development of a new medical field, that of geriatric medicine. Those working in this field were charged with distinguishing between the ‘sick’ and the ‘old’; between those whose condition was able to be improved and those who would continue to deteriorate (Gilleard & Higgs, 2010). Smith (2001a) notes that there is a vigorous deterioration in brain function in old age. Baltes and Smith (2003) reinforce this information with the findings that dementia was detected in slightly less than half of all surviving 90-year olds, though Blazer (2006) noted that cognitive results were

likely to be improved in those who kept exercising their mental faculties and who had attained higher educational levels. Smith (2001a) concluded that a predictor of death in old age was acceleration in the reduction in intellectual and cognitive functioning.

During the twentieth century there was an unprecedented rise in health and social policy that has enabled human beings to live longer. A number of researchers are highlighting the consequences of increased lifespan for society and for those who move into the fourth age. Gilleard and Higgs (2010) believe that reaching the fourth age is “the bitter fruit of that victory” of longevity and “the result of personal bad luck” (p. 125) for those reaching this phase. They postulate that the fourth age does not provide its residents with any choices but rather it offers a loss of ability to function on a cognitive or physical level, and that there is no reprieve from this state of reliance on carers to meet the daily needs of individuals. Baltes and Smith (2003) question using limited resources to maintain those in this phase as opposed to those resources being used to support the children and adolescents who, in the future, will be the ones providing the supports for older people. They also believe that the continued and increasing use of resources in the area of the older people may well reduce the overall economic resources accessible for care of older people (Baltes & Smith, 2003). They believe that this dilemma is even more pertinent for developing countries where resources are more limited than in developed countries. Eiseman (2006) concurs that using the national budget to support those who can no longer repay this societal investment in their health is a poignant question that must be considered.

Successful Ageing and Maintaining Well-being

While it would seem there is little to entice a person to want to live to the fourth age, many people do become 'old-old' and have what they believe to be a satisfying life. The concept of successful ageing has been debated a length in recent years and a number of factors have been identified as ingredients for a successful ageing process. Hinton (2010) states the importance of research about older people being focussed on the "emic" perspective - gaining the insight of the group being studied (in this case older people), rather than the "etic" perspective - what those outside the studied group believe is needed. Research is conducted 'with' older people rather than the research being conducted 'on' older people. Smith's (Smith, 2001b) research with the longitudinal Berlin Aging Study (BASE) analysed data from 516 older people aged 70 – 100 years. The research discovered that there was a loss of positive well-being during the transition from the third to the fourth age coupled with the general demise of a person in the fourth age that constrained positivity about life. Despite this loss, there is a considerable upsurge of a person's well-being when they are about to turn 100-years old, perhaps because of the recognition that society bestows on an individual for this achievement and the associated pride the individual feels. Smith (2001a) acknowledges that it would be useful to find ways to replicate this positive sense of well-being. For an individual to age successfully, with a positive sense of well-being and the feeling that they have a good quality of life, is usually multifaceted. "Ageing positively includes physical, intellectual, emotional and spiritual wellbeing. It is not necessary to be free of ill-health to age positively, although it helps" (Glasgow, 1999).

Most individuals, whether young or old, require a certain amount of autonomy, self-determination, and an ability or freedom to make their own choices to maintain their well-being (Blazer, 2006; Glasgow, 1999; Smith, 2001b) and care for themselves (Blazer, 2006; Zahava & Bowling, 2004). Maintaining independence is a priority for many when they consider their quality of life. Eiseman (2006) mentions one of his respondents who indicated the value of a driver's license by stating that once that had gone it couldn't be replaced whereas a wife could. Zahava and Bowling (2004) reiterated the importance of a driver's license in their own research on quality of life which analysed surveys completed by 999 people aged 65-years and over who lived in personal dwellings in Britain. Many older people deemed as very important being able to continue with day-to-day tasks to look after themselves (Blazer, 2006; Zahava & Bowling, 2004) and not be seen as a burden to family and friends (Glasgow, 1999). Maintaining autonomy to make decisions about how and where to live is a crucial factor in ageing positively (Glasgow, 1999). If an older person moves into residential care they are more likely to adapt and feel they have a higher quality of life if it has been a decision they, themselves, made rather than it being a decision forced through health needs or made by other people (Wilkinson, Kiata, Peri, Robinson, & Kerse, 2012).

As older people age, their ability to accept their changing self and modify the perception they hold of themselves in a positive light is often determined by their personality (Kotter-Gruhn, Kleinspehn-Ammerlahn, Gerstorf, & Smith, 2009; Zahava & Bowling, 2004), (Reichstadt, Sengupta, Depp, Palinkas, & Jeste, 2010; Ruffing-Rahal & Wallace, 2000). Although Smith believes that there is a decrease in positive affect during old age that adversely influences a person's sense of well-being (Smith, 2001b), it is important for older people to optimistically view themselves (Kotter-

Gruhn et al., 2009; Wright-St Clair, Kerse, & Smythe, 2011), maintain a positive attitude and to preserve their individuality (Ruffing-Rahal & Wallace, 2000). The capacity of an older person to positively adapt to their increasing age, changing circumstances and functional ability increases their belief they are ageing successfully (Blazer, 2006; Glasgow, 1999; Reichstadt et al., 2010). Interestingly, successful ageing was not determined by the absence of physical impairment or chronic ill health (Blazer, 2006; Ruffing-Rahal & Wallace, 2000). Those who can accept the things that they can't change, particularly the ageing process, and have the fortitude to change what they can, often age more successfully (Reichstadt et al., 2010). The ability to be realistic about what can and what can't be achieved is a skill (Blazer, 2006; Smith, 2001b). This may mean taking up more socially appropriate activities that are less demanding (Bukov, Maas, & Lampert, 2002) or perhaps accepting help from others to carry out some tasks in order to maintain independence in other more crucial areas (Blazer, 2006). And having "...the wisdom to know the difference" as the 'Serenity Prayer' so succinctly puts it. The ability to maintain a positive attitude during the fourth age of life is dependent on a variety of factors that may be applicable to older people in various combinations. The constant is the individual personality of a person coupled with the experiences which has given them their unique 'world view' with which they interpret life (Zahava & Bowling, 2004). Further research will enhance our understanding of the needs of older people, particularly when they need greater care and support than can be provided for in their family home.

The attainment of wisdom is related to ageing successfully but it is not a spontaneous outcome of growing older (Reichstadt et al., 2010). Wisdom epitomises the ultimate amalgamation of awareness and integrity and demonstrates a

proficiency in the management, significance and explanation of existence (Baltes & Smith, 2003). This can be expressed through knowledge, decision-making skills, putting into context the intricacies of relationships, self awareness (Baltes & Smith, 2003; Blazer, 2006; Reichstadt et al., 2010) and the ability to share these with others (Ruffing-Rahal & Wallace, 2000) and contribute to building a more robust society whose generations are integrally joined (Baltes & Smith, 2003). For many older people no longer possessing the function of contribution to their communities in a physical dimension, the opportunity to share their wisdom through communicating their experience and expertise on living life provides the sense of being a useful and contributing member of their community (Ruffing-Rahal & Wallace, 2000).

A connectedness to others along with participating in life as actively as possible are important aspects of successful ageing (Glasgow, 1999; Ruffing-Rahal & Wallace, 2000; Smith, 2001b) as they provide opportunities for psychological and emotional engagement and support from others (Blazer, 2006; Zahava & Bowling, 2004). As older people age and are less mobile there is a concern they will become more isolated and as a result experience a greater degree of loneliness which adversely affects their sense of well-being (Mellor & Edelman, 1988; Reichstadt et al., 2010). Maintaining connectedness with friends is often referred to as being even more important than connections with family and, in some cases, with a spouse (Reichstadt et al., 2010). Ruffing-Rahal and Wallace in their study of women in a wellness group acknowledge the importance of “caring connectivity” (p. 274). They see these connections as essential at all life stages but as exceptionally relevant in the final life phases as a way for an older person to maintain links with their immediate group and their greater community. This is also reiterated by Age Concern (Glasgow, 1999). Sharing experiences with others is imperative to one’s

corporal existence. Netuveli et al (2006) emphasise the importance of relationships with offspring, family and friends (provided these are positive) (Zahava & Bowling, 2004) and the affirming affect these have on a person's quality of life. Mellor and Edelman (1998) acknowledge that "confiding relationships" (p. 4) help to avert loneliness even for those older people who are in poor health. Smith (2001b) affirms the importance of actively socialising to enable an increased sense of well-being among older people. Coupled with connectedness to others, staying engaged with living and life (Reichstadt et al., 2010) helps provide a sense of being successful in ageing. Reichstadt and colleagues (2010) point out that in their investigation that staying engaged (which included such things as trying something new, being generous through volunteering to help others and having a sense of usefulness) adds increased value to an older person's life. For some older people, connectedness is about connecting the past as much as with the present like remembering the past when carrying out a similar task in the present (Wright-St Clair et al., 2011). An interesting finding in a New Zealand study (Wilkinson et al., 2012) on the quality of life of older people in residential care facilities in two cities was that happiness seemed to be contagious within the social networks. If co-residents were happy then others were likely to be 'infected' by this.

The health status of a person can influence their sense of well-being. The majority of people in the third age are relatively healthy with good physical and cognitive functioning for their chronological years. As older people move into the fourth age, when their functioning diminishes and they acquire co-morbid ailments that cause pain and a weakening of their resilience, it becomes more difficult to maintain the attributes of successful ageing (Smith, 2001b). In Eiseman's study of his graduate classmates of 1939 (who at the time of the study were 86 - 87-years

old) he discovered that 30% were still alive. They had outlived their projected life expectancy at birth by 36 years. He indicates that while a greater number of people are reaching old age this is due to scientific progress that has reduced the mortality rate in infants and children rather than a reduction of illness in the older person. The most that the 'old-old' can expect from health care professionals is to be provided with palliative care (Eiseman, 2006). An interesting finding from the study was the high scoring of self- assessed quality of life with more than 85% scoring between seven and nine on a ten point scale; despite many being severely debilitated through illness and physical or cognitive impairment. Baltes and Smith (2003) also discovered that as people aged there developed an increasing inconsistency between a person's medical conditions and their appraisal of their health, despite the reality of declining health. This demonstrates the ability of older people to reconstruct and internally adapt to their aging and maintain a positive sense of well-being (Baltes & Smith, 2003) (Wright-St Clair et al., 2011). However, Smith (2001b) gleaned from the BASE study that diminished functioning, incapacitating health issues and pain (either physical or mental) reduces an older person's sense of well-being.

Blazer (2006) observes having gained some form of higher education is a protective factor for cognitive functioning. This was endorsed by Eiseman (2006) who summated that it was actually intelligence that was the protective factor, and that this was qualified by the number of years a person engaged in education. He goes further to say not only is the corrosion of mental health delayed, so too is that of physical health. Netuveli et al (2006), Eiseman (2006), and Zahava and Bowling (2004) all concur that a degree of affluence contributes to slowing the deterioration of mind and body and maintaining a sense of well-being. Kotter-Gruhn et al (2009) detected in the Berlin Aging Study that older people who viewed their ageing process

optimistically, who felt comparatively young and were content with their ageing were more likely to suffer fewer illnesses and had an increased likelihood of living longer. Bukov et al (2002), state that educational achievement allows an older person to have a deeper level of social participation.

Another factor that helped enhance or maintain successful ageing was living in a locality that was recognised as a good area (Netuveli et al., 2006; Zahava & Bowling, 2004). Respondents indicated a number of aspects about where they lived that contributed to them having a good quality of life. Living in a nice area was a factor but so, too, was living near family, having a relationship with neighbours who are able to provide help and support, having relationships with friends, feeling as though they were part of the community, and living near frequently used amenities and services such as good transport facilities. A number of participants in Zahava's (2004) research also mentioned that their home played a part in their quality of life, often because they had resided there for many years and there were myriad memories associated with it, especially those involving family. Age Concern promotes the need to maintain physical and mental agility in ways that enrich wellbeing in older people (Glasgow, 1999).

The adaptive ability of an older person to employ "selective optimisation and compensation" (Baltes & Baltes, 1990) enhances their independence by focussing on things they can achieve and allowing others to carry out tasks they can no longer accomplish (Blazer, 2006; Wright-St Clair et al., 2011). Baltes and Smith (2003) use the example of an international classical pianist who was still playing concerts at the age of 80. He practiced fewer pieces more often and used pieces where there were tempo contrasts. This enabled him to condense his compilation by selecting less. He optimised the selection by practicing these pieces more and he used the differences

in speed to compensate for the loss of digit reflex. People who can use these adaptive techniques are likely to feel as though they are still maintaining autonomy and this enables them to maximise their gains. Cultures that encourage this in their older citizens are better able to take full advantage of the benefits of this group (Baltes & Smith, 2003).

Because there is little that can be done to stem or repeal memory loss Eiseman (2006) advises his colleagues to worry about other things and to “get on with smelling the roses” (p. 25). Blazer also mentions “smelling the roses” (p. 4) in relation to the recognition that life is drawing to a close. As a consequence of this realisation, an older person’s focus turns to maximising life’s affirmatives and minimising its pessimistic affect. This is coupled with the reduction of exasperating ambitions and the pursuit of more pragmatic and psychologically gratifying goals. Reichstadt et al (2010) believe that to successfully age a person must maintain a balance between self-acceptance (feeling comfortable about past experiences and having a realistic self-concept) and engagement (actively engaging in life and continuing developing as a person). Baltes and Smith (2003) state that as a person progresses through the fourth age, dignity can be reduced; they believe “healthy and successful aging has its age limits” (p. 133).

Ageing in Place

More of our population are living to old age. As communities, whether these are global, national or local, we are faced with coping with a rise in older people needing care and support coupled with a reduction in the working population who produce much of the revenue that provides this support. In the Health of Older People Strategy (New Zealand Ministry of Health, 2002), Objective 8.1 states: “The

Ministry of Health and DHBs will fund a range of health and disability support services to provide flexible, co-ordinated support for older people to age in place” (p. 58). The sub-clauses further expand the support the Ministry of Health will provide DHBs in order to facilitate this. Davey and colleagues (2004) state “Ageing in place is clearly a favoured approach in New Zealand government policy and more widely. It is likely that the vast majority of older people in the future will be ‘ageing in place’, that is living in non-institutional housing in the community”. They define “ageing in place” as “remaining in the community, with some level of independence, rather than in residential care” (Davey et al., 2004)

The Healthier Canterbury: Annual Plan 2011-2012 & Statement of Intent 2011-2014 (Canterbury District Health Board, 2011b), states that among its older residents there is an increasing demand for health and disability services. They believe that over 50% of its resources are absorbed by the provision of services to those aged over 65. The CBHB acknowledge the expectations of the Minister of Health including that the services provided to older people are closer to them and that pressure is reduced on hospital beds (Canterbury District Health Board, 2011b). The document goes on to say “Provided people have adequate supports and have a manageable level of need, ageing in place will likely result in a much higher quality of life, and people may remain healthier for longer as a result of staying active and positively connected to their communities” (p. 57). The CDHB emphasises that care should be “flexible”, “responsive” and “needs-based” (p. 57) and that it is to be supportive of those over 65 years old staying “well and in their own homes” (p. 57).

A large number of older people greatly value their independence and autonomy and believe that remaining in their own homes will ensure they maintain control over making their own decisions (Davey, 2006a). This belief is further

encouraged by government and local policy that reiterates that 'aging in place' is best for older people, as well as better suiting the budgets of these organisations (Canterbury District Health Board, 2006, 2011b; New Zealand Ministry of Health, 2002). Davey and colleagues (Davey et al., 2004) in their report for the Centre for Housing Research Aotearoa/New Zealand (CHRANZ) stress that if older people are to 'age in place' then a number of housing issues must be addressed, including those of "maintenance, renovation and adaption of their housing" (p. 173). They believe that to 'age in place' requires modified housing that is accessible, safe, and incorporates suitable equipment to meet the needs of the older person living there (Wiles, Leibing, Guberman, Reeve, & Allen, 2012). The CHRANZ report acknowledges that there is a need to provide these things as well as support with such things as payment of local council rates. This report concedes that currently the option of a retirement village is only for those with considerable financial resources. It suggests that housing opportunities for older people such as rental accommodation in retirement villages for single people or couples, or co-housing for groups be further investigated. Davey (2006a) recognises the individuality of older individuals in that some will willingly move to accommodate their changing needs while some prefer to stay where they are and still others have moved and will move again if circumstances require. There is also an understanding that individuals have differing financial situations that may or may not allow them to have a wide choice of where and how they live.

People living in urban areas or cities usually have a greater choice of housing options by virtue of greater population numbers. On the other hand, those living in rural areas are often very limited in their choices (Joseph & Chalmers, 1995; Keeling, 1999, 2001). Sometimes, if an older person is adamant they wish to stay in a rural

area, the choice is limited to either staying in their own home or downsizing. And as they become more incapacitated, they will have to increasingly rely on the support of others because there is not the availability of publically-funded support systems that more populous areas enjoy (Joseph & Chalmers, 1995; Keeling, 1999, 2001). Many of the people that Keeling studied in her research on Mosgiel and Joseph and Chalmers studied in Tirau and Morrinsville felt an attachment or connectedness to not only their homes and gardens but also to the geographical area in which they lived (Keeling, 1999). They were reluctant to leave these familiar surroundings, the services and people in their area they knew and who knew them, their friends and, in some cases, members of their family. Often family members had moved to urban areas or cities in pursuit of employment and a perceived better lifestyle, leaving the older person behind. Small communities often have limited financial and personnel resources person; the community groups that provide these supports must prioritise how and where their precious resources will be used (Joseph & Chalmers, 1995; Keeling, 1999). Not only is there a physical and emotional connectedness that older people feel with their rural community there is also an interconnectedness as the community supports them (Keeling, 1999). These are the bonds of 'belonging' to a small community (Keeling, 1999) which manifests in the community's endeavours to support the needs of the older person (Joseph & Chalmers, 1995).

In their study of 'ageing in place' Wiles and colleagues (2012) explore the perspectives of 121 people aged from 56 - 92years from two different urban communities in New Zealand. They discovered that while policy makers, service providers and researchers were familiar with and understood the term 'ageing in place' to mean "remaining [in their home] in the community, with some level of independence, rather than in residential care" (Davey et al., 2004). Older people in

the study were unaware of the term. Once exposed to it, and after discussions, they saw the meaning of this term to incorporate a more extensive definition - that of remaining within the confines of their community which may include remaining in their home. As Wiles and her colleagues put it; "It is a complex process, not merely about attachment to a particular home but where the older person is continually renegotiating meanings and identity in the face of dynamic landscapes of social, political, cultural and personal change" (Wiles, Leibing, et al., 2012). There was an acknowledgement that individuals varied widely in their interpretation of 'ageing in place' and in their understanding of what the implications of their definition had for them. The degree by which a community is able to support its citizens, specifically older people, is dependent on Government policies on services provided to the public and health (Wiles, Leibing, et al., 2012). There was an acknowledgement by a number of participants in this study that staying in the same house was not always the best option and may inhibit a person's desire to move to more suitable accommodation (Wiles, Leibing, et al., 2012).

For many, 'ageing in place' held the comfort of not only the participant's home and contents, but the familiarity of the surrounding area and all that that entailed. This included familiar places such as the supermarket or church, connectedness with other members of the community, neighbours and friends (many of whom had been know for many, many years), the knowledge that others 'kept an eye out' for them, and their feeling of safety within the community. The social connectedness of being known in the community and knowing the community was of significant importance to many. There were some people who felt these things constricted their independence but for a number of others it was seen as supportive. For some, 'ageing in place' also meant they could decide to keep their pet, which, for them, was

a beloved family member and which may not be welcomed somewhere else. Life in a retirement village was seen by some as a positive option but for many it was too expensive for their budget (Wiles, Leibing, et al., 2012). A great many older people involved in this study emphasised the importance of making their own decisions about where they lived rather than having others make this important decision for them. In endeavouring to answer the question of “What is the ideal place to grow older?” the only answer was, “There is no one-model-fits-all” (Wiles, Leibing, et al., 2012, p. 365). The local area and the community are not just the backdrop for an older person to ‘age in place.’ More importantly they supply the means for a variety of older people to ‘age in place’ in a variety of ways that suit the needs of the individual (Wiles, Leibing, et al., 2012).

United Nations Ageing for 21st Century

In 2007, the United Nations Programme on Ageing combined with the International Association of Gerontology and Geriatrics to produce the Research Agenda on Ageing for the 21st Century (United Nations Programme on Ageing & International Association of Gerontology and Geriatrics, 2007). The Madrid International Plan of Action on Ageing (United Nations, 2002) is connected to the Research Agenda as a tool to support its promotion. Several subsections highlight areas needing research, areas to which this current research thesis intends to make a contribution. This document outlines the ‘major research priorities’ (p.2) and then notes the ‘critical research areas’ (p. 4).

2.6.6 Healthy ageing as individual behaviour and choices, including self-care.
Psychosocial determinants of healthy ageing. (p. 6)

2.9.6 ‘Meaning of life’ for older people. (p. 8)

2.9.12 Age-friendly environments: physical and social dimensions. (p. 8)

2.10.5 Facilitating transitions between care settings, e.g. to/from hospital and home or community. Care continuum models. (p. 8)

2.11.2 Changes in living arrangements, especially multi-generational co-residence and independent living. (p. 9)

As part of the implementation, it states the need for governments and researchers to use a “common language” to enhance, understand and stop the use of complicated and ambiguous jargon that confuses people (United Nations Programme on Ageing & International Association of Gerontology and Geriatrics, 2007, p. 11). Davey’s EWAS paper (Davey, 2006b) highlights the gaps in research. She notes there has been some research conducted on retirement villages but that there is a need for continued research that includes the “views and perspectives of older people” as there is scant research on their experience. She (Davey, 2006b) observes that the life-course can be likened to a “cyclical spiral” (p. 26) into which the various transitions that are encountered in life form a part. Davey (2006b) advocates research being conducted into the transitions older people encounter; those of retirement, loss of a life time partner, failing health and serious illness as well as the move from a family home to more appropriate accommodation.

Based on the information reviewed a clearer picture is emerging of the size and scope of the issues of older people living longer and changing housing needs. The focus of this research is to record the voices of 35 participants aged between 66 – 95-years in order to gain an understanding of how this group of older people formulate their decisions around when and where to move to accommodation that better fits their changing needs.

The following section will discuss the selection of the methodology and how the research was conducted.

Chapter 3

Methodology

Introduction

In order to 'hear the voice' of the older people, I chose to use appropriate research methodology. A qualitative research method has the advantage of allowing the researcher to understand the perspectives of a relatively small sample of participants and sift through these experiences for similarities and differences between the participants who are experiencing a particular phenomenon. This chapter provides the background and evidence to support the selection of the research methodology.

The choice of a methodology gives the researcher a structure to work within. Each method has its own unique characteristics that define its parameters (Giacomini, 2010). As with most areas of life, research frequently does not fit neatly into a clearly defined category; rather it consists of one predominant methodology with elements of other methodologies that sit on the continuum close to the key methodology (Giacomini, 2010; Sandelowski, 2010).

Qualitative methods are relatively new additions to the research field. In the early 1960s a number of significant qualitative research findings were published that focused on observation better fitted to the burgeoning social science field. Lincoln and Guba (1985) differentiated qualitative research from quantitative research by calling it 'naturalistic inquiry' as distinct from scientific inquiry. They further explained that the approach for 'naturalistic inquiry' is from "not knowing what is not known" whilst the "... conventional inquirer ... usually approaches [the] study from [a]

'knowing what is not known' position (Lincoln & Guba, 1985). Giacomini (2010) argue that the content of each person's knowledge is derived from their experience and that rationale is essential for the formation of a structure, thus allocating equal status to both data and theory.

Qualitative research commentates on the individual's profound responses toward the experiences they have. It strives to empower individuals so that their voices are heard and their stories are shared. Collaboration between the researcher and participants on such things as research questions, data analysis and data interpretation considerably reduces the power relationship that often exists in traditional scientific research thus creating meaningful understanding of the environment in which the researched phenomenon occurs (Creswell, 2013).

Health researchers using qualitative methods were (and to a certain extent still are) frequently challenged by sceptics who look to an evidence-based approach that had traditionally been dominated by quantitative methodologies (Giacomini, 2010). They believe that the validity of qualitative research has been attacked due to the uncertainty regarding the credibility of the research data. A number of researchers have tackled the issue of ensuring that qualitative research projects are trustworthy (Frost, 2011; Morse & Singleton, 2001; Shenton, 2004). This will be discussed later in this chapter.

Qualitative Health Research

Qualitative research in the health sector is seen by some as similar to other research fields using qualitative methods. However, due to the vulnerable and sensitive nature of much of the research participants in this area, it is in a niche of its

own (Giacomini, 2010; Morse, 2011). Morse, in her chapter on qualitative health research, clearly states this:

“The complexities encountered by qualitative researchers in the context of health care, the seriousness of the conditions of their participants, the life-and-death nature of the topics that they study, and the clinical significance of their findings, make the qualitative health researcher distinct from researchers who do other forms of qualitative inquiry, and the product, qualitative health research, distinct.” (2011, p. 401)

Morse observes that all too frequently the experience of the patient is treated with secondary importance, lying behind concentration on the disease. In the case of older people, this translates to the perceptions of older people in regards to their aging, playing second fiddle to the knowledge of health care professionals on the process of ageing. In her address to the first Global Congress for Qualitative Health Research (2012a), Morse stressed the importance of the concept of empathy and research in the health sector having an outcome of providing care that is person-centred. She succinctly defines qualitative health research as “... a research approach to exploring health and illness as they are perceived by the people themselves, rather than from the researcher’s perspective.”

Sandelowski and Leeman (2012) noted that qualitative health research is a distinct section within qualitative research. They acknowledge that it is a form of scientific reporting but hold that that is not an excuse for it to be represented in a dull and impersonalised way. They believe that this research can and should be “... informative, evocative and provocative” (p. 1405).

Furthermore, it should reflect the holistic experience of the research participants, including hearing the complexities of their thoughts, feelings and perceptions. This makes it the reader's responsibility to interpret the findings through the lens of their experience and knowledge. However, there is also an onus on the researcher to write their research findings in such a way that this knowledge is conveyed to the reader audience (Sandelowski & Leeman, 2012).

Morse (2012b) believes that qualitative health research makes contributions to both the health sector and research in the qualitative area. She states it is an emerging discipline in its own right because it "consists of modified methods, administered in special circumstances, with unique and tailored interventions" (p. 23).

Finding a 'Fit'

The 'fit' refers to not only finding the best methodology for the research topic but also its 'fit' with the researcher's own understanding of their research topic and the perspective they wish to use to present their findings.

According to Morse and Singleton (2001), it is essential that qualitative researchers are familiar with a variety of methods so that they are flexible enough to select a methodology that ensures that the answers to the research question will generate the most pertinent results. They also note that using a single method is not always conducive to producing the best results.

In respecting and valuing the voices of those that have agreed to share their perceptions and be involved in the research, it is crucial to choose a methodology that allows each person's experience to stand on its own merit, and the voice of each

participant to resonate rather than have its strength diluted in over-analysis. For this study it became obvious that collecting the thoughts, feelings and processes of how a person viewed their shift to a retirement complex or a care facility (regardless of whether this was a historical event or a future probability), the methodology selected must come from within the qualitative category.

Qualitative methodology provides the researcher with the opportunity to explore a phenomenon through investigating the lived experience of the participants; to hear their perceptions of their experience and give “plausible insights that bring us into more direct contact with the world” (Van Manen, 1997, p. 9) . The researcher is often encouraged to commence their investigation from their own personal experience which has frequently piqued their interest in the topic (van Manen, 1997).

The choice of a research method should be compatible with the researcher’s inner motivation for exploring their chosen study (Van Manen, 1997). As a counsellor, it was essential to me that I selected a research methodology that was authentic: fitting with my own counselling beliefs and experience. It was also important that each research participant knew they were valued and respected for their uniqueness. My counselling training and practice uses an eclectic model; it seemed logical that I would select a methodology that allowed me to use a variety of methods to hear the experiences of my participants.

Person-centred Interviewing

All participants involved in each body of research bring to it their unique perspectives and stories that are derived from their experiences and background. It is the responsibility of the researcher to respect this uniqueness and to endeavour to accurately portray, as far as possible, the inimitable voice of each of these brave

souls who agreed to share their story. The attitude and behaviour of the interviewer has a strong influence over the contribution of each participant (Lumbelli, 1997).

Carl Rogers (1957) describes three essentials in the person-centred relationship that help reduce the client's anxiety and encourage them to enter more fully into the relationship. This is particularly relevant to health researchers when interviewing vulnerable people. Rogers' work in this area has been used in a range of disciplines where the emphasis is on recognising the individual person or client as central to the process. These areas include: counselling and therapeutic sessions, staff training, training of those making policy, working in mediation and negotiation, and leadership (Corey, 2001). Rogerian person-centred therapy is at the core of my own practice. When working with the research participants, it was important to me, as a counsellor and the researcher, to adhere to Rogers' "core conditions" of "unconditional positive regard, empathic understanding and congruence" (Kirschenbaum & Jourdan, 2005, p. 41).

Empathic Interviewer

When a person shows "unconditional positive regard" (Rogers, 1957, p. 98) toward another they are accepting them for who they are 'warts and all'. This does not mean that they are necessarily condoning what the other person is saying, but rather that there are no judgments, stipulations or conditions placed on this acceptance by the listener (Corey, 2001). The interviewer conveys their acceptance to the participant by listening intently and encouraging the interviewee to talk in depth of their experience. In return, the participant feels the warmth and caring of the interviewer's acceptance, thus becoming at ease to explore the area of research more fully.

A researcher showing empathy for a participant's experience will have a sense of the "private world as if it were [their] own, but without ever losing the 'as if' quality" (Rogers, 1957, p. 99). Rogers (1957) believed an essential ingredient in establishing a good relationship was that the listener could feel the strength of the emotions of the other (but at the same time) without allowing their own emotions to become embroiled in this. This state allows the researcher to accurately use their skills of reflective listening because they are able to reflect back to the participant the meanings of their experience (Rogers, 1975). In turn, this reinforces to the participant that they are valued (Rogers, 1975), truly being listened to, thus encouraging them to further explore their perceptions (Corey, 2001).

Rogers' (1957) third "core condition" is that of congruence or genuineness. Corey (2001) believes this attribute is the most important of the core conditions. The listener is encouraged to be themselves: what is felt and experienced within the listener is acknowledged by them and presented outwardly to the participant. There are no pretences; the participant is not picking up mixed messages from the listener (Corey, 2001; Rogers, 1957). This does not mean, however, that the listener shares everything they feel toward the participant and their experience of the participant. They should be genuine in their communication with the participant and endeavour to be free of deception towards both the client and themselves (Corey, 2001). This is also ethical practice.

Qualitative Description

Qualitative researchers may feel that they are being asked to perform "methodological acrobatics" (Sandelowski, 2000) in order to fulfil the obligation of fitting their particular research into one of the more common qualitative research

methodologies, such as grounded theory, phenomenology, ethnography or narrative inquiry (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Sandelowski has written and co-authored a number of articles spanning the last decade and a half in order to bring to the foreground a particular methodology - that of qualitative description (Sandelowski, 2000, 2004; Sandelowski & Barroso, 2007; Sandelowski & Leeman, 2012). Sandelowski (2004) notes that without researchers and studies, methods have no reason to exist. She further explains that each researcher will mould a methodology to meet the needs of their study whilst also remaining within the confines of the epistemology and ontology of that particular research methodology. Research methodologies are often not 'clear-cut' and as exclusive to themselves as their theories would lead one to believe: in practice their boundaries are less rigid and defined (Sandelowski, 2010).

The philosophy that underpins Qualitative Description (QD) has its foundations firmly embedded in naturalistic inquiry (Lincoln & Guba, 1985) thus forming a qualitative research methodology. QD could be called an eclectic form of qualitative research as it will often contain elements of other qualitative methodologies, particularly the more common ones of phenomenology, ethnography, thematic analysis, narrative inquiry, and grounded theory (Neergaard et al., 2009; Sandelowski, 2000; Sandelowski & Leeman, 2012; Sullivan-Bolyai, Bova, & Harper, 2005) with the approach to uncovering the phenomena being matter-of-fact and down-to-earth. QD is a legitimate inquiry method for health sciences as it seeks to expose (for greater understanding) the multifaceted encounters, proceedings or tasks that form the phenomena being studied from the perceptions of the study participants (Sullivan-Bolyai et al., 2005).

The sampling is purposeful (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005) guaranteeing that a range of sub-groups of interest to the study is included in the research and ensuring their varying perspectives are brought into focus. Maximum variation sampling is employed (rather than random sampling) as the researcher is focussed on finding participants to represent as wide a range of diversity in the study group as practicable (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

When collecting data for QD studies, the researcher must keep in mind questions that are pertinent to revealing why people behave the way they do in this type of event: what motivates them, what they think and feel about what's happening, and what the obstacles are. The collection of the data varies from "... minimally-to-moderately structured ..." (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005). The questions will focus on the 'who', 'what', 'why', 'where' and 'how' of the incident as they call for in-depth, data-rich responses from participants (Berg, 2001; Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005) that will contribute to a deeper understanding of the "lived experience" (Van Manen, 1990).

The analysis of the data collected must acknowledge that in qualitative research, to a greater or lesser extent, the data are subjected to the researcher's coding whims and their current interpretation of the information (Sandelowski, 2004). This is quite likely to vary from researcher to researcher, and even from one researcher's study to the next depending on new learning and possible changes in perception (Sandelowski & Leeman, 2012). However, in QD, there is a concerted effort to reduce the influence of researcher perception and interpretation by the hallmark of "staying close to the data" (Neergaard et al., 2009; Sandelowski, 2000;

Sullivan-Bolyai et al., 2005) and keeping to ‘the voice’ of individual participants so that their “lived experience” and perceptions are acknowledged (Van Manen, 1990). It is often useful to use “quasi-statistical analysis methods using numbers to summarise the data with descriptive statistics” (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005). Data are sifted in order to locate the common themes and the differing perceptions. Emphasis is placed on both of these. The goal of analysis of QD data is to understand that which is inferred rather than that which is directly communicated and obvious (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

The desired outcome of QD is that the data are described in plain everyday language that represents the language used by the participants. Results should be arranged in a way that is “in-keeping” with the data. This may include organising data in a variety of ways, including in sequential order or by frequency (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005).

QD is a valuable methodological instrument that has often been misunderstood. It is especially valuable for those studying health-related topics among vulnerable populations as it offers a wide-ranging synopsis of an event or experience from the perspective of the participant in their words rather than the interpretation of data from the researcher’s perspective. The researcher must keep close to the data and use it to create plans of action and interventions which can be understood and implemented by the population being studied.

Much of the misunderstanding of QD has arisen from the misinterpretation of Sandelowski’s 2000 article. She provided clarification in her 2010 article where she endeavours to address the matter of researchers incorrectly “... claiming to have

used methods (e.g. grounded theory, phenomenology) to produce findings that show no evidence these methods were used” (p. 77). QD is able to be distinguished from other methodologies in that it has a philosophy; its design, the common approaches it uses for sampling and data collection, and analysis are all specified. However it is not so specific that it is confined to a particular method, nor can it be ascribed to a particular individual as being the ‘parent’ of QD. Because of its eclectic nature QD researchers should refer to the method as an individual describes it rather than as an individual’s method (Sandelowski, 2010). Sandelowski also acknowledges that while there is always an element of researcher perception and interpretation, in the case of QD the researcher is urged to remain close to the data or “data-near” during the analysis period of a study. For some, Sandolowski’s 2000 article implied that those researchers who were unsure about the selection of a methodology and believed that a brief glimpse into the analysing of data would sufficed and they would be able to take the ‘Clayton’s’ (the methodology when you’re not using a methodology) option. In Sandelowski’s 2010 article (Sandelowski, 2010) she categorically states that she does not believe that QD is an excuse for researchers with poor research skills who have a desire to skim over the defining of the methodology. She is adamant that methods are ever-changing because of such things (among others) as the influence of time, interpretation of individual researchers, and interpretation of readers. Far more important than the name given to the method used, she says, is the researcher’s willingness to acknowledge their changing position or perspective during the study process, from inception to completion (Sandelowski, 2010).

Perspectives

Weltanschauung is a German word that literally translated means 'view of the world'. Freud described this as the philosophy by which one lives one's life and addresses the key questions of the purpose of human life (Armand, 2004). The 'world view' of each individual is personal and unique to them. It is their views, values, and beliefs about how the world, their particular world, functions. This view of the world has been derived from their interpretation of their experiences. The 'glasses' that individuals use to interpret the experiences and events they encounter (both as individual events and collectively) during their life time form their perspective about these encounters. Our perceptions are the assumptions we use to decipher and make sense of our own life and the things we experience; it is our reality (Lincoln & Guba, 1985; Richards & Morse, 2007). QD aims to keep close to the data: the experiences and the perceptions, of the participants. As it strives to achieve this, it also calls for the researcher to endeavour to minimise their interpretation of the data thus reducing the researcher's perception of the participant's perception. Any event or experience is likely to be interpreted differently by each person involved, depending on where they are positioned by their 'world view'. Take, for example, the New Zealand koru, one of our nation's symbols. Depending on the position a person stands, both literally and figuratively, their view and interpretation of this will be different. It may be seen by some as a symbolic 'Yin and Yan', a '6' and a '9' the cupping of two hands, two birds feeding each other, a nice design or any one of myriad other interpretations, each of which are quite valid.



Each person will construe a meaning from their own unique 'world view'. None will be wrong; all will be a perspective of an individual's reality of the world.

Capturing the lived experience

Qualitative research calls for the sample of participants to be purposeful (Belgrave, Zablotzky, & Guadagno, 2002; Coyne, 1997). Other researchers (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005) are more specific in advocating the importance of using maximum variation sampling when using QD as the methodology. This allows the researcher to obtain a wide cross-section of participants that covers not only the more common aspects of the phenomenon but also provides the opportunity to investigate its more exceptional facets (Sandelowski, 2000). Participants may be derived from various sources. They are also selected because their unique perspective adds another dimension to the

study. The QD researcher is focussed on obtaining an “information-rich” sample; maximum variation sampling allows this (Sandelowski, 2000).

In order to obtain the richest data from the interviews, the interviewer attempts to create an atmosphere that will enable the participant to relax and be fully present. Vulnerable populations are also frequently marginalised; interviewing participants from this sector calls for greater care and involvement by the interviewer. It is especially important to establish credibility and rapport with these participants. They are not often listened to, and less often are they heard. They have scant experience of their opinions being valued. Older people are often lonely and deprived of one-to-one conversation with someone who enthusiastically seeks their opinions and is eager to hear their experience of a phenomenon.

Rapport

The importance of establishing rapport and trust is seen as fundamental to the interview process (Berg, 2001; Grinyer & Thomas, 2012). Padgett (2012) defines rapport “at a minimum” as “the sense of respect, trust, and positive regard between researcher and study participants that enhances openness in information sharing”. Rapport and trust must be continually worked on to maintain an open relationship between the interviewer and the participant. It is not enough to establish this at the beginning of the process and then just leave it. It must continue to be nurtured; it is part of the foundation of the relationship between the interviewer and the interviewee (Grinyer & Thomas, 2012). Researchers should be aware that there is often a ‘fine line’ between establishing rapport and gaining trust, and becoming overly familiar with participants. Becoming too personal with participants blurs the boundary of the researcher role and can lead to the researcher developing distorted perceptions of

the group being studied and of the individuals within this group. Participants may misrepresent themselves and their experience to “impress” interviewers or they may withhold the details of their experience (Grinyer & Thomas, 2012) that they think may offend or upset the interviewer.

Conducting Interviews

Usually, the aim of QD research interviews is to collect and present the collected data in response to the study statement or question. QD researchers are active in their search for the experiences and insights that participants offer of their knowledge of the particular phenomenon being investigated (Kelly, 2010). Victor (1988) notes that older people are more likely to respond if an interviewer is present when collecting data rather than being asked to complete their responses on their own. Padgett (2012) also stated the importance of face-to-face interviewing in order to obtain the nuances that give words their true depth of meaning. These can only be partially obtained if conducted via written forms or telephone.

All aspects of the interview would appear to have an effect on the outcome, whether it is the race, role, age, status, gender, voice, presentation or manner of either the interviewer or the participant, the rapport between them, the interview location and how the interview was recorded (Berg, 2001; Grinyer & Thomas, 2012; Herzog, 2012). These factors also contribute to building rapport and trust.

Two of Berg’s (2001, p. 99) “Ten Commandments of Interviewing” refer to personal presentation and the location of the interview. The interviewer’s presentation and choice of the interview location can be pivotal points in further developing and establishing the rapport between the researcher and participant. Both Berg and Warren mention that dressing (in the widest sense of the term)

appropriately is important as is being aware of any messages that what the interviewer is wearing may be giving to those being interviewed (Berg, 2001; Grinyer & Thomas, 2012; Warren, 2012). How an interview venue is selected can be significant to participants. It is especially important that the location is one where both the interviewer and the interviewee feel comfortable. The interviewer is often more flexible and adaptable with regard to location so they may, therefore, encourage the participant to select the venue (Grinyer & Thomas, 2012; Warren, 2012). In the case of participants with health and mobility issues or who are in vulnerable or marginalised groups, their needs for physical and emotional comfort must take priority over the physical and emotional needs of the interviewer (Grinyer & Thomas, 2012; Warren, 2012).

Many researchers advocate the use of an audio recording of the interview (Kelly, 2010; Liamputtong & Ezzy, 2000; Van Manen, 1997). This enables the researcher to focus fully on the participant and the progressing conversation (Charmaz, 1991). Some researchers are emphatic that it is crucial for interviewers to record interviews in order to be able to correctly analyse the conversation later rather than to rely on their subjective re-call and interpretation (Grinyer & Thomas, 2012; Johnson & Rowlands, 2012; Kelly, 2010). Participants consenting to audio-interviews must be made aware that the interview tapes will be transcribed verbatim (Belgrave et al., 2002).

After establishing initial rapport and trust, the interviewer commences the interview. While interview techniques can offer the researcher a myriad of choice they roughly fall into one of the three interview categories: un-structured, semi-structured or structured.

Structuring the Interview

A structured, or standardised, interview has a formal structure with predetermined questions (Berg, 2001). This format means that not only is there an assumption the researcher has sufficient knowledge of the topic being investigated but that also the interview schedule covers the study topic in a comprehensive manner (Berg, 2001). The interviewer is controlling the interview in this situation (Grinyer & Thomas, 2012; Wang & Yan, 2012). All participants are asked exactly the same questions, in exactly the same order. Structured interviews as the single source of data are less likely to be used in qualitative research as they are more fitted to a quantitative study. However, structured interviews may form part of an interview or data source for qualitative or mixed method research (Kelly, 2010).

The semi-structured, or semi-standardised, interview consists of some predetermined questions. These are not necessarily asked in the same order and are usually asked to all participants. There is also some scope for the interviewee to digress and for the interviewer to explore additional information as it arises (Berg, 2001; Charmaz, 1991; Kelly, 2010; Richards & Morse, 2007). These digressions, however, have constraints.

Un-structured, un-standardised or interactive interviews tend to be the most common form of qualitative interviewing (Richards & Morse, 2007). They follow the course of a conversation on the research topic whilst contemporaneously deeply exploring the meaningfulness of the experience to the participant (Bowling, 2009). The interviewee is encouraged to tell of their experience of this significant episode in their life (Corbin & Morse, 2003; Richards & Morse, 2007; Van Manen, 1997). Questions are kept to a minimum and are used as 'probes' to glean further

information or to clarify statements the participant makes (Berg, 2001; Corbin & Morse, 2003; Liamputtong & Ezzy, 2000). These questions should be worded so that they are 'open-ended' such as questions starting with 'when', 'what', 'why', 'how' and 'who'. These elicit more in-depth responses than those that are 'closed' and can be answered with a simple 'Yes' or 'No' response (Grinyer & Thomas, 2012; Wang & Yan, 2012).

During the interview and the ongoing analysis process, researchers regularly find themselves redefining their topic. This ongoing reflective method accommodates the increased insights they have gained both during the interview and as they reflect on each complete interview and move to interview another participant (Belgrave et al., 2002; Grinyer & Thomas, 2012; Herzog, 2012). Researchers using this process need to have the flexibility to accommodate their new insights and apply them to future interviews.

QD researchers usually prefer to use the semi-structured or un-structured interview processes that include the use of probing, open-ended questions (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005). Liamputtong and Ezzy (2000) encourage the interviewer to have an active role in eliciting as much as possible of the participant's complete experience of the researched phenomenon. However, this does mean that the interviewer should intentionally or unintentionally exert a degree of influence over the data provided by the interviewee (Corbin & Morse, 2003; Liamputtong & Ezzy, 2000; Richards & Morse, 2007; Talmage, 2012).

QD research participants frequently discover a deeper insight into their experience as a result of the in-depth interview process, thus enabling them to be

reflective and create new understanding about their involvement in the event (Grinyer & Thomas, 2012; Lillrank, 2012). Corbin and Morse (2003) point out that the seemingly easy familiarity that develops through the less structured interview process, where both parties are actively engaged with the research focus, has the potential to be both therapeutic and risky, particularly for the interviewee. They believe that the nature of un-structured interviews allows the participant a greater degree of control over their level of disclosure of their experience than other interview methods. At the same time, due to the increased rapport, there is also a tendency for some participants to disclose more than they had intended.

Credibility, Relevance and Importance

With the rise in qualitative research, particularly in the health and social science areas, there has been a push, originally from proponents of quantitative researchers, for research findings to be validated. The methods applied in order to validate qualitative research have caused rigorous debate, both externally by other researchers who desired scientific methods of validity to apply to this 'new' form of research, and internally from researchers within the qualitative field (Guba, 1981; Krefting, 1991; Liamputtong & Ezzy, 2000; Morse, Barrett, Mayan, Olson, & Spiers, 2002; Neergaard et al., 2009; Richards & Morse, 2007; Whittemore, Chase, & Mandle, 2001). Guba (1981) suggests the four key areas of trustworthiness that should be addressed are those of "truth value" (later identified as "credibility"), (Lincoln & Guba, 1985), "applicability", "consistency" and "neutrality". Credibility in qualitative research is usually derived from the interpretation that the interviewee gives to their lived experience (Krefting, 1991). Sandelowski (1986) defines this as "the description of the experience is such that others who share a similar experience

will immediately recognise this from the interpretation”. Applicability takes into account how transferable the findings are by subsequent researchers, or whether or not the original researcher provided enough information for the studies to be compared to others. Sandelowski (1986) believes that applicability has limited relevance due to the data being collected and is only pertinent to a particular situation with a particular participant. Consistency is measured by the ability to reproduce the same data with the same or similar participants or environment in quantitative research. However, this has little place in qualitative studies where participants are seen as unique, as is their experience of the phenomenon, even though the participant may be seen to represent the norm (Krefting, 1991). Guba (1981) used dependability as the measure for consistency and postulated that it was essential to be able to track and identify variations expected as part of qualitative research. Neutrality takes into account the degree of impartiality of the researcher in the case of quantitative studies. In qualitative research, however, it is the neutrality or confirmability of the data that is taken into account (Krefting, 1991).

Some qualitative researchers (Sandelowski, 2004; Sandelowski & Barroso, 2002; Sandelowski & Leeman, 2012) believe that, provided the researcher has presented the findings of the research in an easily understood style, the reader will use their own “filter” to interpret the findings. There is also an expectation by Sandelowski and Barroso (2002) that the reader will be discerning enough to note where evidence of what is portrayed is lacking in some way. They also observe that the same reader is quite likely to interpret the same text differently. Time, other influences, changed purposes for reading, and new insights from re-reading all impact on interpretation. There is an acknowledgement that the study report is written on the completion of the study and the nature of ‘hind-sight’ means it is likely

that the research process appears to have proceeded in a more systematic and proficient manner than it actually did (Sandelowski & Barroso, 2002). In her article on rigor, Sandelowski (1993), is strident in her belief that endeavouring to adhere to the rigidity of rigor can threaten the loss of flexibility and perception of an experience that comes from using a qualitative research method.

Morse (2012b) presents what she believes is a comparatively new view on the ongoing debate about rigor in qualitative research. Small numbers of participants, an absence of robust data and an over-simplistic examination of this, makes this kind of study ineffectual and poses a threat to the validity of the findings. Qualitative researchers should secure a mentor to “hear themselves think” (p. 103) as this research is a “way of thinking.” It is the mentor who must be satisfied about the integration of the data and the strength in the theory. It is essential that the hypothetical conclusions are formed methodically throughout the duration of the study so that they are “logical”, “plausible” and “interesting” (Morse, 2012b, p. 135). Experience and the perceptions of events give meaning to attitudes which can vary between individuals and groups. These can swiftly transform because they are all both individualistic and subjective. New insights should be emphasised while also linking common themes to the work of others.

Generalisability is another important factor to guarantee reliability. This is achieved through the development of sensible down-to-earth theory that is transferable to other situations within their context. Ultimately, Morse (2012b) contends, the quality of the research is determined by the external reviewer’s assessment or critique of the completed research.

By its very nature, qualitative research is not prescriptive. It is susceptible to the foibles that form the uniqueness of each individual. All attempts to record another's perceptions will always be tainted, in some way, by the 'world views' of both the teller and the listener. These experiences are the reader's perspective of the researcher's perspective of a participant's perspective on an experience they had! This in no way diminishes the huge value of qualitative research and its contribution to improving the real lives of those living within the studied phenomenon. This research utilised QD as the methodology to ensure that the 'voice' of the participants was heard and presented with a minimum of distortion.

The following chapter will discuss how the QD methodology was applied in this research.

Chapter 4

Method

Background

Increased Life Span

There has been a significant increase in the longevity of older people in recent decades. In many families now-a-days the adults are working outside of the home and children are often involved in (both paid and unpaid) activities after school. New Zealanders have an expectation that they can pursue their own individual goals. Prior to the late twentieth century the population was not as mobile and tended to rely on resources within the family and their local community. The majority of families had both parents living with each other and generally only one adult worked full-time. Older people tended to be taken in by their family members when they could no longer care for themselves.

When I was a child, my maternal grandmother, a widow and not in good health, lived between her two married daughters. For some members of my nuclear family this was a very positive experience. Conversely, some found it to be hugely negative while others were rather ambivalent. My mother, however, found herself pulled in all directions, particularly in the area of 'keeping the peace' between her husband (my father) and her mother (my grandmother).

Currently, many older people live into their ninth decade (80 years plus). In the years to come an increasing number of people will live into their tenth and eleventh decades (100 years plus). An older person in their nineties is likely to have surviving children who are seventy plus years old, perhaps in need of care

themselves. With the aid of medication and care older people with health issues are living longer, though they often require specialised care and support.

Reduction of Family Care

In recent decades, as society has become more mobile, in families with two parents living together both parents are likely to be employed, while in single-parent families the parent is likely to be working or living on a government benefit (Bascand, 2012). New Zealanders are now less likely to live in close proximity to their extended family and so may be less involved with them and more focussed on their own individual goals and achievements. As a result, our changing society has meant there is a greater need for retirement living and care facilities for older people. This demand is driven in some cases by older people themselves who want to maintain their independence. In other situations, families do not have the time or capacity to care for an ailing older relative. Caring for an aged relative can result in immense disruption for either the older person or the family member and their immediate family. In yet other situations, maybe because of a rift in a relationship or a desire to maintain independence, there is no desire to care for, or be cared for, by family members.

There is a variety of levels of care of older people in New Zealand. Many facilities are run by multinational corporations, some are run by organisations such as religious denominations and other societies while still others are run by private individuals and organisations. Increasingly, care offered at these complexes includes all or some of the following levels of care: dementia, hospital, resthome, apartment or studio living (assisted care) and villa or townhouse living (independent living). In the case of the latter two, couples or individuals purchase a 'licence to occupy' their

abode which also includes the use of certain facilities within the complex. Some complexes also have a 'licence to occupy' available for their resthome care facilities. Others charge a weekly amount. Charges vary depending on the level of the 'means tested' government subsidy the individual is eligible for. Over and above the original cost of the 'licence to occupy', complexes also charge a weekly fee for such things as the use of amenities and maintenance of residences and surrounding areas. Some residents are fully subsidised by the government when their assets total value is less than the pre-determined government dollar threshold.

In recognition of their own needs, or on recommendations of others prior to health care professionals or family members directing them to dementia, rest-home or hospital care facilities, increasing numbers of older citizens make the choice to purchase a 'licence to occupy'.

Research Topic Inspiration

When I meet with my friends or colleagues, frequently the conversation turns to our perception of how our parents and older relatives are coping, and what we believe they should be doing. Whenever I mentioned my interest in the living arrangements of older people, almost always others volunteer their concerns about various older family members. Many older people are unwilling to discuss with their children their concerns about living in their own homes and living on their own. It is an emotional topic in many families for both the older person and their relatives.

I was born in the middle of the 1950s, as were the majority of my friends. Our parents are mostly in their eighties or nineties. Many are now living on their own and a number of them are no longer in good health. Within my own family there are a number of examples of older relatives in their mid-eighties and older - a widower with

limited mobility who is adamant that he “is not going into one of those places,” a widow just turned 90 who loves her studio in a retirement complex after having had a prolonged period in hospital and being resigned to going home because she believed she had no other options, a widow in her late eighties who, after a series of falls, was ‘told’ by her health care professionals and children she had no option but to move into the resthome section of a retirement complex (she was bitterly resentful towards two of her children and was obviously unhappy for over a year after her shift), a 90-year old single woman who still runs her own home, garden and glasshouse as well as playing bridge and golf every week.

Coupled with my understanding of my friends’ and family members’ concerns and experiences, I had also heard stories of other older people who had cried continuously for several months following their shift into retirement care. These stories were a mixture, reflecting the experience within my family. I started to wonder why some people made the shift to a retirement complex and adjusted to their new surroundings with what seemed like effortless ease while for others it was very obviously a traumatic experience.

These dialogues, and the thought that in another decade I (along with over half of the “Baby Boomers”) will have reached retirement age with retirement complex possibilities ‘on the horizon’ led me to think about how older people made decisions about when to move from their home into a level of care and how this influenced their adjustment to these facilities. The topic for the research was born: Exploring the experience of the older person as they transition their living accommodation.

Aim of Study

It was important to me that the voice of older people was heard in regard to their experience of making the shift into a retirement complex. It seemed that the voices of the people most affected by the shift were often forgotten or silenced. These were the voices that needed to be shared.

Study Purpose

The purpose of this study was to elicit information that could contribute to a greater understanding of important factors for older people as they move from their home. It is intended that the findings of the study will acknowledge the experiences of the participants, and help inform and empower other older people as they make decisions about transitioning from their home to care facilities. Family members may also find the information useful as they support their older relatives to make these enormous decisions and enact the move. The information in the discussion of the research may better inform health care professionals of approaches that could make this transition less traumatic for their patients when they advise them that they need to 'go into care'.

Research Proposal

The working title of the proposal was, "Exploring the experience of the elderly as they transition their living accommodation". Originally, the aim of the study was to hear from a variety of individual older people about their experience of their shift from their family home into a facility that better catered to their needs. The study also included older individuals, who were still living in their home, and included their thoughts about how it would be for them to leave their home if they had to. Additional

to the individual interviews was the intention to conduct two separate focus group interviews, one with six to eight older people some of whom had made the shift into care and others living in their home, and another group for children of older parents to gauge their perspective on parents living at home or in care.

The proposal was further refined and developed with the aid of my supervisors who both have personal experience of finding suitable care for older relatives.

The proposal was submitted and accepted on 16/4/2012.

Ethics Approval

Ethics was applied for through the Human Ethics Committee (HEC) of the University of Canterbury. The application included the flyer calling for recruits, information sheets for agencies advertising for recruits, information sheets for the potential participants and the consent forms for participants. There was some dialogue between the HEC and myself about defining myself as a 'mature student' on the flyer to denote that I was an older student. It was eventually agreed that I could use 'mature student' on the proviso that I used it in conjunction with a photo.

Ethics approval was granted on 1/6/12.

Study Design

Recruitment

Participants were recruited in a variety of ways - a large local retirement complex that forms part of a multinational organisation offering various levels of care, a local hairdresser with a large older clientele, Age Concern, a community organisation that I am a member of (with many members over seventy years old), the parents of several friends and my own father. Flyers and an information sheet were sent or delivered to the various agencies and the community organisation, along with information sheets to be distributed to possible participants. In some cases, these were distributed to members through a regular newsletter. I visited the local retirement complex and discussed the study with the manager who was very keen for the residents of her complex to be involved in the research. I then spoke to retirement residents at their community meetings. This included villa/townhouse occupants, serviced apartment/studio occupants, and resthome occupants. Possible participants contacted me to indicate their interest. The residential managers of both the resthome and the hospital facility communities encouraged particular residents they thought would be willing to share their experience to contact me. Potential participants either gave their names and contact information to me directly, or they contacted me via phone call, text message or email to express their interest.

I then contacted each possible participant by telephone. During the conversation we agreed on a suitable time for me to visit and further discuss the study and their possible participation.

Inclusion Criteria

Participants were required to be over the age of seventy. There was no upper age limit. There were several reasons for setting a lower age limit. A number of retirement complexes only allow residents over the age of seventy years except in exceptional circumstances. One exception was made for a participant in the study in her mid-sixties. Her late husband had been terminally ill and was in need of care when they entered the complex. All other participants ranged from 72 years old to 95 years old.

Exclusion Criteria

All participants were expected to be cognitively capable. No formal testing was used to confirm their mental state. However, when I visited potential participants for a further discussion about the study and to gain consent, if the person showed no recollection of our previous discussion or of having volunteered to participate, even following prompting, I did not continue discussing the study nor did I ask them to sign the consent form. They were excluded from the study. Four possible participants were excluded from the study on these grounds.

Two other possible participants were excluded because they contacted me after the interviews had been completed.

Participants

A total of 35 participants were interviewed either singularly or as a couple, 21 females and 14 males. Seven participants were in their seventies, 24 were in their eighties, three were in their nineties with the remaining person in her sixties. Five participants were classified as Young-Old (aged 65 – 74 years) – two males and

three females; eleven participants were Medium-Old (aged 75 – 84 years) – two male and nine female; and Old-Old (those aged 85 years plus) numbered nineteen – ten male and nine female (Statistics New Zealand, 2007).

There were seven couples where both partners were interviewed. Five of the couples were interviewed together. Two of the couples lived separately. One of the couples was interviewed separately due to mobility deterioration where one partner was in hospital care at a complex and the other lived nearby. The other couple were good friends but each maintained their own home. They had met at their retirement complex when caring for their respective spouses who were terminally ill. There were also four other participants who had partners but for various reasons their partners did not participate in the research.

There was a spread across the types of accommodation participants lived in. One participant lived with family, ten lived in their family home, and the remainder lived in various levels of retirement complexes. Of these, four lived in hospital care, two in resthome care, three lived in serviced/studio apartments and the remaining fifteen lived in a townhouse or villa. All those living in the townhouses or villas, and in studio or serviced apartments, held a 'license to occupy'. Those in resthome home or hospital care paid either the full or partial weekly rental or nothing extra on the government subsidy depending on their assessed asset worth.

Interview Process

When I met with each person who had expressed an interest in being involved in the study, we discussed the research and what was involved and their decision to participate and they signed the consent form. We also arranged a suitable time for the interview to take place.

Naively, I had believed the visit to gain consent would take only about 15 minutes. In reality, I discovered that the visit usually took over an hour and that this time was invaluable. This was the time that rapport was established through making mutual connections with events, places and people. Participants used this visit to ask questions about the study, and told me about their lives and their thoughts about making the transition. I was able to pique their interest in the study and the value of their input by indicating that when they talked to me they should remember particular anecdotes or thoughts for the interview. This visit was therefore a 'warm-up' to the interview and not recorded.

Establishing Rapport

I realised the importance of the first visit and its use as a 'warm-up' when I interviewed the first participant. At the conclusion of his interview, he told me I needed to warm people into the process as it had taken him almost the entire interview to understand what I was wanting from him. This was quite a revelation; I had thought he understood what I was hoping to gain from the interview because we had discussed the purpose of my study on several occasions.

By listening to the participant's exchange, I was able to reassure them that the interview would be like a conversation. I discussed with them whether they were happy for me to use both an audio recorder and an audio-visual camera and explained that these pieces of equipment backed up each other in case one method failed due to my limited technological skills. I also explained that both pieces of technology enabled me to check the audio-visual recording if I was unsure of the feeling behind a statement. I could view the facial expression with the words as I would mainly be transcribing from the audio recording. One couple declined to be

'filmed' but all others agreed on the understanding that the recording was viewed only by me or my supervisors.

Twenty-eight interviews were conducted with 35 participants, in their living quarters. All participants were given the option of deciding for themselves where they wanted to be interviewed; all chose to be interviewed in their own familiar surroundings. This was the lounge area if they lived in their home, with family, in a studio/apartment, or in a townhouse/villa. For those who lived in a resthome or hospital room, the interview was conducted in their room with the door closed.

Many participants were nervous that they would not present well, either visually or verbally. They had taken upon themselves a personal sense of responsibility to provide me, as the researcher, with as much information as they could. There was an overwhelming sense that many participants had volunteered for the study to help me, and, in turn, this gave them a sense of being useful. Many made comments about having a family member who had completed post graduate studies and that they wanted to help me complete my studies. A number of the participants had completed university, teachers' training college, nursing or other tertiary qualifications.

Equipment

The interview was conducted with both an audio recorder and a digital video recorder on a tripod. In all except one of the interviews both formats of recording were completed. One couple declined to have an audio-visual recorder present, however they agreed to an audio recording of the interview.

Unstructured Interviews

Interviews were unstructured and always started with reference to the interview. Most often it was akin to “Thank-you for agreeing to doing this interview and being part of the research. As you know, we are looking at how older people make decisions about coming into a facility like this. I am interested in hearing your story about how you decided to come here.” If they lived in their home it followed the same line but differed with a statement such as “... how older people make decisions about where they live. I was wondering what it would be like for you, if you could no longer live here. How would you make the decision about where you would live?”

Mostly, participants spoke eagerly about their experience of shifting or about their thoughts about shifting. I asked open questions when they ran out of things to say, to clarify points or to further develop the concept they were telling me about. While all interviews had similar questions, no two interviews covered the same set of questions. After the opening statement about the research, any question that surfaced came from either a statement by the interviewee or an inference from them. Each interview was distinct, a unique individual conversation between the interviewee and the interviewer.

As the interviewer, I did not take notes during the interviews because this would have distracted me from being fully engaged in the interview process and may have seemed discourteous to the interviewees. I wanted to be able to focus on the interviewee, listen reflectively, and engage fully in the person-centred process of the interview. Almost all interviewees commented at the completion of the interview that they had enjoyed the process and were surprised about how rapidly they forgot they

were being interviewed and recorded. “It was just like we were having a conversation” was their frequent comment.

Transcriptions

I completed six transcripts using the Dragon Naturally Speaking Professional version 12 software. This software is trained to one voice so I listened to a phrase in the interview and then spoke it into the microphone for the software to transcribe. Following this, I edited the transcript as it took time to ‘train’ the software to a particular voice. Four interviews were transcribed by hand prior to the arrival of the software. For each hour of interview it took approximately twenty hours to transcribe without the software. Using the software, this time was reduced by approximately one third. Because of a long-standing shoulder injury, I was not able to continue transcribing the interviews and The Disability Resource Service at the University of Canterbury was contacted for support with the transcription. The Service transcribed the remaining interviews and I then edited the transcripts.

Themes

During the editing of the transcripts, I noted down various themes that emerged from each interview. I also recorded statements made by each individual that highlighted their perspective of a particular theme. I then grouped the themes and condensed these to main themes that either all, or almost all, participants mentioned. Minor themes mentioned by a number of interviewees were also identified.

Informed Consent

When I visited each participant to further discuss the research, if they had not already received an information sheet (Appendix 2), they were given a sheet and allowed time to read, digest and ask questions about the study. I also discussed with them the key points stated in the sheet. Following this discussion, when potential participants indicated that they were still keen to be involved in the study, they were asked to sign the consent form (Appendix 2). Each point was read over and a tick was placed in the box to indicate that the participant understood the individual clauses. When all boxes were ticked the participant signed the consent form.

Because the eyesight of many older people is not as good as it once was, even with glasses, the consent form was set out in a clear, easy-to-read form with a rounded font in a slightly larger than normal size, one and one half spacing and boxes beside each point to be agreed to. This enabled participants to read the form more easily. The information sheet was kept to one page which meant the font size was slightly smaller than that of the consent form and had single spacing.

Many participants were surprised about the formality that was required by signing the consent form. They were of the opinion that if they had verbally agreed to be interviewed and we had had a dialogue about the interview purpose, format, and conditions under which the information could be used that, we had an agreement and there was no reason to sign the consent form. Some also found the physical process of signing difficult because of failing eye-sight and reduced flexibility in their writing hand.

Several participants commented that they came from an era where, if they decide a person is genuine and they trust them, a hand shake is all that is needed to

'seal the deal'. They would not have consented to being part of the study if they had had doubts about my sincerity and trustworthiness.

Respecting Privacy

Both confidentiality of information and anonymity of identity were explained to participants. Many participants expressed surprise at the need for this, stating that they were more than happy to be identified and saying, "I have nothing to hide" or it's "nothing that I wouldn't say to anyone." However, it was further explained that there was a requirement for their privacy be respected.

Risk Minimisation

Due to their health both physically and cognitively, older people are a vulnerable population. For many, moving into care facilities is an emotional topic. Some have felt coerced by others to move into these facilities due to their failing health and as a result have resigned themselves to the situation. Many participants were in the position of being a widow or widower, separated from their partner of over 50 years, or they or their partner were in failing health. With these experiences comes the recognition that they are in their 'twilight years' and are often no longer able to do the things they once managed with ease.

A clause was included in the consent form enabling those that had consented to participate to "... withdraw from the study at any stage without penalty." If participants became overwhelmed during the interview they were given the opportunity to either withdraw from the study or halt the interview for as long as they needed. Visitors or activities they were keen to participate in had paramount

importance over the interview. My stance was that “If you have a better offer take it, and I’ll come back another time to interview you”.

On the completion of the interview, participants were given a debrief sheet. Usually these were waved aside. It appeared participants felt they were able to decide what they would disclose and what they wouldn’t. For some there was an acknowledgement that participating in the research would bring up feelings of sadness. They trusted that I would be able to respond to their emotions.

Research Validity

Qualitative description calls for the use of maximum variation sampling to ensure the phenomenon being investigated has a wide cross-section of perspectives. When reporting on findings, the researcher has an obligation to ‘keep close to the data’ and allow the ‘voice’ of the participant to be heard and expressed. There is also a responsibility to present the results of the study in ‘clear everyday language’ that the participants and readers can clearly comprehend. As the researcher, it is also my responsibility to acknowledge my own bias in the study and endeavour to keep this to a minimum during all phases of the research process.

By ensuring there are participants with a variety of opinions or experiences of the studied phenomenon, and by allowing the participant’s voice to rise from the research when reporting the findings, the researcher validates the experience of the participants. It is then the responsibility of the readers of my work to hear and interpret the ‘voice’ of each participant.

When undertaking the study I defined the research topic. At that point I made a commitment to stay true to the purpose of the study which was to expose the

'voice' of older people. In remaining true to this purpose I have written in a style that can be clearly understood by my participants, their families, their carers, their health care professionals and others interested in meeting the needs of the older people when they alter their living arrangements. As much as I have endeavoured to 'put aside' my own bias, I am aware that this, coupled with my focus on remaining true to the many and varied voices of my participants, will colour my discussion of the data. Along with their own voices, the research participants have entrusted me to competently act as a conduit for the expression of their experience and emotions on the topic of shifting into a level of care.

Procedure

Recruitment

Recruiting participants was not difficult. I was inundated with offers from older people wanting to participate in the research. They were eager to be involved for a variety of reasons that included helping me as a friend of one of their family members, finding the study something interesting to be involved in, wanting to promote their lifestyle to others (“I want to tell everyone how much I love it”), and being interested in research and knowing this was a topic they knew well and could contribute to. A number of participants had been lecturers, had completed tertiary education or had family members who had completed post-graduate studies and many wanted to feel useful and contribute to others.

Three participants knew me through their family members who were friends of mine. When approached by one of my friends, they readily agreed to participate. Three other participants contacted me as a result of reading about the research in the monthly newsletter of an organisation I belong to. Interestingly, I had not met any of them at the organisation’s meetings. My long-standing hairdresser has a colleague in the same business with many older clients. She promoted my study to some of her clients and this resulted in two contacting me. Two participants contacted me as a result of an article in an older person’s magazine. Neither could remember which magazine, even though one had kindly clipped the article out of the magazine. I spoke about my research at three residents’ meetings in a retirement complex, with mixed results. This was after arriving on several different pre-arranged occasions only to discover the meeting day or time had been changed and they had forgotten to pass this information on to me. On one occasion the scheduled monthly

meeting I had been invited to, had been forgotten so residents were not reminded to attend. Eventually, several months after the original agreement for me to attend the monthly meeting, I managed to speak to the residents from the townhouse/villa, studio/ serviced apartment, and the resthome. Eleven people volunteered after the townhouse/villa meeting. Three indicated their interest following the address to the studio/serviced apartment residents. Subsequent to my presentation at the resthome residents' meeting, two indicated their interest in participating. However, when I visited several days later to discuss the study and gain their consent, they had no recollection of the study or who I was. The manager of both the resthome unit and the clinical manager from the hospital unit promoted the study to a number of people in their care. Some of these residents agreed to discuss further with me the possibility of them participating in the research. Two people participated from the rest-home unit and four from the hospital unit. A further two participants were recruited through their partner who had already agreeing to participate. The final participant was my father who agreed to be my 'guinea pig' so I could practice the interview techniques and become familiar with the recording technology. He was also encouraged to give feedback on improvements, which he did. The feedback he provided was invaluable for the smoother facilitation of the rest of the interviews.

Of the 35 participants, four women and six men lived in their own home (which was either owned or rented by them), one woman lived with her daughter; nine women and six men lived in a townhouse or villa in four different retirement complexes, two women and one man lived in a studio or serviced apartment all within the same complex, two women were from the resthome section of the same retirement complex and three women and one man lived in the hospital section of the same retirement complex.

Informed Consent

Following the first interview, I realised the importance of making sure that the participants were at ease when I interviewed them and that they knew the interview format and aim. I decided to visit each participant to go over the information sheet, discuss the research topic more fully, answer any questions about the interview process and, provided they agreed to participate, have them sign the consent form. The pre-interview visit generally took about an hour. This time was essential for developing rapport; it enabled us to get to know each other and forge some common links.

It was important to most of the participants to feel they had some knowledge of who I was as a person, as well as gaining more awareness of the research topic. In my discussions, I meet up with someone who had been to school with my aunts and discovered a brother of an old family friend. I ended up discussing farming, living in both the North and South Island, rural townships, horse racing, equestrian skills, teaching, nursing, community organisations, sex education in schools, brain tumours, the printing industry, vegetable gardens, grandchildren, the devastation wrought by the Canterbury earthquakes, the effects of the 1968 Inangahua earthquake on structures in the area, writing an autobiography and a myriad other things.

During the discussions at the pre-interview, I would remind participants to remember to bring up at the interview certain anecdotes or thoughts they mentioned in relation to the study. On occasions when they started to tell me something, I would ask them to “hold that thought” and tell me during the interview. This discussion

helped participants focus on the facets of their experience which would be useful in the interview.

In order to establish rapport with the participants, it was vital that I had a wealth of life experience and was able to relate and respond to their diverse range of experiences. They gauged my reactions to a variety of topics and unconsciously assessed my authenticity. Was I who I purported to be? Was I really interested in their story? Was I empathetic? The importance of 'setting the scene' for each interview cannot be over-emphasised. This groundwork made a huge impact on my being able to produce an interview that enabled the participant to share willingly and that, at completion, left them feeling they had had a pleasant encounter. I believed I had a responsibility to ensure my participants knew that the time and experience they shared with me was a valued contribution to my research.

All participants were very careful to note down in a diary or on a calendar when I would return to conduct the interview. Many made statements such as: "If it's not in here dear, it doesn't happen" or "The memory isn't as good as it used to be, you know."

Hearing the Voices

By the time I returned for the interview approximately a week later we had already established rapport. Participants were very keen that I had a comfortable place to sit during the interview. Because many had health issues and found keeping relatively still for a period of time quite uncomfortable it was important that they, too, were in a comfortable place. Usually we chatted while I set up the video camera and audio recorder; often I was offered a "cuppa." Many of the interviewees were rather nervous at the prospect of being interviewed and recorded. They were concerned

that they would not “say the right things” and that they would not appear well on camera.

Once the interview started, the interviewees forgot the recording devices and their nervousness and settled into talking about their experience. Many participants needed to tell me about aspects of their earlier life to set the scene for the interview. Listening to how they had coped with other experiences during their lives provided me with the opportunity to understand their beliefs and values to put these in context.

The majority of the interviewees had never had a chance to talk about their experience or the prospect of moving into care and speaking about this frequently helped them clarify their thoughts and feelings. Different aspects arose as important to the interviewee; some were surprised or caught unawares about their depth of feeling about this. Several participants became quite sad when they reflected on particular things.

One participant broke down and was inconsolable. After a period of time I turned off the recorders and sat with her. I said very little apart from acknowledging her pain and sadness about the event (suffering a stroke) that had instigated her coming into care. I was careful to show that I was not afraid of her cathartic articulation of her feelings. I suspect that if I had reacted in a way that had made her feel she needed to suppress this, she would not have continued with the interview at a later date. She mentioned that this was her first opportunity to talk about her experience, to be heard and for her loss to be accepted. I had allowed her to express her grief uninterrupted. Her husband and family were as upset about her changed circumstances as she was so she was unable to express her anguish to them. The carers in the complex were busy and didn't have the time to listen. I was surprised

when she insisted that I return to complete the interview and demanded we agree on a specific day and time before I left. When I did arrive on the specified day she had a list of the things she wanted to tell me.

One particular resident had a painful condition and had to postpone the interview because of this. At another juncture the same participant had family members arrive for a visit so the interview was suspended until a later date. Several interviews were paused while the participant answered a phone call, or visitors or carers came in. Interruptions during the interview were common for those in the rest-home and hospital care. It was rare that people (visitors or staff) paused and waited to enter a participant's room after knocking on the door; it seemed that having knocked they entered immediately. Some participants were frustrated by these interruptions whilst others seemed to accept them. A close and very long-standing friend of another interviewee's arrived towards the end of the interview and the participant invited the friend to join and give her perspective of how the shift into care had been for her.

When the interview seemed to be drawing to a close, interviewees were asked if there was anything else they wanted to add. This often reminded them of something they wanted to mention. After talking some more and finishing what they had to say, I would ask again if there was anything else they wished to add. Sometimes this was repeated several times before the interviewee stated that they thought they had said all they needed to.

At the completion of the interview I reminded them that the interview would be transcribed verbatim and that this may take some time due to the number of

interviews. I also repeated that when I returned with the transcript they had the right to delete pieces they felt were too personal, or to add things they had remembered.

Transcription

At the completion of each interview all references to the person were made through use of a pseudonym noted on a master sheet. The pseudonyms were only first names, no surnames were used. The pseudonyms used were names common in the 1920s usually starting with the same letter as the participant's real name. Both the recordings and the transcripts were labelled with the pseudonym.

When I returned with the transcript all the participants greeted me like a long lost friend. I gave them the transcription and said I would come back later to see if they had any additions, alterations or deletions. I also reminded them that when speaking in a conversational setting we rarely speak in full sentences. Rather, I explained, we stop and start and fail to complete what we are saying but the person we are speaking to usually is able to understand our message anyway. It was essential to point this out as many of the participants expressed disappointment with their contributions, saying: "It was a load of rubbish," "I can't believe that I rambled on like that, "How you can get anything worthwhile from that I don't know," "Feel free to throw it out," "But my life is so ordinary." Many looked unconvinced when I endeavoured to reassure them that they had given me much valuable information, that I certainly didn't think it rubbish and that I had no intention of throwing anything out.. "Oh well, dear, if you think there's something in it that's the main thing." Other participants were effusive in their appreciation of the transcript and expressed their delight that it represented them in the way that they had intended. "I couldn't have said it better", "it is exactly what I wanted to say". I was humbled by their reactions.

Returning the Favour

Following the interviews, I wanted to be able to give something back to those I had interviewed to express my gratitude to them for sharing their experiences. I considered flowers or chocolate but discarded these because of such things as dietary requirements, lack of space in rooms and poor mobility manoeuvring around smallish rooms. Many of those living in a retirement complex had told me how much they enjoyed 'Happy Hour' and, for the less mobile, how much they looked forward to something different happening. I had also told all the participants I would give them a report of the findings. After thinking about all these things, I decided to make a power point presentation and hold an afternoon tea. I made up special invitations inviting them to a presentation of the findings and an afternoon tea. I invited each person to bring a friend or family member with them. The retirement complex where 20 of the participants lived agreed I could use one of their large lounges and offered to provide tea and coffee. This venue was selected because it meant that those in hospital and resthome care were able to attend. The logistics involved in holding the presentation elsewhere would have been fraught with difficulty for these people. It was also an opportunity for the retirement complex to showcase their facilities to other older people. As well, it provided those who lived in their own homes with the opportunity to see inside a retirement complex as a visitor rather than as a potential resident. Also invited were members of Age Concern, ElderNet, the local District Health Board, my supervisors and colleagues.

Setting up this presentation created an ethical dilemma around maintaining the anonymity of participants, a topic I discussed at length with my supervisors. As I delivered each invitation, therefore, I reiterated to the participants that they were

welcome to bring along a friend or family member and made it clear to them that their anonymity would only be breached if they disclosed their pseudonym to others. Participants seemed amazed that I would be concerned about others recognising them. In fact, a number of people who attended the presentation did recognise each other and were able to catch up.

The presentation was held in early December as it was decided this should be held in the same year as the interviews. As a result, it occurred prior to the completion of all the transcription and analysis. Twenty-eight of the 35 participants attended, most with either a friend or their spouse. Those who did not attend, due to either their own or their partner's ill-health or a prior commitment, were disappointed they could not be there. The presentation was limited to 30 minutes. It focussed on the emerging themes of independence, cost, life-style, future planning, and change, loss and grief, and ended with a short question time. At the completion of the presentation we had afternoon tea. To honour the participants I decided to make the food for the afternoon tea which comprised 'old favourites' that most of the attendees would recognise.

Several participants contacted me following the presentation to say: "I just wanted to thank you for the lovely party," "It certainly makes you think that perhaps you should do some planning for the future", "This [the complex] isn't what I imagined it would be like." One person also mentioned that when she had heard several people say they would like to have been mentioned personally for participating, she had reiterated to them the requirements of confidentiality and anonymity.

Beyond the Twilight Zone

I have been saddened to read in the local newspaper of the deaths of two participants. In both cases family members were asked for permission to use the interview.

Together, Yet Separate

All the participants fitted the societal classifications of elderly, retired, aged, older person or old, and while they had a great deal in common, they were all different. Some had similar backgrounds and experiences, but for others their circumstances were in stark contrast. They were all individuals with their own unique perspective on life. They were a diverse group with opposing views about the same topic in some case, and very similar views about other topics. Whatever the information, it reflected their range of life experiences.

Chapter 5

Findings

When using QD as a methodology to capture the voice of the participants the researcher is looking to explain what motivates these people and why they think and feel about their experience in particular ways.

To discover what motivates older people to shift into a retirement complex and their perceptions of this experience, I interviewed 35 participants ranging in age from 66 to 95-years old. In order to elicit a wide range of perspectives among older people, these participants were recruited using maximum variation sampling. The participants fell into three distinct groups; those that resided in their family home, those who had purchased a 'license to occupy' their villa or service apartment, and those who lived in a resthome or hospital facility. As I sifted through the data from the transcripts common themes emerged, as did differing perceptions of these.

The information gained through the interviews was both implied and communicated directly. Data from each participant in the three groups were reviewed and categorised, with 16 key themes emerging. I have chosen one participant from each group to represent the group for each theme. Some themes have a resonant 'voice' that reflects the solidarity of the group; while for other themes various opinions represented the diversity of perspectives within the group. All participants are referred to by their pseudonym.

Plans and Decisions

Participants who lived in their family homes mostly had 'Plan A' and almost all of them stated this in the first few minutes of their interview. Many continued to reiterate this throughout the discussion. When asked what they would do if they could no longer cope with living in their home, the sentiments of over half of the participants echoed almost exactly Daphane's words.

Daphane, a 90-year old widow, had 'Plan A' - *"I hope to go out of here in a box"* - and 'Plan B' - *"I have a sister in care so when the time comes I may well want to do that too but I hope the Lord will take me first."* Four of the remaining five participants in this group thought they would go into a care facility if that was what they needed. Further on in the interviews, Daphane stated: *"The time will come when I'm not able to do that and one thing I have decided it won't I won't be staying with family I will be going independent somewhere."* However, the men who had stated they intended to die in their home steadfastly refused to countenance any other options. Those in resthome and hospital care all shifted to these places because of health issues. Their health had deteriorated to a point where they could no longer be supported. Peter is 89-years old and lives in hospital care. *"Well it was more or less forced upon us because of circumstances ... my health wasn't really good enough to support my wife for that reason we decided that I would move into these premises and it certainly proved the right thing to do because I'm having all sorts of problems."*

Participants who had decided to purchase a 'license to occupy' had often visited a retirement village previously to "have a look" but with no particular intention to shift there. For some, it was the decline of a partner or themselves, or an event that had happened, that made them realise their vulnerability in their family home.

Mildred is 87-years old and lives in a villa in a retirement village. The Canterbury earthquakes in 2011, was the trigger that made her move. *“It was after lunch when the earthquake hit ... I got home and of course no power couldn’t ring my daughter [overseas] and I couldn’t ring my son in [North Island] my son who usually lives [here] that keeps an eye on me and was [overseas] so I suddenly felt very old and very lonely I thought you silly old fool why not decide that you’re going to move.”*

Village Care and Home Support

The majority of those participants who held a ‘license to occupy’ spoke of the care they received within the village. This was especially evident during 2011 when the region was hit by several devastating earthquakes as well as by two heavy snow falls. Sarah was the youngest participant at 66-years old. *“When it snowed they come around and check that you are alright and the earthquakes ... they were utterly brilliant just making sure that everyone was alright ... if people were feeling isolated ... they could go over at lunch time ... and catch up with other people and it was also for the staff because you know a lot of staff were in dire straits at home as well as being you know having to work”.* She and her terminally ill husband moved into the village primarily to support Sarah continuing to care for him. *“Very hard very hard yeah and you know while we were here he had two or three times when he went over to the main building into respite care so that I could have a break.”*

Maintaining the ability to live in their own family home meant that many of these older people accessed home help. Some were eligible for government-subsidised care whilst others paid for this help. It was often felt that the care time allocated to them was inadequate. Cynthia is a 90-year old living on her own. *“I don’t know ... it’s worth ringing them up ... so I have rung them up and I explained and*

they may give me another half hour otherwise I'll go on paying [for the extra time]." They were also concerned that this support may be withdrawn. *"They're cutting right down. They reckon they want patients that need baths and showers and I'm not so important."*

Resthome and hospital care participants generally had less choice about residing in these facilities. There was an overall feeling of being cared for. Peter is 89-years old. *"They're certainly very good here they have all the answers...it's not perfect by any means..."* The participants in this group were usually affirming about their relationships with staff although many struggled with the roster changes. *"I think the main trouble is they're only casual labour ... anyway that was all that was available so I had to take it."* Staff changes meant that staff had to be proficient at all care needs of all residents. *"I don't know ... there's various personal things that ... have to be thoroughly taught ... so the staff can use it and some staff don't really know what they're doing."*

Autonomy

Those who still lived in their family home had strong views on maintaining their independence. Roy is 84-years old and lives on his own in a rural area. *"... my responsibility in doing my own thing of making my own decisions of ... doing my ... daily for myself ... the responsibility to live that day without aid from other people ..."* He, like many others in his group, is reluctant to enter a retirement complex because his autonomy may be compromised. *"If you went to a home ... or ...consider the various types of home and the diminished input that you've got ... let me put it another way as you accept more help I would expect my independence to recede."* He further clarified this by trying to see the situation from both perspectives. *"I see*

that as a very acceptable and necessary thing ... people if they're running an institution have got to run it for the ... good of most and in making that statement that is not always in consideration of the individual."

Those in the villa and serviced apartment group saw their independence differently. Lillian and Jim live in a villa. They are 83 and 85-years old respectively. Jim's health meant that he had difficulty communicating. Lillian mainly spoke for both of them while Jim indicated his agreement. *"There was a light bulb change ... you just ring up and somebody goes and changes your light bulb."* Lillian compared this to how it was when they lived in their family home. *"And that's the thing you can't do at home anymore and you had to wait for one of the children to come and ask them to do it."* She goes on to explain why this gave them independence. *"And it's very nice that you aren't depending on them all the time ... that's all part of your eighty dollars a week."* Repairs and maintenance are included in the weekly fee paid by those with a 'license to occupy'.

For those living in a resthome or hospital there was a strong feeling that independence has been lost. Marjorie was 75-years old. She had had a stroke and relied on a wheelchair for mobility. *"Not having a car to go around to see a friend is quite hard."* Often there was little choice about the move to these facilities though this went along with an acknowledgement that there was no other option and that family had made the decision about where was best. *"They came up with here ... no choice for me ... that's part of the problem that you don't have a choice."* Many participants relied on staff to help them toilet, get up, go to bed, and for a variety of other issues. Other decisions are made for these residents without consultation, such as dining arrangements and activities. *"They tell you where you sit ... the same*

one every day.” Some of the residents were frustrated with having to wait for staff to answer their call bell to do such simple tasks as turn a light on or assist with more complex issues, like toileting. *“... wait too long for the bell ... and then they fall and hurt themselves ... you can’t expect older people to wait that long.”*

Possessions

Disposing of loved items was seen as a very difficult task for many of those living in their family homes. They accepted that they couldn’t take things with them if they went into a care facility, and deciding what to do with their things was almost overwhelming for some. Rita and Sid were 85 and 87-years old respectively. Rita: *“And of course you’ve got to think of getting rid of everything in your house ... I don’t know what ... will happen I’m starting to sort out trying to sort stuff that I don’t use and if the grandchildren can use it ... it’ll be you know they’ll ... be able to utilise things.”* Items which were very sentimental and held many memories were particularly hard to part with. Sid: *“Well I’ve given all my tools away to a grandson ... you know all the tools I loved ... I’ve got tools that I’ve given them that’d be a 100-years old ... they’re my Dad’s and [Rita]’s father’s ... he was a builder so he had a lot ...”* Many found it easier to gift precious items to others who would appreciate them.

Moving into a villa or serviced apartment meant making decisions about what came to the new home. For larger items the decision was based on whether or not they would fit. Josie is 75-years old and lives in a serviced apartment. *“That was a hard thing ... I just had to harden myself and say right ... we went through things room by room and I said no that can go that can go and we had a garage sale and got rid of a lot of stuff ... and then we had another garage sale.”* Not all treasured items could be accommodated in the new home. *“My clock I inherited from my*

mother was a wedding present for my parents ... I had another clock that was a wedding present to my husband's parents and my daughter's got that." Deciding about the fate of some items was just too difficult. *"... I have a storage unit that I've still got stuff in there that I've still got to go through ... stuff that I couldn't part with but stuff that I've got to go through."*

Possessions were not always inanimate objects. When Harriet, who is 89-years old, shifted into her resthome room she found, like many of the others in her situation, *"I had to scale down a lot."* The possessions she missed most were the ones that gave her comfort. *"My garden is my treasure really I don't think I had any special treasures ... and my little cottage was so sweet ... it was so sunny ... lovely big windows."* However, the item she and others missed the most was a pet. *"... my little dog ... I had to get rid of her and it's hard because I've had a dog all my life ... that was the hardest thing."*

Socialisation and Community Spirit

For some people it is very important to have lots of people around them and to be mixing on a regular basis while others are happy with their own company. Paul is 80-years old and lives in the home he has lived in for the past 51 years. He shares it with his adult grandson; a mutually satisfying arrangement. Paul is happy with his own company. *"I've probably always been a bit of a loner."* For many older people at home a good deal of socialisation is derived from visits from family and going on outings with them. *"... the only thing I do now with my son is a bit of sea fishing because he's got a boat and when he goes out I go out with him."* Some of the participants provided support to friends and neighbours. *"One of my neighbours was in there three weeks ago and I just hopped on the [bus] went to see if there was*

anything she needed ... I've got a friend in [another suburb] ... who I go and see quite a lot." Paul, like others in his group, was involved in various organisations. *"I like keeping active in the gun club because it's a very good social thing, you know ... you continually meet new people ... which I think is good for you."*

Retirement villages provide many opportunities for residents to be involved in social activities. Ruby and Sam live in a villa and, at 72 and 73-years old, are considered by many residents to be the 'babies' of the complex. Sam: *"... participating in the activities you get to know the people and ... is quite interesting ... some of them have got quite a story to tell."* The activities provide opportunities for residents to get to know each other. Ruby: *"... that's quite nice having that companionship ... the sort of people who will say ... can I collect your mail when you're away ... I've got four of them ... it's good."* Non-residents are often included in the retirement village activities. Sam: *"... we like fine dining ... we usually have two or three guests with us and that way we can enjoy them and I don't have to do any preparation no washing up ... I can just be there with them and enjoy it ... they love it in fact some of our friends basically invite themselves back."* The village offers a variety of social occasions and activities that stimulate residents cognitively, and spiritually. Sam: *"I have been involved in church activities and they have a bar-b ... and the church service on a Wednesday morning."*

Resthome and hospital residents often have mobility issues and mainly rely on others to come to them. Shirley is 85-years old and relies on either a wheelchair or very large walking frame to be mobile. *"...get occasional visitors but the neighbours who used to come he can't make it anymore ... the walk from there (carpark) to here is even too much."* For many residents in these facilities even family visits had reduced. *"The family seem busy ..."* Spouses often found visiting

difficult because there was little to talk about. *“He only picks me up on Sunday ... he’s come to the idea now he feels Tuesday morning and I said you can come again tomorrow or ... make it Thursday come back on Thursday ... on Thursday there’s nothing ... I’ll pick you up on Sunday’ ... there’s nothing happening on Friday or Saturday ... he thinks that makes up for everything.”* Much of the socialising for these residents comes from within the complex. *“... if I go to the lounge on a Saturday afternoon I am allowed to join the other people from the serviced apartments or the [villas] ... they come in there and play Rummikub ... they have games ready there and I have been able to find someone who ... I had a game with them they had one spare seat ... and they have real coffee in there.”* Or residents rely on the phone or internet to keep in contact with friends and family. *“... I have got another good friend we ring every week ... she has MS (Multiple Sclerosis) and is not able to come on her own ... she’s a bit like me doesn’t want to pester her husband too much to do things to take her here and take her there.”*

Family and Family Rituals

Family were very important to almost all participants. Family members provide support - a ‘sounding board’ – and participants frequently sort their endorsement before making large decisions. Louise is 86-years old, she moved into a villa when her husband was ill and she was caring for him. *“... didn’t do very much of looking around at the various places because I left that to the girls and I knew that they would come up with the right answer ... they looked at a lot of places.”* The support provided by family members was invaluable. *“The girls used to take him out as well ... I was so lucky really to have such family support it’s just incredible ... I mean our son ... [overseas] came out seven times during his illness and ... he would come for*

a week and make the most of it and take his father out ... we shared ... the whole of his disability as a family ... and that was great ... I can't really express how wonderful it was to have family support cause I would see people in that area [hospital] who went for weeks and didn't see anybody." Family rituals were often continued in the retirement complex even when a couple was in different sections of the village. *"I wanted to be close to him and I knew that if he was admitted to this facility that I could go and visit him anytime of the day or night literally ... I was able to take over a bottle of wine in the late afternoon ..."*

While some residents living in the resthome and hospital facilities did not see as much of family as they would have liked and didn't always feel they had family support, others found it difficult to express the full extent of their gratitude for the support of family members. Mary is 87-years old and has used a wheelchair for the past 30 years. *"I am just grateful ... to have had my parents and [my husband] and for [my daughter] and [son] and [first born son] ... to have them ... they're there if I need them but for my daughter she's been absolutely amazing ... she has always been there if I wanted to say something or do something ..."* A number of participants in this group felt that their move into these facilities was made to reduce the burden on their children. Mary had lived in a flat at her daughter's for over 20 years. *"I used to say to them now, I'm not here for very long but I would like you to start to have a life of your own..."*

Because of the devastation caused by the Canterbury earthquakes, over a third of the participants living in their family home had been forced to leave. Beatrice is 84-years old and has health issues. Following the earthquakes she moved into her elder daughter's lounge and has lived there, now, for more than 18 months. Moving in with family is not always easy. *"It's not easy for her either because as she said to*

me one day Mum I've lived 25 years on my own I said yes and I've lived darn near that too on my own ... it is very difficult ... one day ... I said something out of place ... and she said mother I am grown up I'm not a little girl any longer I said yes and I am your mother and I shall remain your mother till the day I die so I'm sorry you're going to have to put up with that." To resolve disagreements Beatrice had worked out a strategy. *"It's her home it's not mine I'm here at her pleasure and ... for that reason I do back off and I think it's the only way ..."* Older people with earthquake-damaged property are concerned about insurance and EQC (Earthquake Commission) claims being settled in their lifetime and worry about where they will live in the meantime. *"Well family says you're not going back there ... my oldest daughter and her husband are building ... a new place ... which will have a unit in it for me ... [son-in-law] says you've got a front and a back door all of your own ... it's not many son-in-laws that are as good as this bloke ... he didn't have to do it he's my son-in-law he's not ... a son ..."* Beatrice's advice for harmonious family relationships is *"... once you start feeling sorry for yourself and you lose your sense of humour you might as well go and shoot yourself ..."*

Financial

Many participants across all groups spoke of the cost of living for retired older people whose income is derived from either their savings, including funds from a private superannuation scheme, or from the New Zealand Superannuation funded by the government. Part of the dilemma is that no-one knows how long they will live for and, therefore, how to budget their finances, especially if on-going specialist care is required.

Ian is 85-years old. He lives in a rented house close to the hospital where his wife lives. Following Ian's wife's stroke, they had sold their purpose-built home which they had retired to because it was on the other side of the city to the hospital. *"My first thought was that I would buy one of those villas ... which I paid a deposit on ... when I needed to vacate that particular place there're too many ifs and buts ... too many fish hooks ... and I lost too much ... they took the gain of any interest and that sort of thing."* They are above the threshold to receive a government subsidy to pay for care in the hospital. *"It's one of the gripes I suppose ... you live carefully all your life and you save a bob or two and then at the end of it ... gets taken off you whereas people that waste it all of their lives get looked after ... you've sacrificed and at the end of the day you get done ... you sort of wonder why."* They are paying over \$1,500 a week for hospital care and Ian's rental of the house near the retirement complex. Because of his own health issues, Ian's health care professionals have indicated that he needs to take care of himself and that he cannot, therefore, also care for his wife. During the interview, when he was asked what plans he had if he could no longer look after himself, he replied, *"Haven't thought about that at this stage ..."* When it was posed to him that maybe this was something he preferred not to think about, he replied, *"Well yes I don't know ... I honestly just don't know ... the cost from [my wife] is a thousand dollars a week and if I went into the same sort of situation ... I couldn't stand it just couldn't stand that sort of money ... I don't know what I would do ... I hate to think about it."* Ian still owns and works each morning in his business, which is now run by his children and their partners. *"I mean we have a business but it's not the business' responsibility to pay for our care ... the business has got to run as a business not as a ... health care situation ... business is hard right now ... so there's not a lot of money there to be thrown around either."* Ian was keen

to leave the business to his family. *“... you got four of a family ... I mean it’s their inheritance.”*

Jean was 84-years old and had originally moved into a villa. When her health deteriorated to the point where she was no longer able to cope, she had sold her villa and moved into the resthome facility. Licensees are well aware of the depreciation clauses when they buy the ‘license to occupy’. *“I sold it back to [the retirement village corporation] and lost \$20,000 ... I wasn’t too worried about that.”* Many people have established a trust to protect their money. As their personal savings dwindle, they may reach the stage where they are eligible for a government subsidy for care. *“... because it’s a family trust I applied for a subsidy which I got ... you see my own basic savings and what was left in my side of the estate it was enough to keep me going for a while.”* However, the subsidy provided only for a basic room; anything extra was charged. *“... if you get a subsidy you get the basic room the room over there was going to cost me \$25 a day extra ... I said look I can’t afford it I simply can’t afford it ... this one is \$19 a day extra ... it was just the fact that one opened onto the courtyard and had the double doors ...”*

Celia and William are 79 and 85-years old respectively. They each own a ‘license to occupy’ for their respective villas. Before retirement, William was in the finance industry. Many of the participants who lived in a villa or a serviced apartment commented on the investment aspect of their purchase. William: *“It’s not a good investment it’s not an investment at all really but circumstances were such that that’s what you have to do if you want ... the back up ... it’s taking away the stress ... when we came here of course we got the benefit if ... we had other problems you’ve got the back up.”* Those able to afford to purchase a ‘license to occupy’ are usually not eligible for any government subsidy. If a person lives in a villa and their spouse is in

hospital or resthome care that is an additional expense. William: *"I had to pay about \$130 a day at the hospital ... it's \$100,000 or something over the time [my wife] was there ... if you've got any assets ... you have to use them first."* There are also other expenses associated with the village, including use of the facilities, rates, maintenance, window-washing and so on. William: *"We pay a monthly fee."* As well, there are also other substantial expenses. Celia: *"A car is an expense for me ... we pay insurance for our contents."* It is a further expense to move from a villa to another level of care within a retirement complex. The 'license to occupy' must be sold back to the owner. In most cases, 20% on the original purchase price is lost in the process. The move may involve purchasing another 'license to occupy' at current market value or paying a daily/weekly fee. William: *"... people don't understand that that's what's going to happen although I think the legal fraternity do explain it pretty carefully."* For those in government-subsidised rooms it is different. William: *"... when you go in ... you lose your pension ... if you haven't got the cash ... and all you get is a little bit of money for essentials ..."* The philosophy of many with a 'license to occupy' was the same. William: *"... that's the unknown no-one knows how long they are going to live and ... how much money you're going to need ... you've got to deal with it ... and hope that it is right ... that we won't have to worry too much if you're not here you won't have to worry anyway."*

Death and Demise

All participants spoke about their own demise and death, and many spoke of their observations of these in regards to others. Some of those who lived in their family homes acknowledged a gradual decline in themselves. Rita is 85-years old and her husband, Sid, is 87-years old. Sid: *"... you maximise what you can do..."*

There is a realisation that things that have been taken as a 'given' many not always be this way. Rita: "... *it'd be good if I can keep driving.*" Some have made plans. Rita: "... *we did ... buy a plot (at the cemetery) ...*" All those living in their family home had the same end in mind. Sid: "... *we think we'd be far better to be carried out.*"

Joan and Albert have lived in their serviced apartment for nearly 4 years. They are 85 and 95-years old. During their time in the village they have noticed a gradual decline in many of the other residents. Joan: "... *when we came here there were no walkers ... look at them now ... the place is chock a block with walkers ... you have to watch out that you don't trip over one.*" As their hearing declines, many people struggle with crowds. Albert: "... *hearing aids are useless where there's noise ... you can't hear people talking ... if you wind them up you just increase the background noise ... so I go down to get us a couple of ... sherries and bring them up here and have them in the peace and quiet.*" Residents disappearing seem to be a common occurrence and others were often reluctant to ask about their whereabouts. Joan and Albert's room has a view of the main entrance where, among other visitors, they could see the arrival of the undertaker. Joan: "... *you get sort of a bit depressed yourself when you see all these sick people ... you find that ... you'd see them for a while and then you don't see them again and ... there's another one gone and another one gone ... you get a bit depressed ... all of a sudden one after another ... they've had to go into hospital.*" Others didn't let it worry them so much. Albert: "*I don't think you should worry ... it's just another... where's so-and-so oh he's gone'.*"

Those in the resthome and hospital wings are confronted even more often with the death of their neighbours and friends in the facility. Mary is 87-years old and has been living in this care facility for nearly five years. She is one of the residents who have been here the longest. She keeps a photo, death notice or funeral service

sheet as a memento of those who have gone. *"... they've all died and I've got them all on the other side of my door ... there are other people here who have died of course but I haven't really put them up because I don't really know them."* She does have strategies to protect herself from getting too depressed. *"... it's sad but I thank God for what I can do and feel that God's got me here for a purpose to be able to be there and just encourage people ... it's the sadness of being so friendly with people ..."*

Adaptations and Acceptance

Different personalities adapt and accept changed circumstances in different ways. Cynthia was 90-years old and lived in her own home. *"Well I mean it's a bit of an effort ... I knew this yesterday I'd been putting it off for two days ... I thought yesterday ... get out and do that bit out there [gardening] then it becomes a bit bigger and you go on and on ... this morning I looked out and it's all neat and tidy and nice ... I know I get ... so stiff but you'll get stiffer if you don't."* Many people living in their family home accepted they did things more slowly but they still expected to carry out their usual tasks. Sometimes they had made purchases to make things easier. *"... I did change my car a year ago and that's made a great difference because the other car was pretty old and I didn't have the confidence to scoot over the street because I thought it would conk out ... didn't have the steam well this one you know ... you'll get round and that's ... made my life a lot easier with this car."* Accepting that they were getting older and slower was frustrating for many. However, they could see the positives. *"... I try and not dwell and all this thing because wherever I go I hate old age ... well we can't stop it ... we may as well enjoy what we've got ... I think I'm ... lucky to be able to when I see the other people."*

Jack was 86-years old. He lived with his wife in a villa, having moved there because of his failing health. Sadly, Jack died earlier this year. He had had to give up what he loved because of his poor health. *"... I couldn't carry on my garden and no point in staying in a place you can see what wants doing but you can't do it ... so frustrating."* He was frustrated by his increasing inability to communicate. *"... my voice is very odd ... I used to lecture quite a lot ... so my voice has been part of me for a long time but it seems to be disappearing ... if you can't communicate you're in trouble."* Pragmatism seemed to be common among all older people. *"... you got to face facts and just do it before you run out of steam ... if you still got some energy you can keep control of things but if you get to the stage I am now ... I can see me coming down."*

Harriet is 89-years old. She had learned to accept that she needed the specialist support provided by the resthome. *"I knew this is where I'd have to be."* It took time for her to adjust. *"... I just tried not to think I put on tv or the transistor or just kept my mind on to something else I read talked to people."* She had had to give up a number of pleasures. *"I was going out in the car a lot and taking people out with me ... but you've got to come to the end of each stage don't you."* She was also matter-of-fact. *"I just think you've got to get on with it I don't know ... do you complain about what you're doing you've got to find your own way."*

Village Life

Prior to going into a retirement complex, most people have some preconceived ideas of what it may be like. For most, their fears were not borne out.

Roy, at 84-years old, lives in his home without close neighbours. He has some concerns about how being in care might fit his personality. *"... rather than ...*

being a good mixer over my life I have tended to be of my choice ... rather slightly removed from the mob element ... and I do fear for them and for me ... if in ... close contact... I do have friends and I do go and see them ... I am ... very much in the situation of being able to turn the tap on to a trickle to full volume or to turn it off ... at my choice ...” Roy alludes to the choice of escaping life if you live on your own but ponders if that would be reasonable in a retirement complex. *“... should you come into close contact as in a home ... then it mightn’t be good for ... anybody you might be very unhappy and can you escape it it’s a matter of escapes I guess here by myself ... I have got dreamed options of escape once I become part of ... a fixed community ... then I wonder if it would be fair on me and fair on other people ... that element of control of escape ...”*

In contrast, Ralph, aged 85, moved into his village a few months ago. He is very keen to share his experience of village life with everyone. He acknowledges that some people are like Roy. *“... whereas I am the opposite I like to talk to people and I like people just popping in ...”* He is also keen to facilitate hospitality. *“... you can just ring somebody and say come and have a cup of tea if you feel a bit lonely ...”* Ralph also talked of the variety of activities available to residents and the input they could make to these. *“We have two committees. We have a residents’ committee which organizes ... complaints that type of thing ... and they organize functions ... we have a social committee which also organizes functions and outings ...”*

Jean had moved from her villa into the resthome because of ill health. She was 84-years old at the time of the interview. Sadly, she died at the beginning of the year. She had previously been a nurse. One aspect of the change she found difficult was the lack of cognitive capability displayed by other residents. *“We’ve got the Alzheimer’s ... upstairs and ... yet we have got at least ... four from round here that*

should be up there ...they are wandering in and out of this room quite a lot and I get fed up ... and then others that really ... should be in the hospital.” She also spoke of the ‘segregation’ of different facilities within the village. *“... it’s kind of if you’ve got a villa or you are in one of the apartments over there ... sort of it’s a little set on their own more or less.”* Now, she has to attend resthome functions rather than those for villa residents. *“... you’re not supposed to mix you can’t go over there ... you’ve got to stay over here for ... we have our own meetings over here we have our own ‘happy hour’ ...”* Jean was a strong woman and had her own way of getting around some of the ‘segregation’. *“I’ve got a good friend who ... takes painting classes and there’s only two of us ... we go over on a Friday afternoon ...”*

Resilience and Philosophy on Life

Many participants from all three groups spoke of previous experiences which had helped them adjust to their current situation. The huge variety of both positive and negative experiences over a long life time contributed to the development of considerable resilience. This, along with their own philosophies on life, gave them strength in trying times. They were able to employ a diverse range of coping skills to manage the variety of changes their advanced years bestowed upon them.

Donald was 89-years old. He and his partner had moved in together following the 2011 earthquakes which had devastated their respective homes and entire suburb. His partner keeps poor health and Donald finds himself placed in the role of carer. He believes that his experiences in life have enabled him to cope with the stress of the earthquakes, the loss of his home, and a change in living circumstances, and that they will also be helpful for future shifts. *“I’ve been a teacher and moving around ... I think perhaps what helped was being used to moving ...”*

one's able to cope better ... well the army and the air force were great training grounds where you learnt to adapt ... also we were a big family ... so you learnt to live alongside others also ... you work as a teacher you learn to be able to give and to help and it becomes second nature ..." Donald's philosophies are the values he lives by. *"... you just have to keep plugging on ... never a dull moment ... you have to adapt all the time ... to ... whatever the problem you are faced up against ..."*

Those who lived in the resthome and hospital facilities made less mention of what gave them strength. Many had a strong religious faith. Jean was 84-years old. She felt that it was useful to *"... keep an eye to the future..."* and that she needed to be *"... getting on with it..."*

George lived in a villa in a retirement village. He was 86-years old. He was involved in a wide variety of clubs and organizations and kept himself fit by walking most days and swimming regularly. *"... keeping myself busy ... every now and again I think gosh I'm doing far too much."* To maintain a busy lifestyle he also planned and had routines. *"It's a good idea to be able to think ahead ... you've certainly got to think ahead ... saying ... what is going to happen ... you hope ... but it might not happen that way."*

Change, Loss and Grief

Change, loss and grief encompass a variety of issues including the; loss of body function, spouse, home, possessions; change in ability to function physically or cognitively; change to the place where you live and the people you live with; changes in social circumstances - all of these often cause grief not only to the people experiencing these but to their loved ones as well.

Ian is 85-years old. When his wife had a stroke one morning, it changed both their lives forever. *“You don’t plan for this sort of event and it happened just in a split second ... our lives were changed just that quickly ... it has been snatched away.”* Running a house by yourself and daily living is harder when you’ve been married for 54 years. *“... normal living what two of us used to do I have to do and ... it’s double the work ... I never had to cook or do anything ... been well looked after all my life ... my wife bought my clothes ... as I say you worked together yes one has to adapt fairly quickly ...”* It is lonely without the other person. *“I don’t want this to sound harsh or cruel ... but there’s not a lot of things you can talk about at the hospital ... the only company I’ve got is two cats.”*

Sometimes people make a decision not to let themselves grieve. Shirley is 85-years old and lives in the hospital wing. *“... emotion doesn’t come into it if I feel too much of it gets me down no I don’t want to go there ...”*

Myrtle is 82-years old, she moved to her villa sometime after the death of her husband. She is now able to reflect on her grief. *“When I lost my husband you just have to keep going and build a life for yourself you don’t want people sort of sympathizing with you all the time.”* She was also pragmatic about other people’s grief. *“... you do what you can for other people but you don’t ... you can’t take on their depth of sorrow.”*

Having a Purpose in Life and Being of Use

Almost all the participants mentioned, in one way or another, their need to be useful and have a purpose in life. A number mentioned that they had decided to take part in the research because their experiences might be able to help me.

Ruth had recently shifted back to the area with the intention of being able to help her brother care for his wife. Ruth is 77-years old and in relatively good health. When she lived in the North Island, she had been a volunteer for several organizations. Following her shift south she had applied to various organisations that use volunteers, but there had been no vacancies or there were only casual opportunities or paid positions available. Ruth was frustrated about not being able to give to others. *"I wouldn't mind what I did as long as it's practical ..."* She was considering shifting cities to be nearer family so she could help them. *"I just thought well with these youngsters coming along I could perhaps be more use to them I'd rather be more use to them than perhaps doing things in the community really I mean like babysitting or baking or minding the kiddies."*

Marjorie, who lived in a hospital room, was 74 and had suffered a stroke. Her frustration was *"... not being able to do anything for yourself ... I can't."* She had no use of her left arm so wasn't able to work on her knitting or the many crafts she had previously been involved with. She was no longer able to care for her husband, or be active with her children, grandchildren or great-grandchildren.

Rita and Sid are 85 and 87-years old respectively. Sid is very proud of the tomatoes that he grows each year. His sight and mobility are limited so Rita has to help him prepare and plant the tomatoes; it is a joint effort. Rita: *"I had to fork it over from the garage to the shed in the corner and ... it's all done ..."* Sid: *"[Rita] bought me a ... it's like a type of chair with no back in it but it spins around and I can ... whiz up and down on it and do the tomato patch ..."* Rita: *"... he ... digs a hole ... I get them out of the little packets ... then you put fertilizer don't you hit or miss sometimes ..."*

Earthquakes

The disastrous Canterbury earthquakes of 2010 and 2011 have had a considerable impact on everyone in the region. Most of the participants mentioned these events.

Almost all those who owned a 'license to occupy' spoke of their relief about being safe where they were and well cared for. Gladys is 80-years old. *"... in the earthquake time we were well cared for oh they're great on that they left about six bottles of water at your door and came around to check on you and see that you had ... you know ... [provided] ... big bowls of soup and all that sort of thing."*

Some residents in retirement villages were not so fortunate. Retirement complexes have now taken measures so residents will have their investment protected if a village collapses. *"She was able to buy another one but for ... weeks she's talked about [collapsed village] what a wonderful place it was but she's owed a \$100,000 ... but we all got letters to say that if [this village] collapsed we would be paid out ... they sent out those same letters to our solicitors."*

Shirley is 85-years old and was the only person from the resthome hospital care group who mentioned the earthquake. At the time of the first major earthquake she was still at home. *"That was that night and I was at home ... only been home for four days ... from hospital ... the first week home and then that happened and then the carers were still coming and some of them ... came and they said all the effort they had to make to come."*

Richard and Dora are 74 and 72-years old respectively; they were severely affected by the earthquake, having to move because of the damage to their home.

Dora: *"... the earthquake made that decision we didn't ... it made the decision cause the roof came off the house so that was the end of that ... so the earthquake moved us."* The stress of the continuing earthquakes, and dealing with Earthquake Commission (EQC) and insurance companies took its toll on health. Dora: *"... with the stress he did suffer memory loss ... this is the problem we have now ... not total memory loss but with little things like appointments that he can't remember or ... where something is in the house or whatever ..."* They employed an agent to sort out their claims with EQC, deal with engineers and assess new building sites and plans. Richard: *"... so by employing somebody else at an expensive rate an apparent expensive rate ... was one of the best things that we ever did and I've been very much aware of that with other friends and relatives who are working through the process they haven't seen it like that and I feel so sorry and sad for them that they're working through the issues by themselves and don't know who to talk to."*

Wisdom and Advice

When the opportunity arose, a question I often asked during the interviews was: Do you have any words of advice or wisdom you would like to pass on to others from your experience? Most were reluctant to respond but many spoke of things that worked for them.

Paul is 80-years old and lives in his family home. He keeps physically and mentally active. *"My hobbies are clay-bird and rifle shooting ... it's been cold and miserable so ... I've given up on those days I wait for ... sunny days are coming ... I read books and magazines on the paper every day of course ... do the crossword in the Press and the word puzzle ... keeps the brain ticking over."* In order to preserve his independence, he takes precautions which include looking again at activities he

was previously proficient at. *"I do look before I cross the road so I'm not silly about it ... I know ... I can't do things on a ladder that I used to be able to do ... the terrible thing is in my working days I used to be the only one in the maintenance crew who could really go up a very high ladder ... up 30 feet in the roof ..."*

Mary is 87-years old and had been in hospital care for at least five years. Her wisdom was about the autonomy of the older person. *"I think though sometimes the choice has to be their own ... for instance just lately they brought their father in here and anyhow he didn't want to stay I want to go home they went out and said you are staying and left now to me that is cruel."*

Louise is 86-years old, she lived in a villa and also focussed her advice on residents' autonomy. *"Well the first thing ... that comes to my mind is that ... the person needs to make the decision not the family ... the person shifting needs to make the decision ... and not be pushed into it ... I think that's ... pretty important."* She also commented on the loneliness experienced by residents. *"Well I think ... there are quite a lot of unhappy people around but I... I think it's loneliness more than anything really and it's ... I don't think it's so much in the village area ... I think it's in the rest home and the hospital area ... where they are kind of abandoned and ... perhaps it hasn't been their choice to come in here ... don't realise that they've needed care and ... well I don't think we've seen any of that around the village ... around the [villa] areas ... I've seen people who've taken a long time to adapt ... but they get there in the end."*

Insight and Perception

By participating in the interviews, many participants gained a deeper insight into their own experiences. Some shared the insights they had gained through their lives.

Donald at 89-years old lives in his family home. As a result of the earthquake, he now lives with his partner. *"We'd still be in our own homes ... it's a big change and when you've been married there's nothing that replaces your first love ... so to speak ... this is more companionship ... it has its advantages in that ... we have company for each other that's good..."* He also shared his insight about people that he had gained from his teaching career. *"Every person is different ... you have to ... deal with them as you find them and not be hasty in judgments ... and sometimes the biggest rat bags can be underneath the most lovable."*

Harriet's is 89-years old, her insight had guided her decision to come into the resthome. *"Well ... I just think people should know when they've got to unless ... I know a few people that have gone to the children for the rest of their lives ... they've gone from one daughter to another but I couldn't do that ... I know people that have looked after parents and they've just wasted their time ... not waste of time but ... you are better here amongst the same age and you find your mates."*

Myrtle is 82-years old and shared several insights about village life. *"You see someone who walks in here, they're fit and well and next thing you see them on a walker and you think good gracious ... would I cope with that ... I've never discussed it with anyone else so I don't know whether I'm unusual or not ..."*

She was also surprised about some aspects of her adjustment to life in a retirement village. *“I still find it amazing that a shy person like me has managed to fit in here, I think ...reasonably well ... I get on with everyone and... it hasn't been too much of an ordeal to make that change.”*

A number of participants also discussed many of these themes outside the interview, either during the pre-interview, directly after the interview or when the transcript was returned. The interviews were rich in relevant 'voices' coming from many participants which could have been used in each theme. I have endeavoured to give all participants 'a voice' in this section. Due to the numbers in their particular group, some participants have had an opportunity to use their 'voice' on more than one theme. The following chapter considers these findings in the wider context of the population of older people.

Chapter 6

Discussion

The aim of this research was to hear the 'voice' of older people speak about their experience of either; contemplating a time when they may need to move from their family home into a care situation, or choosing to be directed to live in a retirement complex. It was important that the research focus was from an 'emic' perspective – reporting on the concepts and values that older people themselves had stated as critical rather than the 'etic' perspective – reporting on the opinions of what others; possibly - children, health care professionals or retirement complexes felt older people needed or was desirable for them (Hinton, 2010). The selected methodology is Qualitative Description which searches for an increased comprehension of the phenomenon being studied through the insight of the participants (Sullivan-Bolyai et al., 2005).

The 35 participants for this research, on how older people make decisions concerning where they live came from a variety of backgrounds. This provided the researcher with a purposeful sample a requirement of QD (Neergaard et al., 2009; Sandelowski, 2000; Sullivan-Bolyai et al., 2005). In QD, the coding of data is subject to the notion of the researcher according to their elucidation of the information (Sandelowski, 2004). When the interviews were analysed it was resolved to group the participants into three groups according to where they lived. The groups were; Independent – those who lived in their family home, those who held a 'license to occupy' – usually older people in reasonable health living in a villa/townhouse or

serviced apartment/studio, and those residing in resthome or hospital facilities – those who needed specialist care.

These three groups also largely fall into either the 'Third Age' or the 'Fourth Age' (Laslett, 1996). Almost all of those living independently in their own homes, and most of those living in villas and the serviced apartment fit the 'Third Age' classification, which is not necessarily attached to an exact chronological age range. Those in the 'Third Age' are likely to be testing their cognitive capacity by gaining new learning and expanding their expertise rather than being connected to their daily activities of career, edification and recreational activities (Baltes & Smith, 2003). If an individualised person-based definition is used to determine the 'Third Age' and the 'Fourth Age' the onset of the 'Fourth Age' may occur anywhere between the ages of 60 – 90, depending on the limit of each individual's life span (Baltes & Smith, 2003). This age is more dependent on the onset of "terminal decline" (Baltes & Smith, 2003, p. 125) which is connected to the course of the end of life and marked by a demise in cognitive ability and the capability to gain new learning, an increase in frailty or lack of physical functioning, and for many over 90-years old, dementia (Baltes & Smith, 2003). Those in resthome and hospital care facilities were more likely to have failing health including frailty and some loss of cognitive function. Some participants in the other groups, those living in their home and those who had purchased a 'license to occupy' were also entering the 'Fourth Age' because of health issues such as heart failure, Parkinson's Disease, loss of sight and general physical and cognitive decline.

It is essential that a QD researcher ensures they are "staying close to the data" (Neergaard et al., 2009). As each interview was transcribed, common themes began to emerge. Direct quotes were collected to illustrate the themes and maintain the 'voice' of the participants. Prior to the interviews a background literature review

was conducted. Following analysis of the interviews and definition of themes, scholarly articles were explored in order to find literature pertinent to these themes.

Participant numbers were considerably larger than anticipated. It is believed this is due to a desire among older people to have their thoughts and opinions heard and valued, coupled with a craving to be useful and have their expertise recognised.

Shirley (85): *“And now this afternoon I have a lovely afternoon chatting to you”*

The participants had a sense of having made a contribution to something that may make people better informed. Despite some participants leading busy lives or being in very poor health, they deemed it important to have their voice heard and, therefore, put aside time for an interview.

Almost all participants either stated or alluded to a desire to die without suffering in their own home. They saw this as ‘Plan A’. They would prefer not to go into a care facility.

Paul (80): *“I’d like to cark it first.”*

All those who lived on their own in their family homes stated emphatically that this was the option they would choose (if they could) as their means of exiting life. There has been limited research into this area. Rather there is an assumption that older people prefer this option and they frequently state this. Some studies have been carried out with palliative care patients. Seymour, Payne, Chapman and Holloway (2007) acknowledged that while older people initially expressed a desire to die at home. On further investigation it was revealed that if this meant lack of pain

medication, being a burden to family and the bad 'karma' associate with dying at home they preferred to die in a hospice or similar care facility.

'Plan B' - that of moving into a care facility was seen by these participants as a very poor choice and would be executed with reluctance, preferably when their cognitive capacity was unable to comprehend the move. Other participants acknowledged that 'Plan B' was necessary and had given this option some thought. Many had decided that they would know when the time to move from their home into care had come, such as when they became too frail to complete daily tasks of caring for themselves, or when their cognitive function became too compromised for them to be safe. However, they did not believe that making this decision would be easy.

Donald (89): *"If it comes to the stage where I am no longer able to look after myself that would mean going into a home ... but I'd be very reluctant to move into a home to lose my independence."*

It is common that older people are unwilling to contemplate a time when they will need care, often to the point where they refuse to discuss the options (Nolan et al., 1996).

The participants who had moved into the 'license to occupy' premises had moved for a variety of reasons. An event (such as an accident or the earthquakes) could trigger the realisation that they would be safer and more secure in a retirement complex. As well, their own ill health or that of their partner led to a desire for continuing care at increased levels or a wish for the 'well' partner to be settled in with support when the 'failing' partner died. Often it was a combination of these reasons. A variety of studies support this finding (Bekhet, Zauszniewski, & Nakhla, 2009; Gardner, Browning, & Kendig, 2005; Stimson & McCrea, 2004).

Jack (86): *“And then later on my breathlessness got worse and my doctor again said stop all your gardening this was my main interest in life so we had to think ...”*

The participants who needed continuous and specialist care had either selected their village themselves or it had been selected for them by family because they could no longer be supported in their home. Two of these participants had moved from their villa within the complex to a wing offering a greater level of care. Three of this group of six had had to leave their spouse of more than 50 years. The move for five of these participants had been prompted by a desire not to be a burden on loved ones, especially spouses, who, themselves, were no longer young and were unable to continue to care for them at the level required. Heppenstall et al (in press) also recorded the burden of guilt borne by older people requiring care.

Harriet (89): *“I’d had the ileostomy operation and I got a bad leg ... calliper ... it just wasn’t practical.”*

All participants living on their own in their family home had additional support to carry out housekeeping tasks. There were concerns that this may not continue and that a reduction in support may compromise their ability to continue living at home.

Cynthia (90): *“And then you go and do the vacuuming and ... things that you shouldn’t be doing and injure yourself and end up in care.”*

Recent studies have noted the importance of support for older people wishing to remain at home (Heppenstall et al., in press; Jörgensen, 2006).

Those who had moved into a retirement complex had either been proactive in making the decision to move or had resigned themselves, with varying degrees of reluctance, to accepting that this was the best option. Holding a 'license to occupy' gives older people a sense of 'ownership' of their dwelling. But such a purchase had required significant consideration and debate with a variety of people including, among others, family members, lawyers, accountants, and the retirement complex. Often it involved selling an existing property to facilitate the not insubstantial cost of the license. For most participants, several months passed between the time they made the decision to purchase in the retirement village until the time they moved into their new accommodation. During that period, they had sorted out the contents of their home and disposed of many of these items, firstly to family members and then through donation or sale.

George (86): *"I must have spent at least three months up at [family residence] or longer than that probably tidying the place up getting it ready for sale."*

During this time they had also, in most cases, sold their family home. Many also had to wait until their new home at the village was either built or refurbished. There was an understanding among the participants that the time lapse had given them an opportunity to gradually adjust and prepare for their new life. They anticipated the shift with excitement for the new phase in their lives (Nolan et al., 1996). Residents in the hospital or resthome section of the village however had often shifted because they needed 24-hour care and did not want to be a burden to their family (Heppenstall et al., 2012). Despite accepting this was the best pace for them they had been less enthusiastic about their new living arrangements. Most of the

participants in this sector had, at best, only a week or two to find a place and move in. One participant was living at home one day and in hospital care, the next.

Harriet (89): *“I wasn’t going to do it with my daughters because they’ve got their own families and grand children and it means you tie them up with not being able to go away and all that sort of thing I don’t think it’s viable really I don’t think it is fair to them.”*

Several of the ‘license to occupy’ participants had spent time in other complexes while waiting for their new abode to become available. This transition had given them a taste of village life and increased their positive anticipation about moving into their chosen accommodation. All participants had selected, their retirement complex, or it had been selected for them with due consideration to its locality – in or near their existing community or where they desired to live, and accessible for family.

Myrtle (82): *“It was convenient ... for my daughters’ it’s still in the area where I ... used to live so I still go to my same library ... the same shops belong to the same croquet club and still got lots of friends in the area.”*

Many also knew they were in the right place by the atmosphere of the village when they first visited for a viewing. Often they had viewed other complexes but these hadn’t seemed right.

Ralph (85): *“I was made extremely welcome in the lounge area by a number of people ... and when I was shown into this particular unit after two others I just said this is me I’ll take it.”*

There was a definite demarcation in the perception of independence or autonomy among participants. Those who lived in their family home believed they were maintaining their independence by continuing to live there. They were proud that they could care for themselves and carry out the tasks of daily functioning (Birkeland & Natvig, 2009). Many of those living at home perceived there would be a loss of autonomy in a retirement complex (Lee, Woo, & Mackenzie, 2002; Wiles, Leibing, et al., 2012).

Daphane (90): *“I have a large walking frame ... with a basket in it I'm able to go to the shops and do my shopping I can bring home three plastic bags two in the basket and one on the handle.”*

Those who lived in a 'license to occupy' situation, however, believed they had greater independence once they had moved. They felt they could focus on enjoying the remainder of their life while someone else took care of the day-to-day maintenance issues. This was consistent with the findings of Gardner, Browning and Kendig (2005). Previously, these participants had had to wait until one of their children had come around to help, or they had the stress of needing to source, call and pay for a service person. Now, the weekly fee entitled them to this support: there were no hassles.

Sarah (66): *“You have a maintenance man on call so that if the light bulb blows he comes and replaces the bulb because they don't want you up ladders particularly.”*

The resthome and hospital residents gave little indication that they felt they had any independence: they made no mention of it. During interviews with these participants it was noted that staff made a cursory knock on the door and then entered without being invited, there were no menu choices, and two of the four hospital residents mentioned waiting considerable time for staff to answer the call bell for such things as toileting and turning on lights. However, while these participants did not necessarily acknowledge that they had diminished autonomy, they did make decisions about their involvement in daily activities (Rodgers & Neville, 2007). The need for autonomy of individual residents in hospital and resthome facilities often succumbs to the perceived greater needs of institutional routines and customs (Bland, 2007; Rodgers & Neville, 2007).

Being able to make a contribution to society and having a purpose to get out of bed each day is an important aspect of living. As older people age and are less able to maintain doing the things they previously took for granted, they begin to question their purpose for living.

Roy (84): *"... my useful part of life is been and done and ... I really... in a way look forward to sort-of giving it ... finality ... you are ... treading water hopelessly on to inevitability"*.

Other participants had adapted their expectations and were thankful for the tasks they could still accomplish.

Mary (87): *"I'm just so grateful that I can still knit I can still do things"*.

Ruffling-Rahal and Wallace (2000) noted the importance of “caring connectivity” through contribution to a group and the community; that this sense of connection was a vital ingredient for well-being.

Social connectedness is an important factor in maintaining mental wellbeing (Koopman-Boyden & van der Pas, 2009). All of those interviewed maintained social connections through involvement with organisations, social activities, volunteer work or family (Wiles et al., 2009). Those who owned a ‘license to occupy’ had the least effort to make in order to interact with others. They maintained their contacts outside the village while also making new friendships in the village. Gardner et al (2005) , noted that those living in a retirement complex were likely to have increased social network whereas those living in their own home were more likely to have their social network decrease and be more reliant on family for social interactions. Almost all participants who lived in a retirement village, at any of the four levels, mentioned ‘happy hour’ and the fitness classes among myriad other opportunities such as outings, bowls, community events, craft groups, volunteering in the complex shop and so on. These were seen as important opportunities to interact with others and develop friendships (Buys, 2001). A number of the participants stated that while they did not drink alcohol they still attended ‘happy hour’.

Louise (86): *“And then the bar’s open on Thursday night and a Friday night ... and a Saturday night ... I go to the Keep Fit classes twice a week”.*

An important factor to consider when moving to a retirement complex is that of being in relatively close proximity to a social network of friends (Mellor & Edelman, 1988).

A delineation occurred between the various sectors within the retirement villages (Perkins, Ball, Whittington, & Hollingsworth, 2012). Some of this 'segregation' was constructed by the village management. 'License to occupy' residents had facilities and events that those in hospital and resthome care were not privy to.

Marjorie (75): *"The people who are in the apartments ... they wouldn't like us to be in the pool when they were there."*

This delineation between residents included those who, due to health issues, had had to move from a villa or serviced apartment to the resthome and/or hospital facilities within the same complex. Friends and family from within the greater village visited those in the hospital or resthome wing, but this was only reciprocated in certain cases, such as when a spouse visited their partner still living in the former residence. Decisions made by management with regard to 'segregation' based on where in the complex people lived, inhibited some participants from socialising. As well, some residents in the resthome noticed that some of their cohabitants would be better placed in other areas of the village complex.

Jean (84): *"I can name you at least four from round here that should be up there [in dementia wing]."*

Perkins et al (Perkins et al., 2012) noted that among older people there was a fear of being 'contaminated' by the decline in others which they saw as a threat to the identity of the more-able person. While this leads to the establishment of various village sectors, it also, in turn, means some residents are marginalised and stigmatised (Perkins et al., 2012).

The participants who did not live in a retirement village had preconceived ideas about life in a 'home' and the condition of the residents. These were often reinforced when they visited people in these establishments and helped confirm their desire to continue in their own home and, preferably, die there.

Paul (80): *"...a friend of mine ... I went to see her when I was [away] last year it was terrible they were just sitting there gaga ... to me I would rather be dead."*

Gilleard and Higgs, (2010) noted that older people are aware they are balanced on the precipice of the 'Fourth Age' and their trepidation of this prospect is eased if they are able to protect themselves from the confrontation of their future prospects (Perkins et al., 2012). "Shadows in the mirror that those enjoying the Third Age half see and half turn away from." (Gilleard & Higgs, 2010, p.126 & 127).

The shift into a retirement complex invariably involved making decisions about possessions. What items would be shifted into the new accommodation and what items would have to be disposed of. Possessions are important artefacts of life. For older people, they are often seen as an extension of the individual and 'paint a picture' of that person's past. They are also triggers for memories of people, events, places and times (Cram & Paton, 1993; McCracken, 1987).

Myrtle (82): *"... my paintings mean a lot to me ... I just like them because then I remember when I chose them and how I chose them."*

Family members were encouraged to accept possessions an older person could not accommodate in their new home. When family became saturated with

gifted items, what was left was either, donated to a charity organisation, sold, or recycled.

Mildred (87): *“She did a lot of culling and [son] took about three trailers of stuff out to the recycling ... you don’t have to throw stuff away that somebody might get use of.”*

Most participants seemed happier if they believed that someone else was now taking care of their treasures. McCracken (1987) noted that parting with possessions was frequently very difficult. In this research, the majority of participants had few regrets about their decisions they had made with regard to their possessions. A number made reference to the Canterbury earthquakes of 2010/2011 when many of the regions population experienced considerable loss of possessions and homes. Canterbury residents are often heard to say “it’s just stuff.”

William (85): *“The earthquakes got rid of a lot the crystal.”*

Myrtle (82): *“It’s one of these things but funny enough you know if I’d lost my wedding ring prior to the earthquake it would have been a... mammoth thing and I think with all the things that we lost and friends lost in the earthquake all of a sudden you realise that things don’t matter they’re memories...”*

Some retirement complexes allow new residents to bring the pets they already have with them. There is usually a requirement that the pet is introduced and assessed by management to gauge their suitability for living in the complex. If they are deemed acceptable occupants they are sent a welcoming letter inviting them to

join the village. McCracken (1987) discovered that pets are often the hardest possession for an older person to part with.

As people age, particularly as they reach the Fourth Age, they experience changes in their physical and cognitive capabilities. Often they experience the loss of a life-time partner of 40 or more years, and a diminishing number of friends. These changes and losses are not easy for older people to talk about with family members. In many cases the family, too, are grieving the same loss. This, coupled with the perceived (by the researcher) lack of public acknowledgement to residents about death in retirement complexes, makes it very difficult for older people to come to terms with loss and grief. Manthei and Nourse (2012) observed an increase in older people seeking counselling particularly in the areas of anxiety, depression, grief and loss. This programme was offered only in a smaller District Health Board in the North Island.

The importance of family support to older people cannot be under-estimated (Neugarten, 1974; Zahava & Bowling, 2004). Family is frequently involved in searching for a suitable retirement complex, endorsing a decision to move and which complex to move to, and acting as legal and financial advisors. Families also provide the care and support for older relatives which enable them to continue living in their own home. Family visits are eagerly anticipated whether the older person lives at home or in a retirement complex. Almost all participants spoke of their family and the support they gained from them.

Canterbury Earthquakes

The Canterbury earthquakes of 2010/2011 that devastated the city of Christchurch and caused serious damage to a number of townships within Canterbury have significantly affected all residents in the region. Many older people were evacuated from the city due to the destruction of their retirement complexes and care facilities. Others were left feeling vulnerable, lonely and frightened by the force of these events and the devastation they caused. For many residents of Canterbury, including older people, their perceptions about what is valuable and what is not has been changed for ever. Older people, like all other citizens of the area have endured in excess of 13,000 earthquakes; at the same time, they have developed a greater resilience.

Myrtle (82): *“Strange that’s how earthquakes can bring... bring out something in you that wasn’t there before (resilience).”*

Research Limitations

All participants were of European descent. Future studies may consider how to encourage the participation of older people from other ethnic groups predominant in New Zealand, particularly Maori, Polynesian and those from Asia. An exploration of the care of older people from the dominant cultural groups within New Zealand would enable better accommodation options for all New Zealanders.

Most participants in this research either owned their own homes or had owned their own homes prior to moving to a retirement complex. Those with the financial resource of home ownership are more able to make decisions about moving into a retirement complex when they want to. Currently those without the financial

resources must wait until they meet assessment criteria for resthome or hospital care. Future studies may consider other options that allow a greater accommodation choice for this group.

This study was limited to those living in retirement complexes and those maintaining their family home. Only one person lived with a child and this was due to the earthquakes. A wider study incorporating older people living with a family member, and in other housing situations, would better inform agencies and policy-makers of the experiences of older people and their accommodation needs.

This study did not include participants with obvious dementia or other mental health issues. It is important that their 'voices' are also heard.

Future Research

A number of further topics for investigation arose from this research.

Death is the closure to a life: the full-stop or exclamation mark. Investigations into how retirement complexes can celebrate the life of a resident and at the same time support and reduce the anxiety of residents that are threatened by these events would normalise this in a village. It would also enable those close to the deceased resident an opportunity to celebrate and mourn the passing of a friend or loved one.

Change, loss and grief in older people are common. However, there appears to be little support or counselling to enable older people to come to terms with these events. There is acknowledgement that depression and suicide rates among the older population are higher than previously thought. Would counselling of individuals or in small groups be an effective solution to medication or a funeral?

Do personality and previous life experience have a role to play in the decisions older people make when deciding where to live? How can resilience and adaptation skills be increased in those who are placed in care?

How can people in the Fourth Age maintain a feeling of usefulness and purposefulness in their lives? How can their expertise and experience be harvested and handed on so that the older person, giving and the younger person receiving benefit from this exchange?

Transition anxiety is often experienced by residents that feel they have had little input into the decision to move into, particularly, resthome and hospital care. What are the ways that could enable the older person to come to terms with this option or explore alternatives that better meet their and their carer needs?

There is a need for research to be 'emic' and come from the constructs of the older person. Their voice should resonate in the research. Being old and frail does not have to mean a lack of autonomy about accommodation and care.

Conclusion

The purpose of this research was to hear the 'voice' by encouraging the 35 older participants to explore their experience of moving to a retirement complex. As well, those who remained in their own homes expressed their 'voice' about their views on the possibility of not being able to continue caring for themselves there.

Ageing after retirement can be a difficult and an uplifting time. Those in their Third Age generally experience good health, a degree of fitness and mental agility are engaged and learning new skills. During this period, there is now time, energy, and often financial resources, to enjoy and indulge themselves. They are now largely divested of their responsibilities of family and employment; disgracefully aging and spending their children's inheritance, some might say.

Awaiting them is the Fourth Age when frailty, mental and physical decay is starting to take its grasp which can only lead to terminal decay. For many older people the onset of this stage is slow and insidious, creeping, like a thief in the night. Small aspects of daily tasks gradually become harder and then impossible. The ability to learn new skills becomes more difficult and eventually unattainable. Finally, the mind is no longer able to retain the knowledge it once treasured and the once agile body is a gnarled and twisted mass huddled in a bed. Unable to complete the most simple self care routines, the distant past is a current event, hazy shadows crossing the horizon of vision, the volume of life a faint whisper.

The commencement of ageing begins with birth. It is unavoidable. Nature takes us from a state of helplessness and for many who live to the Fourth Age returns us to this state. Becoming an older person is not all doom and gloom. Research during recent decades has seen an improvement in conditions for older

people physically, mentally and in the care offered. There is still some way to go to allow older people the dignity they deserve in this, their final phase of life.

This research aim was to explore the experiences of older people moving from their family homes into a retirement complex by either their own initiation or as a directive of others. Managing a shift of residence, at any age, is an extremely stressful process. When the situation means that the older person has little choice about their need for continuous specialist care it is common for others to select their care facility. The research considered factors that constitute the whole shift process.

Through listening to the 'voice' of older people this research shows that people that have autonomy around the decision making for a shift into a retirement village are more likely to adjust and have a positive experience. However, there are myriad factors that contribute to helping an older person settle into their new living facilities and these must be taken into account. Every older person is an individual and as far as possible their needs are paramount when the time comes that they have chosen to or have to leave their family home.

This research would indicate that for many older people those that decide to make the move into a retirement complex before they are directed, there is likely to be better adjustment and a greater contentment with life. At the same time many of their cohorts are adamant that they will 'age in place'; within their own community and preferably in their own home. The research has gathered together many interconnected facets of how older people experience shifting their accommodation and the concerns that those that remain in their homes have about the impending shift many will be directed to make.

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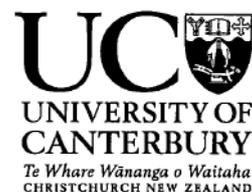
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Appendix 1



HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2012/54

1 June 2012

Robyn Johnston
Health Sciences Centre
UNIVERSITY OF CANTERBURY

Dear Robyn

The Human Ethics Committee advises that your research proposal "Exploring the experience of the elderly as they transition their living accommodation" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 28 May 2012. Further, as discussed, you may use the word "mature" on your advertisement if you include your photograph.

Best wishes for your project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Michael Grimshaw'.

Michael Grimshaw
Chair
University of Canterbury Human Ethics Committee

**Researcher on the elderly
needs your expertise**

ELDERLY RESEARCH

I am a mature student at the University of Canterbury undertaking my thesis for a Master of Health Sciences. I will be researching how older people make decisions about changing their living environment.

I would love to hear about your experience.

I will be individually interviewing some people and talking with others in a group setting. As a participant, your contribution will assist organisations develop procedures that will make this transition easier for others.

If you are interested in being involved in the research please collect an information sheet from reception to find out more about this research as well as my contact details.

I look forward to hearing from you.

Robyn Johnston (Researcher)



Email: robyn.johnston@pg.canterbury.ac.nz

kate.reid@canterbury.ac.nz

dean.sutherland@canterbury.ac.nz

Telephone: 027 2828449 (Robyn Johnston)
03 3667001 ext.3680 (Kate Reid)
03 3667001 ext. 7176 (Dean Sutherland)



Exploring the Experience of Elderly as They Transition Their Living Accommodation

I am a student at the University of Canterbury undertaking my thesis for Master of Health Sciences.

I will be studying the essential items that help elderly people change their living arrangements and feel positive about this change. The project is being carried out in partial fulfilment of the requirements for a Master of Health Sciences

I would like to invite you to encourage your members to participate in this research. Their experience will be invaluable to the research. Being involved would mean either them spending about an hour talking to me individually about their experience or in a small group of other elderly, discussing their experiences. I will be recording the conversations either by video or by voice recorder, as suits the participant. Participation in this study is voluntary. Those that decide to participate will have the right to withdraw from the study at any time, without consequence.

I will be taking particular care to ensure the privacy of all information I gather for this research. I will also take care to ensure that participants are not able to be recognised in publications of the findings. All the information will be securely stored in locked storage at the University of Canterbury for five years following the study. It will then be destroyed. I would ask that your organisation respect, the confidentiality and anonymity of those willing to participate in this study. Your organisation will receive a copy of the report on the study outcomes.

I hope the results of this research will help families and health care professionals to be better informed about the needs of elderly people when they are changing their living arrangements. This will mean that older people are able to adjust to their new environment quicker and with greater success.

If you have any questions about the study, please contact me (details above) or my supervisors Kate Reid, Lecturer in Health Sciences and Dean Sutherland, Senior Lecturer in Health Sciences (details above). Should you have a complaint about the study, complaints may be addressed to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, [Christchurch](http://www.canterbury.ac.nz). Email: human-ethics@canterbury.ac.nz

I would be most grateful if you would display the information included so potential participants can access this if they are interested in participating in the research.

Robyn Johnston

I



Exploring the Experience of Elderly as They Transition Their Living Accommodation

I am a student at the University of Canterbury undertaking my thesis for Master of Health Sciences.

I will be studying the essential items that help elderly people change their living arrangements and feel positive about this change. The project is being carried out in partial fulfilment of the requirements for a Master of Health Sciences

I encourage you to participate in this research if you have recently undergone a move or change in your living arrangements. Your experience will be invaluable to the research. Being involved would mean spending approx. an hour talking to me individually about your experience or in a small group of other elderly, discussing experiences. I will be recording the conversations either by video or by voice recorder, as suits the participant/s. Participation in this study is voluntary. Those that decide to participate will have the right to withdraw from the study at any time, without consequence.

I will be taking particular care to ensure the privacy of all information I gather for this research. I will also take care to ensure that participants are not able to be recognised in publications of the findings. All the information will be securely stored in locked storage at the University of Canterbury for five years following the study. It will then be destroyed.

I hope the results of this research will help families and health care professionals to be better informed about the needs of elderly people when they are changing their living arrangements. This will mean that older people are able to adjust to their new environment quicker and with greater success.

If you have any questions about the study, please contact me on Ph0272828449, email: robyn.johnston@pg.canterbury.ac.nz or my supervisor Kate Reid, Lecturer in Health Sciences Ph 3667001 ext.3680.

Should you have a complaint about the study, complaints may be addressed to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, [Christchurch](http://www.canterbury.ac.nz). Email: human-ethics@canterbury.ac.nz

I would be most grateful of your support.

Robyn Johnston

Email: robyn.johnston@pg.canterbury.ac.nz

kate.reid@canterbury.ac.nz

dean.sutherland@canterbury.ac.nz

Telephone: 027 2828449 (Robyn Johnston)
03 3667001 ext. 3680 (Kate Reid)
03 3667001 ext. 7176 (Dean Sutherland)



Exploring the Experience of Elderly as They Transition Their Living Accommodation

I am a student at the University of Canterbury undertaking my thesis for my Master of Health Sciences.

I will be studying the essential factors that help elderly people change their living arrangements and feel positive about this change. The project is being carried out in partial fulfilment of the requirements for a Master of Health Sciences

I would like to invite you to participate in my research. This would mean spending about an hour talking to me about what it will be like for you when you have to shift from here. I would like to record our conversation either by video or by voice recorder. When I have written up our conversation then I hope you will have time to read over it and talk to me about any changes that you would like made.

Your participation in this study is voluntary. If you decide to participate, you have the right to withdraw from the study at any time without consequence. If you withdraw, I will do my best to remove any information relating to you from my research.

I will take particular care to guarantee the privacy of all information I gather from you for this research. I will also take care of your information to ensure that you are not able to be recognised by others or in publications of the findings. All the information will be securely stored in locked storage at the University of Canterbury for five years following the study. It will then be destroyed.

I hope the results of this research will ensure families and health care professionals are better informed about the needs of elderly people when they are changing their living arrangements. This will mean that older people are able to adjust to their new environment quicker and with greater success.

As a participant you will receive a report on the outcomes of the study.

If you have any questions about the study, please contact me (details above) or my supervisors Kate Reid, Senior Lecturer in Health Sciences and Dean Sutherland, Senior Lecturer in Health Sciences. Should you have a complaint about the study, complaints may be addressed to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch. Email: human-ethics@canterbury.ac.nz

If you agree to participate in this study, could you please contact me on the above phone number or through my email address.

I look forward to meeting with you and thank you in advance for your time and contribution to this research.

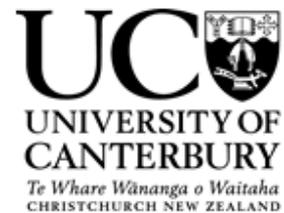
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I will be studying the essential factors that help elderly people change their living arrangements and feel positive about this change. The project is being carried out in partial fulfilment of the requirements for a Master of Health Sciences

I would like to invite you to participate in my research. This would mean spending about an hour talking to me about what it was like for you when you made the shift here. I would like to record our conversation either by video or by voice recorder. When I have written up our conversation then I hope you will have time to read over it and talk to me about any changes that you would like made.

Your participation in this study is voluntary. If you decide to participate, you have the right to withdraw from the study at any time without consequence. If you withdraw, I will do my best to remove any information relating to you from my research.

I will take particular care to guarantee the privacy of all information I gather from you for this research. I will also take care of your information to ensure that you are not able to be recognised by others or in publications of the findings. All the information will be securely stored in locked storage at the University of Canterbury for five years following the study. It will then be destroyed.

I hope the results of this research will ensure families and health care professionals are better informed about the needs of elderly people when they are changing their living arrangements. This will mean that older people are able to adjust to their new environment quicker and with greater success.

As a participant you will receive a report on the outcomes of the study.

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If you agree to participate in this study, could you please contact me on the above phone number or through my email address.

I look forward to meeting with you and thank you in advance for your time and contribution to this research.

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Exploring the Experience of Elderly as They Transition Their Living Accommodation

- I have been given a full explanation of this project and have been given an opportunity to ask questions and have these answered to my satisfaction.
- I understand what will be required of me if I agree to take part in this research (a recorded interview – approximately 1 hour long, reading the transcript of the interview and checking its accuracy as to any comments you have contributed)).
- I understand that my participation is voluntary and that I may withdraw at any stage without penalty.
- I agree to an audiovisual / audio recording of the interview. *(Please circle the preferred)*
- I understand that any information or opinions I provide will be kept confidential to the researcher and that any published or reported results will not identify me.
- I understand that all data collected for this study will be kept in locked and secure facilities at the University of Canterbury and will be destroyed after five years.
- I understand that I will receive a report on the findings of this study. I have provided my contact details below for this.
- I understand that if I require further information I can contact the researcher Robyn Johnston, or her Supervisors Kate Reid and Dean Sutherland (details above). If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee.

By ticking the above boxes and signing below, I am indicating I understand the research and I am agreeing to participate.

Name: _____

Date: _____

Signature: _____

Contact Address: _____

Please return this completed consent form to Robyn Johnston

Email: robyn.johnston@pg.canterbury.ac.nz

kate.reid@canterbury.ac.nz

dean.sutherland@canterbury.ac.nz

Telephone: 027 2828449 (Robyn Johnston)
03 3667001 ext.3680 (Kate Reid)
03 3667001 ext. 7176 (Dean Sutherland)



Exploring the Experience of Elderly as They Transition Their Living Accommodation

Thank-you for participating in this research, I really appreciate you giving up your time to share your experiences with me.

Please remember your participation in this study is voluntary. You are able to decide to withdraw from the study at any time without consequence. If you withdraw, I will do my best to remove any information relating to you from my research.

I will take particular care to ensure the privacy of all information I gathered from you for this research. I will also take care of your information to ensure that you are not able to be recognised by others or in publications of the findings. All the information will be securely stored in locked storage at the University of Canterbury for five years. It will then be destroyed.

I hope the results of this research will ensure families and health care professionals are better informed about the needs of elderly people when they are changing their living arrangements. And as a result, older people will be able to adjust to their new environment quicker and with greater success.

As a participant you will receive a report on the outcomes of the study. Please make sure that you have supplied your address on the consent form so I can send the report to you.

In a few days time, if you feel unsettled following your participation in this research it might be a good idea to talk over your feelings with someone. You can contact the Charity Hospital which provide a free counselling service – 03 3602266, they are situated in Papanui at 349 Harewood Road or you may like to select another organisation that you feel more comfortable with.

Should you have any further questions about the study, please contact me (details above) or my supervisors Kate Reid, Lecturer in Health Sciences and Dean Sutherland, Senior Lecturer in Health Sciences (details above).

Should you have a complaint about the study, complaints may be addressed to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch. Email: human-ethics@canterbury.ac.nz

Thank you in again for your time and contribution to this research.

Robyn Johnston