Holding Momentum:
A Grounded Theory Study of Older Persons Sustaining Living at Home

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Thesis submitted for the degree of Doctor of Philosophy
University of Western Sydney
School of Nursing and Midwifery
2010
Acknowledgements

I would like to thank the following people for their support and encouragement throughout my candidature:

My supervisors, Professor Esther Chang, Dr Jane Cioffi and Associate Professor Virginia Schmied, for their advice, guidance and continued support on the conduct of this thesis.

Staff employed at the seniors’ centre who assisted with recruitment of participants and gave their support for the study.

The 21 men and women who generously gave their time to share their experiences.

My family for their patience and encouragement.

The University of Western Sydney and the School of Nursing and Midwifery for financial support and academic study leave.

Colleagues and friends for their continued interest and encouragement.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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# Table of Contents

Chapter 1 – Introduction to the study ..................................................... 13

1.1 Background to the study ................................................................. 14

1.2 Researcher background ................................................................. 19

1.3 Rationale for the study .................................................................. 21
1.3.1 Independence .............................................................................. 22
1.3.2 Ageing in place ........................................................................... 24
1.3.3 Healthy ageing ........................................................................... 26
1.3.4 Positive ageing .......................................................................... 28
1.3.5 Successful ageing ....................................................................... 28

1.4 Strengths and significance of the study ......................................... 31

1.5 Purpose of the study ..................................................................... 33

1.6 Research questions ....................................................................... 33

1.7 Research objectives ..................................................................... 34

1.8 Thesis structure ........................................................................... 34

Chapter 2 – Perspectives on older Australians living at home .......... 37

2.1 Range of perspectives on ageing.................................................... 37

2.2 Historical perspectives on ageing .................................................. 40
2.2.1 Ageing in the 20th century......................................................... 41
2.2.2 Ageing in the 21st century ........................................................ 43
2.2.3 Summary of historical perspectives on ageing ......................... 44

2.3 Theoretical perspectives of ageing ................................................ 44
2.3.1 Biological perspectives .............................................................. 46
2.3.2 Psychological perspectives ......................................................... 50
2.3.3 Sociological perspectives .......................................................... 54
2.3.4 Gerontology: Social and environmental perspectives ............... 58
2.3.5 Summary of theoretical perspectives of ageing ....................... 64

2.4 Chapter 2 summary .................................................................... 64
Chapter 3 – Older persons in Australia: Characteristics and policy directions

3.1 Older persons in Australian society
3.1.1 Classifying older persons
3.1.2 Older persons and diversity
3.1.3 Health, disability and chronic illness
3.1.4 Family, income and workforce
3.1.5 Health and social services
3.1.6 The community care and residential aged care system
3.1.7 Summary of older persons in Australian society

3.2 Policy perspectives
3.2.1 International perspectives on ageing
3.2.2 National frameworks for ageing
3.2.3 Summary of policy perspectives on ageing

3.3 Chapter 3 summary

Chapter 4 – Research methodology

4.1 Study approach
4.1.1 Origins of grounded theory
4.1.2 Approaches to grounded theory
4.1.3 Rationale for using grounded theory

4.2 Study methods
4.2.1 Study setting
4.2.2 Study sampling
4.2.3 Participant recruitment
4.2.4 Participant profile

4.3 Data collection
4.3.1 Focus group discussion data collection
4.3.2 Focus group formation and composition
4.3.3 Focus group discussion procedure
4.3.4 Individual interview data collection
4.3.5 Individual interview participant selection
4.3.6 Individual interview procedure

4.4 Data analysis
4.4.1 Constant comparison
Chapter 7 – Staying safe

7.1.2 Staying safe ................................................................. 194

7.2 Consequences of not protecting self ........................................ 199

7.3 Chapter 7 summary ............................................................. 201

Chapter 8 – Connecting with others

8.1 Connecting with others .......................................................... 203

8.1.1 Being there for each other .................................................... 205

8.1.2 Positioning self ............................................................... 211

8.2 Consequences of not connecting with others ............................ 218

8.3 Chapter 8 summary ............................................................. 221

Chapter 9 – ‘Holding momentum’: Sustaining living at home

9.1 The central category and process .............................................. 222

9.2 Characteristics of ‘holding momentum’ ...................................... 224

9.2.1 Realising .......................................................... 225

9.2.2 Knowing and persisting ..................................................... 227

9.2.3 Reviewing and making a move ......................................... 239

9.3 The storyline of older persons sustaining living at home ............ 242

9.4 Chapter 9 summary ............................................................. 250

Chapter 10 – Discussion and Conclusion

10.1 Central process: ‘holding momentum: sustaining living at home’ .... 253

10.2 Decision making processes ................................................... 253

10.2.1 Making the decision to stay .............................................. 255

10.2.2 Making the decision to move .......................................... 260

10.2.3 Renegotiating the environment ....................................... 266

10.3 The meaning of one’s own home .......................................... 268

10.3.1 Home as centre of identity ............................................. 269

10.3.2 Home as a sanctuary: familiar and secure ......................... 272

10.3.3 Home means freedom and autonomy ............................... 274

10.3.4 Home as the base for social interaction ......................... 276

10.4 Developing strategies .......................................................... 279

10.4.1 Depending on inner resources ....................................... 279
10.4.2 Maintaining wellbeing ................................................................. 282
10.4.3 Negotiating relationships and services ....................................... 286
10.5 Limitations of the study ................................................................. 293
10.6 Implications for older people, policies and healthcare services .......... 294
10.7 Suggestions for future research ...................................................... 299
10.8 Conclusion .................................................................................... 300

References .......................................................................................... 302

Appendix A Focus group information sheet and consent form ............ 325
Appendix B Interview information sheet and consent form ............... 327
Appendix C Participant personal profile form ..................................... 329
Appendix D Focus group discussion schedule ................................. 331
Appendix E Interview questions ......................................................... 332
Appendix F Participant profile .............................................................. 333
Appendix G Summary of participant biographical data at
commencement of study ................................................................. 335
List of Tables

Table 1  Open coding example ................................................................................... 129
Table 2  Category development example ................................................................ 131
Table 3  Memo example ................................................................................................ 133
Table 4  Major category ‘maintaining autonomy’ and subcategories ..................... 170
Table 5  Major category ‘protecting self’ and subcategories .................................... 186
Table 6  Major category ‘connecting with others’ and subcategories ................. 202
List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Process of data collection and analysis</td>
<td>115</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Model of 'holding momentum'</td>
<td>226</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Cycle of knowing and persisting</td>
<td>228</td>
</tr>
</tbody>
</table>
Chapter 1 – Introduction to the study

One of the current trends in contemporary Australian society is for older persons to stay living in their homes rather than relocating to retirement villages or residential care. Concomitant ageing, individual, family and community changes present challenges which impact on the older person’s capacity to remain at home. With increasing longevity and population ageing, more older persons over the next few decades will have to find ways and implement various strategies to stay living at home. This phenomenon is creating healthcare, social and economic challenges, and has implications for older persons themselves, their families and governments.

The focus of this study is to examine the phenomenon of sustaining living at home in relation to the older person’s everyday living. It seeks to understand how older persons manage to remain living at home by examining the strategies they use. This chapter introduces the thesis, contextualising the study by providing background information derived from a range of literature sources, explaining the need to understand the processes used by older persons themselves. The purpose and objectives of the study, and the research questions the study set out to answer are described. The researcher’s background and assumptions as they relate to the research are also identified. Rationale for the study and its significance are introduced through the examination of relevant empirical evidence. The chapter concludes with an overview of the content addressed in each subsequent chapter.
1.1 Background to the study

Continuing to live at home is arguably one of the most common but significant challenges older persons are faced with as they age. The ability to remain living in a place of choice is vitally important for the older person as it has a major impact on their everyday life. This is largely because older persons spend most of their time inside their home (Gitlin, 2003; Quine & Morrell, 2008). It is not new to suggest that as people age, conditions resulting from the changes accompanying the ageing process, lifestyle choices, and other social and environmental factors present some anticipated but at times unpredictable challenges to everyday living. Living at home assists the older person by providing a familiar environment within which to contend with these challenges on a regular basis.

The context of ageing in relation to policy and practice needs to be understood and examined within the broader global context. As people are living longer, increased ageing has become an international phenomenon (Bowling & Dieppe, 2005). Burgeoning numbers of older persons is occurring in both developed and developing countries, and has been referred to as population ageing (WHO, 2002). According to the World Health Organization (WHO, 2002), although population ageing has progressed gradually in developed countries, it has increased more rapidly in developing countries due to a rapid decline in fertility and advances in technology.

The economic impact on government resources of large numbers of Australians ageing has meant that sustaining older persons in their homes has been placed high on the agenda at all levels of government, influencing the development of health and social policies, and the implementation of services suitable for older persons. Current international and national policies support the older person’s decision to stay at home
and are directed at keeping older persons in their homes for as long as possible with the provision of services for support and care where needed (Australian Institute of Health & Welfare (AIHW), 2006; Cheek et al., 2005a; Commonwealth Department of Health and Ageing (DOHA), 2009). These services are made available to provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). For many older persons, informal assistance and care provided by families, friends and others in the community are complemented through the delivery of services.

The major decisions the older persons face revolve around the option to stay living at home or relocate to alternative accommodation. Demographic and health factors (Ng, Lee, & Chi, 2004), life experiences and economic factors (Faulkner, 2007) and individual and social factors (Faulkner, 2007; Ng et al., 2004) all have a bearing on choice of accommodation. Current alternatives to living at home, such as retirement living or supported care including hostel and nursing home care are limited and strongly influence the decision to stay or relocate. As there are many housing alternatives available, older persons must make the complex decision to stay at home or move out (Miller, 2009).

Despite the availability of these alternatives to living at home, the decision to move into alternative accommodation is not one that has generally been welcomed. Relocation to care accommodation is often associated with stress (Lee, 2001; Nay & O’Donnell, 2008; Stein & Morse, 1994), trauma, loss of autonomy (Lee, 2001), loss of independence (Lee, 2001; Quine & Morrell, 2007) and poorer self-esteem and quality of life (QoL) (Hearle, Prince, & Rees, 2005). Although relocation to a retirement village recognises ageing in a positive way (Clark & McCann, 2003), individually and collectively, the current cohort of older persons in Australia
generally prefers to stay living in their own homes (Cheek et al., 2005a; Nay & O’Donnell, 2008; Taylor, 2008).

Demographic data from the AIHW (2007) show the majority of older persons in Australia make the decision to remain living at home (Buys & Miller, 2007), with 94% in 2006 living in private dwellings (AIHW, 2007). Of these, 58% live with a partner and 29% live alone (AIHW, 2007). Although the number of older persons moving to a retirement village is low, more recently the move to retirement village living has become a more attractive option (Clark & McCann, 2003), with 2.7% relocating to retirement villages (Stimson & McCrea, 2004). It is thought that the next generation of older persons, the postwar or baby boomer generation, will make different choices and the numbers moving to retirement villages may continue to increase (Faulkner, 2007; Kendig & Duckett, 2001).

In contrast, only a small number of older persons live in supported care (Chater, 2002). In 2006, just 6% of persons 65 years and over lived in other accommodation, such as non private dwellings and care accommodation, including residential care, and 26% of persons over the age of 85 years lived in non private dwellings and care accommodation (AIHW, 2007). Cullen (2007) states the percentage of older persons likely to spend some time in a residential care facility is 32.4% of men and 49.9% of women aged 65 and over. Of these, only a short time is spent in aged care, as on average women stay for 3.5 years and men stay for 2.3 years.

The decision to stay living at home is also largely influenced by what home means to people, and the perceived benefits of living there. Home often remains the one stable entity in the lives of the older person when everything else is changing. Policies directed at keeping people in their own homes are based on the belief that home is a
place of meaning to older persons, and to move out of the home is a threat to self-
identity (Davison, Kendig, Stevens, & Merrill, 1993; Kendig & Duckett, 2001) and
wellbeing (Sixsmith & Sixsmith, 2008). Living at home enables the older person to
have purpose as they retain some control over their daily domestic lives in a time of
enormous technological and global change. Additionally, when living in their own
home, the older person can be independent (Sixsmith & Sixsmith, 2008).

Independence assists older persons to maintain wellbeing despite illness and
disability (Kendig, Browning, & Young, 2000). According to Kendig and Duckett
(2001), the sense of autonomy and control gained from living at home has been
shown to assist in the transitions of ageing.

As it is essential to have evidence based policy and practice (Bartlett, Underwood, &
Peach, 2007), staying at home has become a focus in medical, gerontological nursing
and social work research. The Report of the Valencia Forum found priority directions
include promoting health and wellbeing into old age and ensuring enabling and
supportive environments (International Association of Gerontology, 2002). Other
research has a focus on older persons adapting their home environments to enable
them to be supportive and overcome their physical limitations (Kendig & Duckett,
2001). However, as conditions relating to ageing at home are individually
experienced, and the current cohort of older persons encompasses more than 40 years
of collective generational experiences (AIHW, 2007), it has been difficult to address
the phenomenon to sustain living at home, comprehensively and holistically.

In the literature, it is generally recognised that older persons are not a homogenous
group (Green & Watson, 2006), and the health and social needs of individuals and
communities differ. The acknowledgement of the heterogeneity of older persons
creates the need for interdisciplinary perspectives to inform health professionals
Accompanying this shift, there has been a change in the focus of theoretical perspectives on ageing, with less importance on biological models and a more multidisciplinary or interdisciplinary focus on ageing.

Throughout the literature and empirical research, ageing is viewed quite differently now than it was previously. Currently, ageing is regarded more positively, with the emphasis in research on healthy ageing, successful ageing and *ageing in place*. This focus aims to develop an evidence base of identifying factors to maximise independence and self-care, and enhance QoL (Sims, Kerse, Naccarella, & Long, 2000). In Australia, the Federal Government has developed a national approach for positive ageing which includes promoting education for positive attitudes towards the ageing process.

Despite this change in focus, the experience of older persons as they manage to remain in their home has received little attention in the literature. There continues to be a lack of research on how home affects health (Green, Sixsmith, Dahlin-Ivanoff, & Sixsmith, 2005), the “physical and social housing environment” (Sixsmith & Sixsmith, 2008, p. 221) and the processes of daily life (Gitlin, 2003). Bartlett (2003) argues there has been limited research into the current cohort of older person’s attitudes regarding health and aged care, and that more research needs to be done from a gerontological community perspective highlighting the needs of older persons themselves. Furthermore, Heywood, Oldman, and Means (2002) claim there needs to be more research on the experiences of older people living at home.

This study is designed to understand the phenomenon of older people living at home to provide a perspective which can influence policy and practice. Through an interdisciplinary focus, this thesis draws from literature and empirical studies from
many disciplines, including psychology, sociology, medicine, nursing and allied health, and incorporates demographic, historical, cultural, political and economic influences from practitioners, policy makers and service providers to provide support for the grounded theory generated. It examines the phenomenon of sustaining living at home from the perspective of 21 older persons living in Western Sydney, Australia. It does this by exploring what they are experiencing at a personal and community level, and what they understand to be their requirements to remain living at home. Hence, this study aims to add insight into understanding the phenomenon of sustaining living at home, encompassing the meaning of home. Most other studies examine how older persons are supported to age in place. This study from an interdisciplinary perspective examines how older persons navigate and negotiate the process themselves.

As a result of this study, a substantive grounded theory ‘holding momentum: sustaining living at home’ is proposed to explain the process engaged by older persons as they experience changes in their health and community, and respond to them to stay living at home. Recognising and acknowledging all older persons have different experiences, this study explores the process through individual experiences, and collectively describes common strategies used in the experiences of older persons who have chosen to remain in their own homes.

1.2 Researcher background

Professional and personal experiences have shaped my attitudes towards ageing. With regard to professional experience, I have worked for many years as a nurse caring for older persons in nursing homes and at a large veteran affairs teaching hospital. Later in my career, I had many more years of professional experience
teaching gerontology and older adult nursing to undergraduate and postgraduate students at an Australian university.

These professional experiences have influenced and challenged my ideas and assumptions about ageing. Working as a nurse in the hospital and residential aged care, my earlier assumptions were that ageing was a time of change and loss, and that a large number of older persons lived in facilities, cared for by others. Looking back, these assumptions were shaped by the experiences working in facilities where older persons depended on my assistance and care for their everyday living. Working within a model of dependency, I spent time enthusiastically doing things for older persons that they were no longer able to do for themselves. It is highly probable that these assumptions were also influenced by the negative views of ageing in Australia at the time.

More recently, my experiences of learning and teaching about gerontology changed this negative perception of ageing. Through reading the professional literature widely, I became familiar with the evidence base in relation to ageing and developed a more positive attitude to ageing. I recall how surprised I was upon first learning that the majority of older persons live independently in the community. Again, the changing beliefs and attitudes in Australian society had influenced my perceptions of ageing. Through my interpretation of the literature written by others, and the healthy, positive focus on ageing, my enthusiasm again led me to promote an unrealistic view of ageing, one that was overly positive. Perhaps this idealistic view was exacerbated by seeing my own parents and others close to me ageing, necessitating a need to view ageing in a positive light.
There was no single experience that inspired this study. It is through these professional and personal experiences that my interest in older persons living at home with little or no support became the basis for this research. The perspectives with which I entered and maintained throughout the research were that, traditionally, research had been focused on the frail aged, ignoring other older persons who work hard on a daily basis with only minimal access to assistance to stay living at home. Upon starting this study I believed this research could help older persons and their families to have better choices to stay living at home. This research attempts to put aside what is known by others and explore what older persons themselves reveal about staying at home.

1.3 Rationale for the study

There has been a considerable amount of research and literature generated on ageing and different aspects relating to ageing. Whilst this has been explored through many separate concepts, there is a lack of research combining these concepts together to explore the experiences of older persons living at home. The interconnecting concepts of independence, ageing in place, healthy ageing, positive ageing and successful ageing comprise a broad spectrum across various areas and disciplines. When examined together they have relevance to this thesis.

In addition to the various conceptual approaches, there are many empirical studies which inform knowledge of older persons’ experiences of living at home and assist in understanding what is already known about older persons’ experiences of ageing. Examining this information enables the identification of the questions that have not been previously asked and the gaps existing throughout the literature.
Bartlett (2003) suggests there needs to be a greater understanding about ageing attitudes and expectations from the perspectives of older persons. This thesis addresses this gap in the literature and explores and describes these experiences from the perspectives of older persons themselves.

A forerunner to this research, and in an Australian context, a study by Alice Day in the 1980s examined older persons managing at home. This was a landmark study as at the time research tended to focus on residential care and not living at home. Although this is not a recent study, the findings are still relevant today. In her monograph titled *We can manage*, Day (1985) described the focus of the study was to explore family circumstances and what the older persons will do when they can no longer manage at home. Although the study focused on older persons living at home and argued the importance of gender issues and family support, it did not explain how the older persons made use of their personal capacities and resources to sustain the experience of living at home.

To position this study, this section explores some of the major themes in empirical studies, including independence, ageing in place, healthy ageing, positive ageing and successful ageing.

1.3.1 *Independence*

Towards the end of the 20th century, gerontological research focused on independence and ageing. Considerable interest in independence came about in the 1990s in an attempt to change the negative stereotypes and images of ageing and redirect the focus on residential care that existed at the time. This shift led to a strong focus on the more positive aspects of ageing and in particular, the concept of independence.
The various meanings of independence have contributed to the complex interpretations of the term and as a result research exploring independence follows diverse directions. Many studies have concentrated on the social factors impacting on independence, for example social support, disability, culture and ethnicity, community attitudes toward older persons and social inclusion (Centre for Research & Education in Ageing (CREA), 2005). Other studies have concentrated on the environmental factors influencing independent living and social participation, for example environmental adaptation, the built environment, accessibility issues, transport, affordable housing (CREA, 2005) and professional services such as assessment and service use, community care and residential care (CREA, 2005; Newall et al., 2006).

Other dimensions explored within and relating to the concept of independence include quality of life (QoL) and self-care.

**Quality of life (QoL)**

The concept of QoL has engendered an abundance of literature and research into QoL of older persons has gained significance (Tsang, Liampuuttong & Pierson, 2004). Like independence, QoL is a multidimensional concept, one that is not simple to define as it has different meanings for individuals (Courtney, Boldy, & Moyle, 2009). Internationally, it was described by the WHO as a broad concept incorporating “physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features in the environment” (WHO, 2002, p. 13). At a national and local level, QoL is used for measuring an older person’s experience of wellbeing, particularly in relation to health care delivery for chronic illness (Courtney et al., 2009). A broad view is usually referred to as
QoL, another view is that of health-related QoL (HRQoL) (Courtney et al., 2009; Hellström, Persson, & Hallberg, 2004).

QoL is usually associated with policy discourse relating to wellbeing, with a focus on prevention, in particular preventing the need for services. More recently, as prevention relates to preventing negative consequences, there has been a shift from prevention to the more positive notion of promotion of health and wellbeing.

**Self-care**

Other researchers have used self-care to study independence and the experiences of QoL with ageing. With regard to health and functional ability, self-care encompasses health promotion behaviours that older persons undertake to maintain responsibility for their own health (Backman & Hentinen, 1999; Easom, 2003). Self-care is therefore necessary to maintain functional capacity and independence (Easom, 2003). Consequently, there is a considerable amount of research on self-care found throughout nursing, medicine, psychology and sociology literature. However, this research is often fragmented and is mostly quantitative (Backman & Hentinen, 1999).

1.3.2 *Ageing in place*

In addition to independence, another major theme in gerontology research in Australia has focused on older persons ageing in place. Initially, ageing in place related to residential care and led to changes in service provision in residential care, particularly in low level hostel care.

More recently, the desire of many older persons to age at home (Gitlin, 2003; Shotton, 2003; Stimson & McCrea, 2004) and the focus of policy to keep older persons at home (De San Miguel & Lewin, 2008) and receive higher levels of short
or long term care, have redirected the notion of ageing in place. The Commonwealth Department of Health and Ageing (DOHA, 2002, p. 4, as cited in Courtney et al., 2004, p. 19) states, “ageing in place relates to the provision of responsible and flexible care in line with each individual’s changing care needs in a familiar and appropriate environment.” In support of this view, Tanner and Harris (2008, p. 170) describe ageing in place as enabling the older person “to continue living in their preferred home environment for as long as possible.” In this way, the concept encompasses a broader meaning and supports older persons remaining in their home.

Despite an increased use of the term ageing in place, the complexity of this concept prevents it from being well understood. Like the other concepts of independence, QoL and self-care, ageing in place cannot be studied in isolation and is often linked to independence. To date, there is only a very small amount of research exploring the positive and negative effects of ageing in place (Sixsmith & Sixsmith, 2008). Other perspectives on ageing in place include those resulting from research on housing and support at home.

Combining the concepts of self-care and ageing in place with housing, Lubben and Damron-Rodriguez (2003) argue there is a body of research suggesting housing adaptations can enhance self-care and enable older persons to continue to age in place. Gitlin (2003) describes that this research includes studies on home hazards involving those that contribute to health issues and dependence, such as falls. Other studies examine the use of assistive devices to stay living at home (Gitlin, 2003). Researching housing adaptations is important to understand the facilitation of self-care, independence and ageing in place. However, research on housing adaptations has usually been conducted on older persons with impairment, either physical or cognitive (Gitlin, 2003) and addresses only one component facilitating the
experience of living at home. In this way, it ignores other resources older persons require and the strategies fully functioning older persons use in their everyday living to stay living at home.

Support at home
An ageing population has necessitated research into support for older persons to age in place at home. In the early 1980s in Australia, increasing longevity led to a growth in research addressing ageing at home (Pfeffer & Green, 1997; Russell & Kendig, 1999). Early studies, such as the Australian National University Ageing and the Family Project (1980-1986) dispelled myths about older persons’ dependency on others and neglect by their families. Other Australian studies, including the Older People at Home study in 1981 informed policy and highlighted the views that older persons wanted to remain living in their homes and did not want to move into residential care (Russell & Kendig, 1999).

Over the last two decades there has been a considerable amount of research on informal and formal support relating to ageing in place. Ageing in place poses risks for some with regard to services and support (Phillipson, 2004). However, there is only a small amount of research on the perceptions and use of support by older persons themselves (Gallagher & Truglio-Londrigan, 2004).

1.3.3 Healthy ageing
As a consequence of the ageing population, many older persons are living longer but with complex health needs. To minimise the effects of negative health issues, healthy ageing has become an important topic to address for ageing populations (Lee & Fan, 2008; Quine & Morrell, 2007). Ageing in a healthy way results in benefits for individuals and their communities (Nay & O’Donnell, 2008). The promotion of
healthy lifestyle prevents disease and disability, and extends QoL for older persons. In addition, good health reduces the demand for services, and care from the family and community. Furthermore, minimising the effects of health issues will result in financial benefits for Australia (AIHW, 2007).

Healthy ageing is another concept defined in various ways in the literature. Generally, it is referred to as the way older persons actively maintain or restore their health and wellbeing. Wellbeing is related to health but affected by many other factors, such as social interaction, socioeconomic status and environment (Ebersole, Hess, Touhy, & Jett, 2005). Kendig and Duckett (2001) claim maintaining activity and independence supports an attitude of wellbeing even when the individual is experiencing illness and pain. Additionally, healthy ageing is also described as having an appropriate level of health to adapt to the ageing process that is most suitable to the person (Bryant, Beck, & Fairclough, 2000; Lee & Fan, 2008). In this way, healthy ageing is about maximising independence and wellbeing, and encompassing what is required to enable older persons to be active, independent and have good QoL.

Recent empirical research in Australia has focused on healthy ageing, and expectations about care and support at home. The Australian Longitudinal Study on Women’s Health (ALSWH) conducted in 1996, 1999 and 2002, focused on healthy ageing and has provided information about the effects of ageing on QoL including physical, psychological, social and health service use (Byles, Powers, Chojenta, & Warner-Smith, 2006). More recently, improving the health of older persons has been made a national research priority in Australia (AIHW, 2007). An evidence base on healthy ageing will have significance as the population continues to age (Byles, Parkinson, Nair, Watson, & Valentine, 2007).
In researching the evidence base, healthy ageing has been identified as one important area influencing the experience of living at home that has been researched widely. The various components of healthy ageing are considered to constitute one dimension necessary for older people to stay living at home. Another dimension involves the concept of positive ageing.

1.3.4 Positive ageing

The review of the literature reveals current research used to explore the experiences of ageing also has a focus on the concept of positive ageing. Positive ageing is another broad concept, supported by a social model of health focusing on wellbeing rather than on illness (Russell & Kendig, 1999). It encompasses the older person’s attitudes to ageing as well as community attitudes and interactions with older persons (City of Swan, 2004). Furthermore, positive ageing recognises the contributions older persons make to society.

In terms of positive ageing, it is important to note that the majority of older persons live independently at home and provide assistance to their families and community (Nay & O’Donnell, 2008). Tanner and Harris (2008) described research back in the early 1950s in London by Peter Townsend (1963) found older persons living at home were not lonely and led active lives. Despite this finding, rarely did the literature or policy reflect this positive notion of ageing and the dominant discourse on ageing remained negative until the late 20th century.

1.3.5 Successful ageing

In addition to the emphasis on independence, ageing in place, healthy ageing and positive ageing, there is a substantial amount of literature on successful ageing. An increase in literature on successful ageing appears to have been brought about by the
phenomena of increased longevity, the changing expectations of ageing and a greater interest in the promotion of healthy ageing, in particular “how to age ‘successfully’” (Bowling & Dieppe, 2005, p. 1548).

Nilsson, Ekman and Sarvimäki (1998) propose that successful ageing is synonymous with terms including QoL, wellbeing and satisfaction. Alternatively, the current focus on successful ageing is on maximising wellbeing through the promotion of activity and participation in society (Wells, Foreman, & Ryburn, 2009). Ageing successfully defines part of the ageing experience and linking this knowledge to the specific strategies older persons use further explains the experience of ageing at home.

Bowling and Dieppe (2005) argue successful ageing is multidimensional, interdisciplinary and holistic as it is more than health and QoL, and includes the social component. They assert some investigators have attempted to include psychosocial components but attempts at having interdisciplinary models are rare and successful ageing is still studied within single disciplines. Flood (2002) echoes this view and argues researchers have studied successful ageing according to their disciplines which does not account for the multidimensional nature of ageing. She adds successful ageing is found commonly throughout the literature but the term is vague due to its use across many disciplines from various perspectives. Successful ageing appears to be a pre-requisite to age at home and whilst it has implications for being able to age well, it neglects to explain how older persons use this concept to stay living at home.

From a gerontology perspective successful ageing is considered to include many facets, including social and lifestyle factors (Miller, 2009). In contrast, Weaver
(2006) from a psychology perspective proposes that successful ageing needs to be based on finding meaning in life, and having identity and supportive relationships. Berk (2001) argues societal contexts that help older persons to manage life changes promote successful ageing.

A useful understanding of successful ageing is that it is a process of development throughout the life course (Bowling & Dieppe, 2005). This includes the ability to learn from past experiences and to use this knowledge in present situations whilst keeping a “realistic sense of self” (Bowling & Dieppe, 2005, p. 1549). It involves life satisfaction, social participation and functioning, and psychological resources including personal growth (Bowling & Dieppe, 2005). Flood (2002, p. 106) believes a better definition is that by Wong (2000) who defines successful ageing as having “positive meaning and purpose” despite deteriorating health. The strength of this definition is seen in its inclusion of a more complex spectrum including the acknowledgement of changes in health status which may be inevitable. Flood (2002) states three themes in the literature defining successful ageing include desired outcomes, deteriorating physical changes, and purpose in life. Further, she believes successful ageing is a subjective, individualised concept.

The literature demonstrates there have been a number of studies exploring successful ageing in recent times. The concept of successful ageing was also known as ageing well and became popular when it was termed by Rowe and Kahn in 1987 (Macera, 2004). Their model identified successful ageing includes low probability of disease and disability, high cognitive and physical functioning, and engaging actively with life (Bowling & Dieppe, 2005; Hartman-Stein & Potkanowicz, 2003; Macera, 2004; Miller, 2009).
Despite the substantial amount of research on successful ageing, there have been few studies that have explored in-depth the perspectives of older persons. In their research in the UK, Bowling and Dieppe (2005, p. 1549) surveyed perceptions of successful ageing from people aged 50 years and over and found 75% of participants “rated themselves as ageing successfully.” These findings are critically important to understand as they suggest that successful ageing is a subjective concept and consequently this may account for the variation in experiences of sustaining living at home.

1.4 **Strengths and significance of the study**

The study explores the experiences and describes the strategies used by a group of older persons to stay at home. Although the findings are not generalisable, they may be transferable to other similar communities of older persons. One of the strengths of this study is that it is interdisciplinary, combining different perspectives from various disciplines. Studies conducted and interpreted through different perspectives and methodologies have relevance because they reflect the complex nature of experience, however, separately they do not explain the concept (Mittelstrass, 2002). The knowledge inherent in various perspectives throughout contemporary literature assists in confirming the concepts generated. Hence, in developing an understanding of sustaining living at home for the older persons in this study, utilising these different perspectives adds richness to the picture: without different aspects of the literature, the complexity would not be seen.

A further strength of this study is the generation of a substantive grounded theory explaining the older person’s experiences and the strategies they use to stay living at home. As a grounded theory, this theory has explanatory power, it adds to and
reinterprets existing literature and strengthens the evidence that currently exits. The findings from this study can be utilised to have a significant contribution to policy, health service provision, and to the lives of older persons.

This research will contribute knowledge for policy makers to incorporate into policies about ageing. It has the potential to facilitate discussion between older persons and policy makers. More attention should be paid to the knowledge from older persons so they can influence policies and funding for research, in particular, policies relating to community care and service provision. In this way, the lives of older persons living in the community will be enhanced and their needs conducive to living at home in their community will be addressed.

This research has significance for health service providers as it identifies existing gaps in health service provision and could lead to an understanding of a different focus. Through the understanding from the perspective of older persons themselves, this study provides a basis for informing health and aged care service providers how service provision can be improved to meet the needs of older persons living in the community. This information will assist them to help older persons identify appropriate, accessible and affordable resources required, and promote ease of access to these resources.

Furthermore, understanding factors affecting living at home will help health service workers develop strategies to support older persons. Although the research focus is currently turning to the baby boomers who are now beginning to enter what is considered old age with different life experiences, it is important to continue to research the current group of older persons as there are implications for health care practice and services in future decades.
Choice is important for the older person to age positively and many older persons express a preference for living at home. Through exploring what older persons are experiencing on a personal and community level when living at home, and understanding how to remain at home, the findings of this study will provide evidence for seniors groups and organisations representing older persons to argue for services and support to assist older persons to stay living at home.

1.5 Purpose of the study

The background information reveals many older persons wish to remain living in their homes and current policy and service provision supports this decision. However, in the context of ageing, various health and social conditions present older persons with personal and community changes to which they must respond in order to stay living at home. The reasons why older persons want to remain living at home and how they achieve this experience is the focus of this thesis.

The purpose of this study was to explore and describe the experiences of a group of older persons over the age of 65 years who continue to live in their homes. In particular, the focus was to gain an understanding of those experiences of the older persons themselves and explain the processes they use to make it possible for them to sustain their living at home.

1.6 Research questions

To achieve this purpose, the study set out to answer two questions. These were:

1. What are older persons’ experiences of living in their homes?

2. How are older persons able to continue living in their homes?
1.7 **Research objectives**

Guided by the research questions there were four objectives this study set out to achieve. These were to:

1. Explore the experiences of a group of people over the age of 65 years who are independent at a community level

2. Describe what a group of people over the age of 65 years are experiencing as they continue to live at home

3. Determine the actions and strategies used by a group of people over the age of 65 years to stay living at home

4. Develop a substantive theory explaining the process a group of people over the age of 65 years engaged in to remain living at home.

1.8 **Thesis structure**

The thesis comprises 10 chapters. This chapter presents an overview of the background to the study, including the researcher’s background. It includes a review of empirical studies overviewing past and current research relating to this thesis to identify research that has already been done. The chapter includes the purpose of the study, research questions and objectives, and strengths and significance of the study.

To set a context for the study, Chapter 2 provides a review of the literature relating to perspectives on older Australians living at home. In this chapter, the relevant historical and theoretical perspectives of ageing are examined to identify what is known about ageing today.

The empirical literature is presented in Chapter 3. In the section, older persons in Australian society, the demographic characteristics of the current ageing population
and their health and social experiences are described. This section is followed by policy perspectives, describing international and national policies relating to ageing.

The research methodology is described in Chapter 4. The theoretical approach informed by a post-positivist theoretical perspective and guided by grounded theory methodology is explained through the discussion of critical concepts and their applicability to this study. This chapter also describes the research method, outlining the setting, sampling, issues of rigour, ethical considerations and the methods of focus group discussion and individual interviews to collect and analyse data.

The findings of the study are presented in Chapters 5, 6, 7 and 8. The major category, ‘it’s home’ presented in Chapter 5, provides a context for the study, describing the various meanings and benefits of home. The chapter concludes with a description of the entry point into the process to stay living at home.

Chapter 6 presents the analysis of the strategies engaged in by the older persons to stay living at home. This is presented through the discussion of the major category ‘maintaining autonomy,’ describing how the older persons stay in control and remain independent at home.

In Chapter 7, the major category ‘protecting self’ is presented. This chapter describes the strategies the older persons engage in to keep well and stay safe to stay living at home.

Chapter 8 presents the major category ‘connecting with others’ describing the strategies of maintaining support, friendships and assistance to stay living at home.

The grounded theory is presented in Chapter 9 through a description and model of the central category and process ‘holding momentum: sustaining living at home’
and its main characteristics of **realising, knowing and persisting**, and **reviewing and making a move**. This explanation is supported by a storyline explaining the complex process by which older persons respond to change and stay living at home. It includes a discussion of the intervening conditions, facilitating and constraining older persons living at home and a description of the **exit point** from the process.

The thesis concludes in Chapter 10. In this final chapter, the findings as they relate to existing literature are presented through a discussion of the central process **‘holding momentum: sustaining living at home’**, decision making processes, the meaning of ones own home, and the developing strategies used by the participants. Using the literature helps explain and strengthen the findings, and highlights the contribution of the theory. Limitations of the study and implications for older people, policies and healthcare services are also identified along with suggestions for future research.
Chapter 2 – Perspectives on older Australians living at home

Sustaining living at home is a complex experience influenced by various perspectives on ageing. This chapter presents a review of the literature relating to the variety of perspectives explaining the experiences of older persons living at home. It provides a context for developing a critical understanding of what is already known about the everyday experiences of ageing at home. The literature presented in this chapter is approached within an interdisciplinary framework examining society’s perception of ageing and how ageing is understood today through historical and theoretical perspectives.

Increasing numbers of older persons are living longer (AIHW, 2007) and the growing group of older persons is viewed in different ways by different groups. These varying perspectives influence individual and societal responses to ageing at home. As this research aims to understand how older persons experience living at home as they age, this section commences with some of the ways ageing is defined in the literature.

2.1 Range of perspectives on ageing

Ageing is conceptualised in different ways. Ageing is a complex, diverse phenomenon and the complexity of ageing is due to its multidimensional nature (Mittelstrass, 2002). Consequently, ageing is generally defined throughout the
literature using a variety of meanings that reflect the different theoretical perspectives of scholars.

Historically, ageing has been defined biologically utilising a reductionist focus (West & Bergman, 2009). This focus continues to dominate medical literature and some nursing literature. Harris, Nagy and Vardaxis (2010, p. 52) define ageing from this focus as “the process of growing old, resulting in part from a failure of body cells to function normally or to produce new body cells to replace those that are dead or malfunctioning.”

In contrast, from a nursing perspective, Ward (2000, p. 560) suggests ageing is “a natural process” and old age is “a state of mind and does not simply represent the passage of time.” Taking a broader perspective, Heywood et al. (2002, p. 2) contend ageing is much more than a biological process, and suggest definitions of ageing “are well known for being socially and culturally bound.” Alternatively, Crews (1993, p. 281) claims that definitions of ageing focus at two levels; at a “population level… demographically as life span, life expectancy, percent of elders, or as mortality,” or at an individual level as “frailty, vigor, failure to thrive, loss of physiological function, or decreased adaptability.”

There is no single definition that adequately or completely defines ageing. When comparing definitions, no single definition encompasses the concept of ageing across all contexts. Acknowledging these differences and difficulties in defining ageing, it is necessary to gain further understanding from the different perspectives on ageing. Generally, ageing is defined throughout the literature from three main perspectives, including chronological age, functional capacity and life stage (Atchley, 2000).
Chronology has been used for centuries to mark old age. However, it is recognised that chronological ageing is not an accurate measure of ageing (Atchley, 2000; Ebersole, Hess, Touhy, Jett, & Luggen, 2008; Miller, 2009) as it does not explain the individual’s experience of ageing or whether the person feels old (Nilsson et al., 1998; Nilsson, Sarvimäki, & Ekman, 2000). Despite these limitations, chronology is still used in contemporary studies to define ageing, as it is considered to be a convenient, universal objective measure (Miller, 2009; Tanner & Harris, 2008).

Alternatively, other researchers use functionality when referring to ageing. The emergence of gerontology in the 1940s shifted the emphasis from chronological and physical ageing to functional ageing (Miller, 2009). This change in emphasis results from the belief that functional ageing allows for differences amongst individuals, as it is based on the individual’s ability to perform ADLs such as eating and drinking, and IADLs, for example doing the shopping. Currently, gerontologists and geriatricians use the term *functional age* based on the individual’s ability to contribute to society and the idea that there is benefit to themselves and others (Miller, 2009).

In addition to the two perspectives of chronology and functionality, ageing is also defined through the life stage perspective. From this perspective, ageing is viewed through the physical, psychological and social changes affecting a person’s health and QoL (Atchley, 2000). Life stage views ageing as one experience in the continuum of life, and although it has its own meaning, it is built from and builds upon previous life stages. Similarly to the other stages in life, the experience of ageing is different for individuals, as it is shaped by individual and societal perspectives.
Consequently, there are many factors influencing the complex and multidimensional nature of ageing. The literature indicates that the process of ageing and the way a person adjusts and adapts to ageing are influenced by individual, biological, psychological and social factors within the economic and political context in which they live (Tanner & Harris, 2008). These factors are related to historical, environmental and educational influences, and lifestyle choices (Atchley, 2000). In addition, experiences of ageing are further influenced by the time in which older persons live their ageing years (Kendig & Duckett, 2001).

Each of these factors varies amongst individuals and it is recognised that the process of ageing is an extremely complex one. West and Bergman (2009) suggest that to enhance an understanding of ageing, a more integrated approach is required. In the context of this study, ageing is considered from a more positive, integrated focus based on a lifelong foundation within an interdisciplinary perspective. This approach combined with the perspectives of older persons themselves provides a greater understanding of the experiences and processes involved in sustaining living at home.

The following section examines historical perspectives on ageing as these perspectives have contributed to setting the context for the current group of older persons, that is, those over 65 years, to sustain their living at home.

### 2.2 Historical perspectives on ageing

Throughout time there have been popular beliefs about ageing in which it has been both highly valued and held in low esteem (Ebersole et al., 2005). These beliefs have been based on individual lifespan development and what older persons have to offer society. The origins of these perspectives on ageing were derived from ancient
civilisations and their search for immortality (Miller, 2009). Early philosophers and scientists including Aristotle, Hippocrates and Galen related ageing to a decline in heat and fluid in the body (Miller, 2009). Aristotle viewed ageing as a time of disengagement, whereas Galen perceived ageing as a stage of statesmanship and responsibility (Ebersole et al., 2008). These early views created the foundations for modern ideas about ageing in the 20th century.

2.2.1 Ageing in the 20th century
In the first half of the 20th century, improvements in maternal health and reduction in childhood diseases accounted largely for increasing life expectancy in Australia (Bishop, 2000). In addition, improved public health, sanitation and the accessibility of antibiotics have enhanced health (Andrews, 2005). Since the 1960s, further increases in life expectancy have been associated with lower mortality among middle-aged and older persons, particularly from cardiovascular disease (AIHW, 2006) and better technology in medicine (Lucke & Hall, 2006; Shotton, 2003).

These demographic changes, coupled with the introduction of compulsory retirement policies and the development of gerontology, the scientific study of the biological, psychological and sociological phenomena associated with old age and ageing, have changed the way ageing is viewed (Gilleard & Higgs, 1998). With increasing numbers of older persons, the biological focus on ageing was replaced by gerontology’s social focus and from the early 1970s, the economic consequences of an ageing population directed public debate (Gilleard & Higgs, 1998).

As the global population aged, representations of ageing were based on negative stereotypes of decline, loss and dependency, and this led to widespread negative discourse on ageing. Butler (1969) used the term ageism to refer to discriminating
against people on the basis of their age. His work created awareness through research of the attitudes and myths about ageing in society. Further, Sax (1993) believed it was the proliferation of literature based on illness and frailty due to the medicalisation of ageing at the time that perpetuated these negative attitudes. Regrettably, discrimination and negative stereotypes continue to influence the experience of ageing today. Older persons are discriminated against because of their appearance (Nay & O’Donnell, 2008). Ageism is the one form of discrimination every person will experience if they live a long life (Calasanti, 2005).

In the latter part of 20th century older persons were mainly represented in the literature as frail and a burden on society (Leveratt, 1999; Nay & O’Donnell, 2008). This representation continued to be reflected throughout the 1980s and 1990s when the focus of research was on ageing and decline, and the potential burden and challenges to society of a large ageing population (Australian Bureau of Statistics (ABS), 2004b).

Research at the time studied dependent older persons living in residential care or using community services (Russell & Kendig, 1999). Nay and O’Donnell (2008) argue this was aimed at managing costs associated with providing support and service provision for large numbers of older persons. Other research focused on older women as high users of services, and as carers for the frail aged. Unfortunately, frailty is a term still used when referring to older persons (Johannesen, Petersen, & Avlund, 2004) and tends to have negative connotations. Subsequently, ageing continues to be associated with poor health and chronicity (Nay & O’Donnell, 2008).

In contrast to this view, in the late 1990s scholars began to shift their focus to a more positive view of ageing. Major themes in research, policies and practices focused on
independence and interdependence. Other research focused on how to keep older persons out of residential care (Russell & Kendig, 1999) and remain living in the community. This positive focus on ageing in the community has continued into the 21st century.

2.2.2 Ageing in the 21st century
At the turn of the 21st century, the focus on ageing shifted to health status and health promotion, and accumulated evidence about lifestyle changes. Negative perspectives among scholars have changed and although ideas about how to address the increasing ageing population and demand for resources remains a global issue, the focus has moved to the promotion of positive attitudes towards ageing. Throughout the literature, the emphasis is now on positive, active, healthy and successful ageing (Russell & Kendig, 1999).

Society continues to embrace youth and search for ways to retard the ageing process. The emphasis is now on increasing longevity. Current developments in biotechnology focus on slowing physical ageing and include interventions for modifying the cell ageing process and imitating caloric restriction (Lucke & Hall, 2006). Current research on genetics and ageing focuses on single gene mutation to extend longevity (Ebersole et al., 2008; Miller, 2009).

The way ageing is viewed now differs from previous times, and this is influencing the way older persons see themselves and make decisions about where and how they live. A current focus is on the health of people born 1946-1964, commonly referred to as baby boomers (Miller, 2009; Swerissen, 2009). As the baby boomers start to turn 65 in 2011 (Hartman-Stein & Potkanowicz, 2003; McDonald, 1997), the profile of the ageing population will change. It is anticipated narrow negative stereotypes
will reduce as the baby boomers are more ethnically diverse, have less children, higher education, are more health conscious, rely on superannuation, live on their own and live on the urban fringe (Bartlett, 2003; Hugo & Thomas, 2002). As the profile of the older cohort changes, it is anticipated the experiences of living at home will also change.

2.2.3 Summary of historical perspectives on ageing

Historically the way ageing has been represented and researched has undergone major change. Past representations of ageing encompassed a biological focus and were based on illness and decline. In comparison, recent views focus on independence and positive ageing. At the turn of the 21st century, in response to changing societal perspectives, the focus of research and policies has shifted from ageing as a time of dependency and the need for residential care to healthy ageing at home with the provision of services, informal care and community care when required.

These historical perspectives on ageing provide a context for the development of theoretical perspectives of ageing outlined in the following section. Knowledge of these theoretical perspectives contributes to developing a greater understanding of the experience of ageing and the needs of the older person in the context of how they sustain living at home.

2.3 Theoretical perspectives of ageing

Theories of ageing provide another perspective on ageing (Evans Madison, 2000). Specifically, theories of ageing explain change as they focus on what happens to people as they age and why it happens (Ward, 2000). There have been different schools of thought on ageing and each one has had some influence on the current
understandings of ageing. Drawing on this theoretical knowledge assists in identifying factors contributing to the experience of ageing (Miller, 2009) and sustaining living at home.

Ageing is complex and has been viewed from a range of theoretical perspectives described throughout the literature. To date, ageing has been most commonly understood according to individual disciplines and their different knowledge base. Despite the contributions of each theoretical perspective and each discipline, there is no single theory which completely explains the ageing experience (Atchley, 2000; Evans Madison, 2000). However, it is recognised each theory has a place in contributing some understanding of the experience of ageing (Mittelstrass, 2002).

Using a single disciplinary perspective only is a fragmented approach to understanding ageing. When concepts from the different disciplines are brought together they provide a basis for understanding the complexity and diversity associated with what happens to the older person and what influences the experience of ageing successfully (Ebersole et al., 2008; Eliopoulos, 2001). Reviewing these theoretical perspectives provides knowledge for understanding older persons’ experiences and the reasons why they engage in specific processes to stay living at home.

During the last two decades there has been a move to a more integrated approach through an interdisciplinary perspective to understanding ageing. However, research on ageing from either a multidisciplinary, interdisciplinary or transdisciplinary perspective is conceptually incomplete and ageing continues to be researched through specialisations such as geriatrics, bio-gerontology and psychological gerontology (Mittelstrass, 2002).
During the 20th century the complex nature of ageing in gerontology literature has been commonly explained from three perspectives including biological ageing, psychological ageing and sociological ageing (Miller, 2009). Generally, biological perspectives focus on cellular process (Ebersole et al., 2008) and examine “the causes and consequences of the body’s declining capacity to renew itself” (Atchley, 2000, p. 3). In contrast to biological theories, psychological theories focus on changes in human development (Atchley, 2000), cognition (Shin, Kim, & Kim, 2003), perception and personality (Atchley, 2000; Shin et al., 2003). In addition to these theories, sociological theories are oriented around the influence individuals and society have on each other (Atchley, 2000), including social roles and relationships (Evans Madison, 2000; Shin et al., 2003).

These theoretical perspectives, coupled with an applied gerontological perspective, inform this study. Although other theoretical perspectives exist, it is not possible to include all of them in this thesis. The theories that are presented in this section were formulated in a specific context and therefore reflect the views of society at the time. While some of these theories are no longer generally accepted, they have influenced debate and research. Although an interdisciplinary perspective informs this thesis, to gain a better understanding of the contribution of each perspective these theories are discussed separately in this section under biological, psychological, sociological and gerontological perspectives.

2.3.1 Biological perspectives

Biological perspectives on ageing are widely found throughout medical and nursing literature and provide various explanations of the biological and physiological process of ageing. They address why people age differently, providing an explanation of what happens to individuals biologically and physiologically as they
Theorists using a biological perspective focus on the causes of physical decline and reduced functional capacity, looking at the older person’s ability to perform their ADLs. Biological theories explain how biological changes that are genetically programmed, progressive and irreversible, affect physiologic function (Eliopoulos, 2001; Miller, 2009) and why ageing differs amongst individuals (Miller, 2009).

Biological theories have evolved from the examination of cellular, tissue and body system changes throughout the lifespan (Evans Madison, 2000; Grossman & Lange, 2006) and there are two main categories, Stochastic and Nonstochastic theories (Ebersole et al., 2008; Evans Madison, 2000; Grossman & Lange, 2006). Stochastic theories include the Wear and Tear Theory formulated by August Weismann in 1891 (Crews, 1993). This theory proposes that cells are limited in their function to renew themselves (Ebersole et al., 2008; Miller, 2009) and repeated use and disease wear the body out (Ward, 2000). According to this theory, the ageing body is unable to replace damaged neurons, cardiac muscle and brain cells (Grossman & Lange, 2006). The Wear and Tear Theory provides an explanation for diseases such as osteoarthritis affecting the older person’s capacity to remain at home (Miller, 2009).

The other Stochastic theory still widely accepted in the literature, the Free Radical Theory explains how ageing is based on random events and occurs as a result of error at the cellular level (Miller, 2009). This theory proposed by Harman in 1956 postulates that free radicals replace molecules with faulty molecules (Eliopoulos, 2001; Miller, 2009) and cause cellular ageing (Grossman & Lange, 2006). Proponents of this theory believe the formation of free radicals increases with age or that defensive mechanisms decrease with age (Ebersole et al., 2008; Miller, 2009). In an effort to explain this theory and its relationship to ageing, Grossman and Lange
(2006) describe cell damage resulting from the presence of free radicals accelerates the ageing process and causes diseases such as diabetes and arthritis. Atchley (2000) adds free radicals lead to functional decline.

In contrast, Nonstochastic theories including Cross Linkage Theory and Immunity Theory emerged in the 1960s and propose that life expectancy is genetically pre-programmed and genes influence the physiological changes related to ageing (Ebersole et al., 2008). The Cross Linkage Theory developed by Hayflick indicates the inability of the cell to divide causes apoptosis or cell death (Grossman & Lange, 2006; Miller, 2009). Looking at this theory from an ageing perspective, cell death can cause loss of skin elasticity, diseases such as arteriosclerosis (Miller, 2009), and also contribute to functional decline as people age (Atchley, 2000; Evans Madison, 2000).

Alternatively, the Immunity Theory proposes the body’s immune system declines with ageing (Eliopoulos, 2001; Miller, 2009) and there is an increase in autoimmune responses (Ebersole et al., 2008; Miller, 2009). Researchers believe older persons experiencing immune deficiency have greater susceptibility to infection, cancer, autoimmune disease such as arthritis (Atchley, 2000; Miller, 2009) and Alzheimer’s disease (Ebersole et al., 2008; Miller, 2009).

In addition to these theories, new theories such as Neuroendocrine theories are still emerging today. Scholars report Neuroendocrine theories propose ageing to be a result of endocrine gland and brain changes (Eliopoulos, 2001; Miller, 2009), producing neurological and endocrine changes. These changes can lead to increased susceptibility to disease and decreased functional capacity (Atchley, 2000).
Advocates of Neuroendocrine theories believe the increased insulin growth factor associated with these changes increases ageing (Grossman & Lange, 2006).

When considering the influence biological theories have in creating an understanding of the experience of ageing, the literature recognises that due to their scientific focus, biological theories have had a great impact on societal attitudes to ageing in the past (Tanner & Harris, 2008). The significance of biological theories in understanding the experience of ageing is that they provide knowledge of the physiological changes associated with ageing and the different conditions these changes create. This knowledge further assists in understanding the strategies used to manage issues associated with health breakdown, including chronic illness when living at home.

However, critics argue that the dominance of biological theories of ageing is increasingly being balanced by arguments that they do not explain the differences in functional capacity and physiological changes in individuals as they age (Eliopoulos, 2001). Therefore, the use of a biological approach in understanding the ageing experience is inadequate as the focus on functional limitation alone does not include social and environmental factors preventing older persons from living at home.

Weaver (2006) from a psychological perspective and Tanner and Harris (2008) from a social work perspective agree with this criticism and argue that to view ageing only from a biological perspective promotes a negative view of ageing. Gilleard and Higgs (1998) further explain criticisms of biological theories have been brought about by the inability of these theories to explain the relationship of chronological age to physical capacity. Scholars agree it is therefore not sufficient to view ageing from a biological view only as was evident in earlier views (Mittelstrass, 2002). An alternative view is that proposed by psychological perspectives on ageing.
2.3.2 Psychological perspectives

In contrast to biological perspectives, psychological perspectives on ageing provide knowledge about the development of individual attitudes, behaviour and personality (Grossman & Lange, 2006). In particular, these perspectives address variables such as learning, memory, feelings, intelligence and motivation (Evans Madison, 2000). According to the literature, theorists using a psychological framework view ageing as an individual process through addressing behavioural and developmental aspects of ageing (Ebersole et al., 2008). These aspects cover adaptation, adjustment and the individuals’ ability to cope with the transition of ageing, including emotional development (Evans Madison, 2000). Furthermore, this perspective contributes to an understanding of the ageing experience as it proposes the ability to age optimally is influenced by individual attitudes, personality and behaviour.

Throughout the literature a number of psychological theories have been described including human needs, personality development and lifecourse (Miller, 2009). These theories by Maslow, Jung, Erikson, Peck, and Neugarten, Havinghurst and Tobin presented below provide some explanation for the strategies used by older persons to stay at home.

One of the seminal psychological theories addressed throughout the literature is Maslow’s Human Needs Theory. Despite some criticism that needs may not be hierarchical, many scholars have embraced this theory as it focuses on the bio/psycho/social needs of the person (Ebersole et al., 2008). In his theory proposed in 1954, Maslow describes a hierarchy of needs where there are five basic needs motivating human behaviour (Miller, 2009). In this model, needs are categorised from the most basic to the most complex, where lower order needs must be met before higher order needs can be met (Ebersole et al., 2008). When considering the
relationship of this theory to the ageing experience, it is Maslow’s higher order need of self-actualisation that provides some insight into individual capacity to live at home. Ageing is an evolving process (Ebersole et al., 2008) and upon reaching the level of self-actualisation, older persons are believed to possess autonomy, independence, creativity and good interpersonal relationships (Miller, 2009).

In contrast to the Human Needs Theory, other psychological theories relating to personality development are generally based on the work of Carl Jung or Erik Erikson. Although Jung’s theory of individualism (1960) is based on a lifespan approach to personality development and is not exclusive to older age (Grossman & Lange, 2006), it is the last stage of life that relates to an understanding of older person’s experiences of ageing. Jung believes this stage of life is a time for reflection, to cope with choices made throughout life (Donlon, 1999). He postulates older persons search for the meaning of life by reviewing their beliefs and accomplishments and adapting to them (Grossman & Lange, 2006). Successful ageing according to Jung is therefore reliant on the individual’s ability to accept the past, come to terms with their reduced capacity and adjust to their increasing losses in functional ability (Grossman & Lange, 2006; Miller, 2009).

Similarly, one of the most well-known theorists in psychology, Erikson focuses on individual development. In his original Personality Development Theory in 1963, Erikson proposed personality development occurs through Eight stages of life with corresponding life tasks (Erikson, 1963; Wadensten & Carlsson, 2003), progressing from infancy to older age (Barkway, 2009; Weaver, 2006). He postulates the eight stages are predictable and structured by roles, relationships and values (Grossman & Lange, 2006). In this theory, it is Stage Eight: Late Adulthood ego integrity versus despair, the last stage of psychological conflict, which is experienced by the older
person. According to Erikson, integrity is achieved through the older person finding satisfaction with achievements and adaptation to accomplishments and disappointments in life (Erikson, 1963), whereas despair occurs when the older person feels they have made wrong decisions in life and have insufficient time to find satisfaction (Barkway, 2009). The foundation for successful ageing in Erikson’s theory is laid during the first seven stages of life and when the older person achieves ego integrity in the eighth stage of life, they are then prepared for dignified ageing and death (Weaver, 2006).

Other theorists have developed Erikson’s theory and concur that development of the personality determines successful ageing (Berk, 2001). One of the most notable of these theories was proposed by Robert Peck in 1968 when he further developed the eighth stage of Erikson’s theory ego integrity versus despair (Eliopoulos, 2001; Evans Madison, 2000). In his theory, Peck determined older people must resolve three crises or tasks to achieve ego integrity. These three crises include; ego differentiation versus work-role preoccupation where individuals develop valued activities which are separate from their role of a parent or worker, body transcendence versus body preoccupation describing older persons have satisfaction in their social interactions not affected by ageing, and ego transcendence versus ego preoccupation explaining older persons gain satisfaction in contributing to others so that death is not important to them (Evans Madison, 2000; Miller, 2009). This theory has relevance to the experience of ageing as it identifies the need for older persons to have the capacity to manage losses associated with ageing and gain satisfaction through participating in activities and social interaction with others (Berk, 2001).

In addition to these theories another very popular personality development theory described in contemporary literature is the Continuity/Development Theory,
proposed by Neugarten and associates Havinghurst and Tobin in 1968 (Miller, 2009). This theory describes how personality is consistent throughout life and individuals adjust to changes when they are older (Evans Madison, 2000; Grossman & Lange, 2006), suggesting individual coping ability is developed prior to ageing (Miller, 2009). Furthermore, Continuity/Development Theory proposes past influences on satisfaction and past coping strategies recur so that older persons can adjust to ageing. Consequently, individuals who like to be in control of their own decision making when young will want to remain in control when they are older (Donlon, 1999).

One of the criticisms of the Continuity/Development Theory is that it ascribes problems with the ageing experience to an individual’s lack of capacity and does not include the influence of social factors (Tanner & Harris, 2008). However, Eliopoulos (2001) believes there is merit in this theory as it recognises the individual continues to adapt when they are older and this influences their capacity. Further, in support of the Continuity/Development Theory, Weaver (2006) takes the position that this theory views ageing in a positive manner and acknowledges the continuous contribution by older persons to society. Atchley (2000) claims continuity can lead to successful ageing.

Existing literature examining psychological perspectives demonstrates they have an important role to play in terms of understanding individual personality, motivation and the ability to age well today. Psychological theories are useful for dispelling the myths about ageing as they provide information about beliefs of older persons (Evans Madison, 2000). However, as noted with biological perspectives, psychological perspectives are also inadequate in providing all the answers about the
factors affecting individual experiences of ageing and their responses to sustain their living at home.

The knowledge provided by these psychological perspectives combined with the other perspectives presented in the previous sections enables further understanding of the factors influencing the experiences of ageing and the ability of the older person to age successfully at home. Building on this, the following provides an examination of relevant sociological perspectives presented throughout the literature on ageing.

2.3.3 Sociological perspectives

In contrast to biological and psychological perspectives, sociological perspectives on ageing focus on people in relation to their environments. Sociological perspectives specifically address the influences of family, friends, community, culture, education, roles and home on the ageing experience. Theorists using a sociological framework concentrate their attention on the social structure of ageing (Weaver, 2006) as they attempt to explain changes in relationships and roles with an emphasis on adjustment (Evans Madison, 2000). Based on this knowledge, sociological theories endeavour to explain how people achieve healthy ageing through examining the influence society has on older persons and older persons have on society (Miller, 2009). In particular, sociological perspectives are significant when attempting to understand the experience of ageing at home, as the context in which people live is a social phenomenon and creates factors influencing the experiences of older persons living at home.

Sociological theories developed prior to the 1970s focused on adjustment to loss whereas those proposed after this time focused on larger societal issues. The more recent theories focus on the relationships between the individual and their physical,
political and socioeconomic environments (Evans Madison, 2000; Miller, 2009). Structural functionalist perspectives within the sociological perspective relating to ageing perceived society as an equilibrium and that adaptations maintained order (Leveratt, 1999). This perspective has led to the development of the Disengagement Theory and Activity Theory (Victor, 2006).

One of the earliest and most well-known sociological theories on ageing described in the literature is the Disengagement Theory (Cumming & Henry, 1961). This theory originated from a structural functionalist perspective and views ageing as a process whereby the individual and society separate in a reciprocal manner for mutual benefit (Atchley, 2000; Eliopoulos, 2001; Grossman & Lange, 2006). It was believed withdrawal from society facilitated reflection (Grossman & Lange, 2006) and preparation for death, making it possible for society and the individual to function (Weaver, 2006). Proponents of this theory claim disengagement allows a smooth transition of power from older persons to younger persons (Donlon, 1999) and that older persons benefit as they are released from social roles and have more time to focus on themselves.

However, many authors have questioned the relevance of this perspective and suggest it has limitations. Scholars believe not all older persons wish to disengage from society, and society can benefit from the continued engagement of older persons (Ebersole et al., 2008; Eliopoulos, 2001). It is also suggested disengagement marginalises older persons and gives a negative view of ageing (Tanner & Harris, 2008). In addition, others argue that although friendships generally become less with ageing, they usually become stronger (Weaver, 2006), so the nature of engagement is modified.
Social policy in the 20th century was widely influenced by the Disengagement Theory (Donlon, 1999). As a result, compulsory retirement for older persons became an accepted part of the experience of ageing. Compulsory retirement too has been criticised by authors as it marginalises older persons (Tanner & Harris, 2008), and many older persons want to contribute to society past the age of retirement (Donlon, 1999). Others claim Disengagement Theory also influenced models of service provision for older persons and led to segregation of older persons into residential care (Tanner & Harris, 2008). Consequently, Disengagement Theory has had a significant influence on the context of ageing in the past.

In contrast to the Disengagement Theory, Havighurst and Albrecht in 1953 postulated in their Activity Theory that older persons continue their middle-aged activities and do not disengage from society (Tanner & Harris, 2008). Although originally developed earlier than the Disengagement Theory, the Activity Theory was further developed after the Disengagement Theory in an attempt to disprove it (Katz, 2000; Tanner & Harris, 2008). Over time the Activity Theory has proved to be a popular alternative to the Disengagement Theory. The Activity Theory proposes life satisfaction is gained through being active and involved in society and that keeping active enhances successful ageing (Evans Madison, 2000; Grossman & Lange, 2006). In support of the Activity Theory, Eliopoulos (2001) and Katz (2000) point out that it challenges negative stereotypes of ageing and further supports participation of older persons in society.

However, not all scholars support the Activity Theory and some criticise the theory for denying the ageing process, claiming it preserves middle-aged attitudes (Weaver, 2006). Further, some argue an assumption of this theory is that older persons want to continue their middle-aged lifestyle and have resources to enable them to do so.
(Eliopoulos, 2001). Unfortunately, this is not always the case and some older persons may not have the additional resources required to maintain a previous lifestyle.

A more recent sociological theory is the Age Stratification Theory by Riley and colleagues in 1972 (Miller, 2009). This theory “focused more broadly on societal and structural factors” (Evans Madison, 2000, p. 27) and suggests age cohorts share similar experiences, beliefs and expectations. In this way, the Age Stratification Theory adds to an understanding of the experiences of ageing as it places ageing in a historical context with the view that different generations have different experiences through significant events that have shaped their lives. It is proposed these experiences influence the roles and expectations of older persons in society (Grossman & Lange, 2006). In addition, drawing on this work provides a context for understanding the various perceptions of health and wellbeing found amongst current older persons.

Sociological theories therefore, provide a basis for understanding older persons in relation to their environments. Similar to the biological and psychological perspectives presented, sociological perspectives on their own are inadequate in providing a complete understanding of the experience of ageing. However, the strengths of sociological theories can be found in their ability to provide an understanding of the importance of living environments for older persons and ways to assist them to remain living in their homes (Evans Madison, 2000).

As previously mentioned, gerontology brings together the strengths of these theories in an attempt to achieve a more integrated approach to ageing. Bringing these perspectives together under a shared perspective moves gerontology from an explanatory or descriptive perspective to a more interventionist perspective
(Mittelstrass, 2002). The following section provides an overview of gerontological perspectives relevant to the ageing experience at home from the fields of social and environmental gerontology.

2.3.4 *Gerontology: Social and environmental perspectives*

Gerontology is an applied approach to studying ageing and older persons (Miller, 2009). The field of gerontology has been concerned with investigating and explaining the developmental processes of ageing from a multidisciplinary perspective since the 1940s. As a multidisciplinary perspective, gerontology uses the strengths of various perspectives on ageing including biological, psychological, sociological and more recently spiritual perspectives.

Traditionally gerontology has been concerned with studying loss and decline and has been criticised for this approach. In particular, gerontology has been criticised for its preoccupation with illness and disease, and lack of positive features or views (Rowe & Khan, 1998). In addition, although gerontology’s theories and research on ageing have supplied a general understanding of ageing, it has had only some impact on attitudes to ageing (Nilsson et al., 2000). Furthermore, gerontology has been criticised as it addresses only some of the complexity of ageing and does not promote synthesis of the different perspectives, and therefore remains an approach shaped by individual disciplines (Higginbotham, Albrecht, & Connor, 2001). Hence, the emphasis in gerontology on biological and social constructionist views of ageing means there is less written in gerontological academic literature from other disciplines (Kontos, 1999).

In contrast to these criticisms, now that gerontology sits within a multidisciplinary field involving nurses, geriatricians, occupational therapists, psychologists and
sociologists, it may have a different impact in the future (Markson, 2003). In efforts to obtain a more integrated perspective, gerontologists are developing a paradigm to account for individual differences in biological and psychosocial factors influencing ageing (Miller, 2009). Consequently, using an approach of different perspectives, gerontological research is beginning to gain more coherence and acceptance.

Social gerontology
Distinct fields of gerontology have assisted with developing a multidisciplinary focus. Social gerontology is one field of gerontology studying the non-physical aspects of ageing and has researched social aspects of ageing since the 1950s (Atchley, 2000). These aspects include family, friends, social communities, healthcare, economic situations and housing arrangements (Berk, 2001; Wahl, 2006). Research from this perspective including the work of Freund and Baltes in 1998 and Schultz and Heckhausen in 1996 has focused on how older people minimise losses and maximise gains (Berk, 2001).

Theories specifically related to social gerontology include structural functionalist, structural dependency and political economy of ageing, critical gerontology and post modernism. The Structured Dependency Theory developed by Peter Townsend in 1981 (Heywood et al., 2002) arose in response to the structural functionalist theories outlined previously under sociological perspectives. Structured Dependency argues dependency rises from situations of dependency throughout life and reinforced after retirement when older persons are no longer engaged in the workforce due to compulsory retirement and pension policies (Gilleard & Higgs, 1998; Tanner & Harris, 2008). These policies tend to reinforce poverty and a low consumer profile, and therefore increase the constraints of ageing (Gilleard & Higgs, 1998).
Furthermore, they create dependency through residential care that segregates older persons from the rest of the population (Tanner & Harris, 2008). Structured Dependency Theory has been criticised as it views older persons as passive and there is a lack of acknowledgement of individual opposition to conditions creating dependency (Tanner & Harris, 2008).

Alternatively, the political economy of ageing perspective examines how work, income and the impact of class and resources, affect the older person’s experience of ageing. The focus of the political economy perspective is on the structural constraints of ageing and the economic context influencing the ageing experience, including gender, ethnicity and social class, instead of the problems located within the older person themselves (Heywood et al., 2002; Ozanne, 1997). In addition, as the theory relates to involvement in the labour market (Victor, 2006), it views how social policy contributes to dependency (Tanner & Harris, 2008) through retirement and pension policies (Heywood et al., 2002; Victor, 2006). The political economy perspective has been criticised as it does not take into account the heterogeneity of older persons (Victor, 2006), and views older persons as passive (Heywood et al., 2002).

Continuing from the political economy perspective, the perspective of critical gerontology arose in the late 1980s in the USA through the work of Achenbaum in 1978, Moody in 1988 and Minkler in 1996 (Heywood et al., 2002). Critical gerontology focuses on structural inequalities, but also challenges social policy (Heywood et al., 2002). Critical gerontology embraces three perspectives, namely political economy described previously, the phenomenological perspective comprising moral and existential themes, and the biographical approach incorporating the life course (Heywood et al., 2002). To address the limitations of the
political economy perspective in studying ageing, this perspective includes a focus on morals, meanings and purpose in ageing (Heywood et al., 2002).

One of the recent theories, Gerotranscendence, associated with individual spirituality was proposed by Lars Tornstram in 1994. In this theory, Tornstram postulates that as people age they become less interested in “material possessions, meaningless relationships, and self-interests,” and have a desire for significance of life and a connection to others (Eliopoulos, 2001, p. 27). According to this theory, older persons become more selective in their life choices. It is thought older persons shift from a “materialistic metaperspective to a more cosmic and transcendent vision,” including a decrease in self-centredness, fear of death, materialism, and an increase in altruism, solitude, cosmic union, feelings of affinity with the past and a redefining of perception of time, space and objects (Miller, 2009, pp. 42-43).

The theory of Gerotranscendence is at times seen as an addition to the Disengagement Theory. This is largely because midlife characteristics are replaced with spiritual qualities (Miller, 2009). Gerotranscendence is different from other ageing theories in that it claims reality and lifestyle in older age are unlike those of middle-age, and that the process of human development continues into older age. Furthermore, the theory claims that when Gerotranscendence is enhanced, it can result in new perspectives which increase QoL and reduce the implications of ageing (Wadensten & Carlsson, 2003).

The other recent perspective is the Life Course Theory. This theory proposes understanding ageing through the experiences of the life course, including those of the past, present and future. According to this theory, ageing is seen through the meaning of the whole life, and it is believed that the past assists in understanding
present needs (Tanner & Harris, 2008). Proponents of the Life Course Theory argue it provides an explanation for the ways individuals and cohorts adapt to opportunities presented (Ozanne, 1997). The modernised life course largely influenced by the economy, relates to productive middle-age with a path leading to retirement and maintaining social order. Alternatively, the postmodern life course is based on an individual consumption culture brought about by globalisation, privatisation and marketisation of health care (Heywood et al., 2002). Postmodernity offers choice and lifestyle and an extension of middle-age identity in older age (Heywood et al., 2002). Implications of this theory for ageing include that it helps reduce negative stereotypes of ageing (Ozanne, 1997), and that having an understanding of an older person’s past will assist in understanding their current needs, particularly in relation to service provision (Tanner & Harris, 2008).

*Environmental gerontology*

The other field of gerontology used to inform research on ageing at home is defined as environmental gerontology. Environmental gerontology emerged in the 1920s-1930s in response to the failure of gerontology to include the environment as part of the context of ageing (Wahl, 2006). It studies the relationship between the older person and their environment (Miller, 2009; Phillipson, 2004), focusing on psychological perspectives relating to consequences of behaviour (Miller, 2009; Wahl & Weisman, 2003). Since the 1960s, this focus on psychological perspectives has led to the emergence of environmental psychology studying the complexity of the physical, social, cultural and organisational environment, commonly termed the sociophysical environment (Wahl & Weisman, 2003).
The early focus of research on the home environment studied living arrangements, housing standards and wellbeing in relation to characteristics of housing (Gitlin, 2003). The focus of environmental gerontology research now is on “the internal sociophysical environment” of the home and supporting individual competencies at home (Gitlin, 2003, p. 628). However, studies have not explored the relationship between home and psychological wellbeing (Gitlin, 2003; Sixsmith & Sixsmith, 2008). Making the link with the older person and how they stay living at home is relevant to new research directions and to this study in particular.

One of the recent theories of ageing in environmental gerontology used in many research studies is the Person-Environment Fit Theory (Gardner, Browning & Kendig, 2005). This ecological theory proposed by Lawton in 1982, describes how individuals are shaped and influenced by their personal factors (competencies), and these competencies assist them to negotiate with their environment (Lawton, 1985; Miller, 2009). According to this theory, personal competencies commonly referred to as functional capacity (Iwarsson, 2005), change with ageing and affect the person’s ability to interrelate to their environment (Lawton, 1985). Competencies include ego strength, motor skills, biological health and cognitive and sensory-perceptual capacities (Evans Madison, 2000). This theory highlights the role of motivation (Wahl, 2006) and is concerned with adaption, particularly in relation to independence with ADLs (Iwarsson, 2005). It provides a new understanding of how an older person’s competency, when influenced by impairment due to chronic illness, affects their ability to negotiate their environment (Evans Madison, 2000), and their experience of living at home. It relates to housing residency, including composition, satisfaction, standards, home modifications and design, relocation and the local community (Wahl, 2003).
2.3.5 Summary of theoretical perspectives of ageing

In summary, the biological, psychological, sociological and gerontological perspectives on ageing add knowledge to enhance a conceptual understanding for exploring an interdisciplinary perspective of what it means to be an older person today. When combined, the various theoretical perspectives are valuable in providing a context for understanding experiences of ageing at home.

2.4 Chapter 2 summary

These different perspectives on ageing provide the context for understanding and critiquing ageing today. Although there has been much research conducted on these theories from the different perspectives of scholars, there is little research available from an interdisciplinary perspective. The research questions for this thesis focus on the experiences of older persons and how they stay living at home. To address these questions, this chapter examined the literature on the various historical and theoretical perspectives on ageing.

The following chapter provides an empirical review of the evidence relating to the characteristics of older persons and policy directions influencing their living at home. Specifically, the chapter is organised under two categories: older persons in Australian society, examining the demographic, health and social aspects of ageing; and policy perspectives, describing past and current international and national policies on ageing.
Chapter 3 – Older persons in Australia: Characteristics and policy directions

This chapter begins by exploring older persons in Australian society, providing an overview of the current ageing population of Australia and their demographic characteristics, health and social aspects. The demographic literature identifies the current trends in the health and social experiences of older persons and highlights the implications for health service provision and social support.

The second section examines ageing from a policy perspective. It describes international and national policies formulated during the latter part of the 20th century and early 21st century, and their influence on supporting older persons to remain living at home today.

### 3.1 Older persons in Australian society

Researchers concur that over the course of the 20th century, Australia’s aged population became older, more numerous and therefore larger in proportion to the population as a whole (AIHW, 2007). Demographic studies show that Australians currently have one of the highest life expectancies when compared to other countries (AIHW, 2010). Over the course of the 20th century, a man’s life expectancy has improved by approximately 24 years and a woman’s by 24.9 years (AIHW, 2010). When the oldest persons in this study were born between 1901 and 1910, they had a life expectancy at birth of 55.2 years for men and 58.8 years for women. With these
increases in life expectancy, those born in 2006-2008 can now expect to live 79.2 years if male, and 83.7 years if female (AIHW, 2010). In 2005 Australian males participating in this study aged 65 can expect to live a further 18.5 years and females for another 21.6 years. Males and females currently aged 85 years can expect to live a further 6 and 7.1 years respectively (AIHW, 2010). Increasing longevity has meant that older persons may experience living longer in their own homes and will need to respond to the impact of ageing by implementing various strategies to continue to stay living at home.

Accompanying increasing longevity, fertility rates have been falling and they are expected to remain at low levels (AIHW, 2010; Andrews, 2005). However, recent increases have been noted. An effect of the declining birth rate and increasing longevity over the last half of the 20th century has been a rise in the median age of the Australian population (ABS, 2005b; AIHW, 2010).

The postwar baby boom and high levels of immigration after World War II have led to greater numbers of Australians who will turn 65 from 2011 (Organisation for Economic Co-operation and Development (OECD), 2009). By this date, the proportion of the population in OECD countries aged 65 years or over is projected to be 14% (OECD, 2009). By 2051 older persons will make up 26% of the population in Australia (ABS, 2006c). These numbers were 1.1 million people in 1971 (AIHW, 2010) and will increase to 6.3 million by 2036 (AIHW, 2007). Increasing numbers of older persons will pose different demands on health and social services (AIHW, 2010; Swerissen, 2009). These demands for services will influence the availability of services to support living at home, and older persons may need to rely more heavily on their own strategies and resources.
3.1.1 Classifying older persons

There is no single agreement over what is meant by an older person. Internationally, the UN refers to an older person as aged 60 and over, as ageing is often accelerated in developing countries in comparison to developed countries. Alternatively, common to contemporary western societies including Australia, an older person is classified as 65 years and over (AIHW, 2007).

It appears the only foundation for this classification used for the current cohort of older persons in Australia is based on the previous age of retirement set in the early 20th century (Ebersole et al., 2005). However, as compulsory retirement has now been abolished and Australians are living longer (AIHW, 2007), and at 65 years they are healthier than before (AIHW & DOHA, 2002), it is anticipated this classification will change.

In addition to this classification, increased longevity has necessitated the need to categorise older persons further into subcategories (Nilsson et al., 2000). Firmly established in the literature, the most common subcategories include young-old, middle-old, old-old and oldest-old (Miller, 2009). The literature (Ebersole et al., 2008; Eliopoulos, 2001; Hearle et al., 2005) describes persons aged between 65-74 years as young-old, 75-84 years as middle-old and those 85 years and over are classified as old-old. Lueckenotte (2000) and Eliopoulos (2001) add the oldest-old, that is, those persons over the age of 100 years are now termed the elite old. It is this classification and the subsequent categories which are used as markers in this thesis to define older persons.
3.1.2 Older persons and diversity

Despite the convenience of using categories and classifications, it is recognised throughout the literature on ageing that there is great diversity amongst older persons and they are not a homogenous group (AIHW, 2007; Bowling & Dieppe, 2005; Kendig & Duckett, 2001). As the current category of older persons extends across 40 years (ABS, 2006c; AIHW, 2007), it is recognised there are more diverse backgrounds, lifestyles and cultural, religious and social practices than any other age group (AIHW, 2007). It is these characteristics and differences, particularly in gender and ethnicity that impact on the experiences of older persons as they age (Ebersole et al., 2005).

Gender

Gender has particular significance for ageing as the majority of older persons in Australia are women, because women tend to live longer than men (AIHW, 2007). In 2006, women comprised 55% of the population aged over 65 years and 67% of those aged 85 or over (AIHW, 2007). These statistics have implications for women as there are a greater number of older women living alone (ABS, 2006c; AIHW & DOHA, 2002) with less financial security and support. Furthermore, as there are more women living longer, women are the major recipients of aged care (ABS, 2006a; Kendig & Duckett, 2001) and are therefore the ones most likely to be at home.

It is predicted that the number of older men in Australia will increase in the future. This is largely because life expectancy for men in Australia is increasing faster than women (AIHW, 2007), possibly because of increased awareness of health issues. The gender difference amongst older persons is likely to decrease over time, so that by 2041 only 64% of the 85 years and over age group will be women (Bishop, 2000). Consequently, the relevance of a greater number of older men will need to be
understood. More older men living longer may have a different impact on the experience of ageing and require further considerations for living at home.

Culture and Language

Many older persons in Australia are migrants from non-English speaking backgrounds (Access Economics, 2006). In 2006, 35% of people 65 years and over were born overseas (AIHW, 2007). It is believed as a result of post World War II immigration, the number of culturally and linguistically diverse (CALD) older persons will increase in the future (Access Economics, 2006). According to Bartlett (2003), it is projected that in 2026 in Australia, 1 in 4 persons aged 80 years and over will be from a CALD background. Furthermore, it is recognised the different groups of older persons will turn 65 in the same order that they migrated to Australia (Bishop, 2000). As the profiles of these groups change, they will have different needs (Stein, 2004), which will have implications for health and social service use and affect their experiences of living at home.

Various factors including language, communication, education, financial status and the location of migrant communities affect the health and social needs of CALD older persons, particularly when accessing services (Rao, Warburton, & Bartlett, 2006). The inability to communicate, cultural differences and attitudes to ageing especially in terms of support from services can lead to social isolation and impact on the ability of the older person to stay living at home. As the needs of older persons from a CALD background to stay living at home may be more varied (Rao et al., 2006), a variety of policies and services are necessary. Issues arising from language barriers and cultural expectations relate to care and family support, which
are required to assist older persons from a CALD background to maintain their capacity to remain living in their homes (Kendig & Duckett, 2001).

The increase in the numbers of older persons with a CALD background is particularly important. Despite the fact older persons from CALD backgrounds have lower mortality rates (AIHW, 2007, Stein, 2004) and higher self-reported levels of disability (Stein, 2004), they are less likely to move to residential care, and are more likely to remain living at home with a higher use of community services (AIHW, 2007; Stein, 2004). This suggests Community Aged Care Packages (CACPs) need to be culturally sensitive to prevent isolation and enable the older person to stay living at home (AIHW, 2007; Stein, 2004).

It is thought older Australians from a CALD background in future will be concentrated in cities as they tend to age in place near family (Bartlett, 2003). In this way, close proximity to family enables support for older persons to remain living at home. Nevertheless, contrary to their cultural beliefs, generally children of older persons from CALD backgrounds are averse to giving up work to provide care for their families (Bartlett, 2003; Thomas, 1999). These changes to cultural values and low home ownership in some groups (Bartlett, 2003), may create problems for older persons from a CALD background to sustain themselves living at home.

Indigenous Australians
Although no Indigenous Australians participated in this study it is important to note here that only some Aboriginal and Torres Strait Islander persons live to 65 years (Bartlett, 2003; Edwards & Madden, 2001). Indigenous Australians have lower life expectancy of about 10-12 years and a younger population profile than the nation as a whole (AIHW, 2010). Only 2.5% of Aboriginal and Torres Strait Islanders was 65
or over in 2005 (AIHW, 2007), and life expectancy is 67 years for males and 73 years for females born in the years 1996-2001 (AIHW, 2010). Therefore, the current marker of 65 years and over used for older persons in Australia, is not considered appropriate for Indigenous Australians, and Indigenous Australians are defined as an older person at age 50 years (AIHW, 2007; Nay & O’Donnell, 2008).

Indigenous communities are disadvantaged across a wide range of socioeconomic indicators which accounts for poorer health status (AIHW, 2010). There is a higher incidence of chronic illness (Nay & O’Donnell, 2008; Stein, 2004) and higher rates of hospital admission (AIHW, 2010; Stein, 2004) compared with non-Indigenous Australians. Poverty and other social and economic circumstances, such as poor housing, low levels of education and employment, inadequate nutrition and substance misuse underlie the health issues of cardiovascular and respiratory disease, cancer, diabetes and renal failure (AIHW, 2010; Stein, 2004).

There is great cultural and linguistic diversity amongst Indigenous Australians (Stein, 2004). Generally, older Indigenous Australians are female from “a range of intra-cultural backgrounds” (Stein, 2004, p. 91). In terms of service provision and support, there are some culturally specific services available, including housing for older Indigenous Australians, Home and Community Care (HACC) and CACPs, Aboriginal health workers and traditional healers. In 2007, 3.6% of people receiving CACPs were Aboriginal or Torres Strait Islander peoples (AIHW, 2008). Of these, 4% were 50 years or younger, 51% were aged 50-69 years and 49% were aged over 70 years. In comparison, other Australian recipients of these packages were much older (AIHW, 2008). It is recognised that these services need to provide care that is culturally appropriate (AIHW, 2007) and they need to be accessible for Indigenous Australians 20 years prior to their availability for rest of the Australian population.
(Stein, 2004). The aim of these services is to enable older Indigenous Australians to stay living at home in their community (AIHW, 2007; Stein, 2004).

**People 85 years and over**

As the population of Australia is ageing, the older population is also ageing and this presents further considerations for living at home. In the past, the number of persons 85 years and over was small, but this number is increasing and is projected to increase more rapidly in the future than any other age group (AIHW, 2007). In 2006, during the time this study was conducted, the percentage of Australians 85 years or over was 1.6% (AIHW, 2007). This rate is expected to increase to 2% in 2021, rising to 3.8% in 2041. Thus, the number of persons 85 years and older is projected to increase to 1.1 million in 2036 (AIHW, 2007).

It is believed an increase in the number of persons aged over 85 years will have significant economic and health service impacts on Australia (AIHW, 2010). This category of older persons is the most probable group to experience dementia (Access Economics, 2009; AIHW, 2010; Nay & O’Donnell, 2008) and will require additional support to remain living at home. In addition, greater needs for support and services for older persons occur in the last few years of life (Kendig & Duckett, 2001). The requirement for assistance will have implications for older persons over the age of 85 years sustaining their living at home.

**3.1.3 Health, disability and chronic illness**

Increasing life expectancy has impacted on the levels of health and disability of older persons, and these factors influence the experience of living at home. Health is usually viewed as functional ability where the older person has the capacity to do what is important to them. Alternatively, disability is defined as “a limitation,
restriction or impairment, which has lasted, or is likely to last, for at least six months” (ABS, 2006a, p. 5).

Generally, older persons view their health positively and in Australia 77% of older persons are free from disability which requires personal care (AIHW, 2007). Despite the fact many older persons suffer chronic illness, the majority of older persons report they are content with their level of health and QoL (AIHW, 2010; Bowling & Dieppe, 2005). Chronic health conditions can limit personal satisfaction and social participation (AIHW, 2010; McCallum & Geiselhart, 1996). Consequently, there are benefits to individuals and society if older persons are healthy. Older persons with good health have less chronic illness and disability, better QoL, remain independent and reduce the demand for services (AIHW, 2007).

Although it cannot be claimed that older persons are in poor health, generally there is increased frailty and decreased functional decline with the ageing process (ABS, 2006c; Swerissen, 2009). It is understood the risk of co-morbidities, both disease and disability, and the severity of disability increases with age (AIHW, 2010). There is very little difference between the rates of disability amongst males and females, although severity is reported to be higher in females (AIHW, 2010). However, it is important to note that a disability for example, short-sightedness may not be age-related or reduce QoL (AIWH, 2010; Donald, 2005).

As increases in life expectancy continue, the literature is unclear whether the additional years of life will be disability free. One view is that morbidity will be condensed into fewer years at the end of life (Bishop, 2000). Evidence supporting this view from the OECD (1998) shows that severe disability tends to be concentrated in later life, and as life expectancy increases healthy life expectancy
also increases and average life duration with a disability remains the same. This view is further supported by research from the Berlin Ageing study and the US MacArthur study of ageing showing that increased longevity has resulted in less years of disability (Bowling & Dieppe, 2005).

The opposite view is that ill health and disability will be extended over the additional years of life gained (Bishop, 2000). Australian data collected from 1988-2003 supports this view showing an increased life expectancy is spent with disability (AIHW, 2007). Further support for this view is found in the incidence of substitute morbidity, as it is believed improvements in cardiovascular disease correspond to an increase in Alzheimer’s disease (Bishop, 2000). Currently, the main causes of death for older persons in Australia are circulatory and respiratory system disease, and malignant neoplasms (AIHW, 2010; Byles et al., 2007). In contrast, the main causes of disability are nervous system disorders such as dementia, hearing loss, musculoskeletal conditions such as arthritis (AIHW, 2007; Byles et al., 2007) and cardiovascular disease (AIHW, 2007).

Dementia is “a slow, progressive disorder” (Nay & O’Donnell, 2008, p. 231), posing a high burden of care (AIHW, 2010; Andrews, 2005; Bruen, 2005) and an equally high loss of QoL. In Australia, statistics show that 6.5% of people over the age of 65 and 22% of people over 85 years have dementia (AIHW, 2007). Current evidence shows no decline in the rate of dementia and in the next 40 years the rate is expected to increase by 410% (Access Economics, 2009). Implications include that dementia undermines self-care of the older person and is very demanding on carers (Kendig & Duckett, 2001). Furthermore, some health complications highlight the burden of care. Presently families provide 75% of home care for older persons with dementia (Bruen, 2005), and it is thought that high demands on families to provide care at
home will continue in the future (Nolan, Ingram, & Watson, 2002). Due to these implications for care, dementia is a major focus of policy in Australia.

Arthritis is the most common occurring condition in older people, with 48% of older persons suffering disability to some degree (ABS, 2008). It is believed the incidence will continue to increase in the future with the growth in the ageing population (AIHW, 2007). The Survey of Disability, Ageing and Carers (ABS, 2004a), found over 22% of older persons in Australia had a profound or severe limitation and half of those suffered from arthritis to the extent of a profound or severe core activity limitation. The AIHW (2006) believes as these are self-reported statistics they could be an underestimation when illness is in the mild stage, moderate stage or undiagnosed. Disability resulting from arthritis impacts daily on the older person’s experience of living at home.

During the last 10 years, the incidence of circulatory illness has declined and mortality has halved. Age specific stroke has declined by more than 30% (AIHW, 2010). However, it is important to note that a reduction of incidence may have been masked by an increased aged population (Donald, 2005). In addition, smoking has declined steadily (AIHW, 2010) through the 20th century, particularly among persons over the age of 65 years.

In addition to nervous system, cardiovascular and musculoskeletal causes, older persons often have many concurrent health problems contributing to disability (ABS, 2006a; Bishop, 2000). The risk of falls and fractures are increased with co-morbidities such as osteoporosis, Parkinson’s disease and poor eyesight (Bishop, 2000). It is believed the number of fractures is increasing with the number of older persons and this trend is expected to continue. Implications of these musculoskeletal
conditions include a disruption to daily living and an increase in service use (AIHW, 2007).

These causes of disability can greatly influence an older person’s experience of ageing and their ability to remain living at home. Chronic illness, such as arthritis and other musculoskeletal conditions impact on an older person’s capacity to move around in their home. Consequently, the home can influence the way an older person manages their health and disability. Lubben and Damron-Rodriguez (2003, p. 339) define disability as including the characteristics of the person and the “constraints and opportunities presented by the home and community environments in which that person resides.” In support, Heywood et al. (2002) claim the social model of disability sees the house as causing disability. Hence, home environments with stairs or steps can impose further problems for older persons with disability to negotiate and stay living there.

3.1.4 Family, income and workforce

Demographic trends reveal there have been major changes in family and community (ABS, 2005a; Miller, 2009). In particular, changes in family structure and income affect the experiences of those over 65 years living at home. Marital status is one particular change in family structure that has impacted on living conditions. During this study in 2006, 57% of older persons over 65 years were married whereas 65% of those over 85 years were widowed with 80% of these being women (AIHW, 2007). In addition, 58% of all older persons lived with their married or de facto partner and this rate decreased with age as only 26% over the age of 85 years lived with their partner in private dwellings. Furthermore, 29% of all older persons lived alone in private dwellings and this rate increased with age to 39% of those over 85 years (AIHW, 2007).
The ageing of the population has been in line with changes in family structure (Bishop, 2000). Despite recent falling rates of divorce (Barkway, 2009), changes in family structure have been further complicated by higher levels of divorce in the past. The consequences for older persons living at home include changes in the provision of support and the potential for isolation (Bartlett, 2003). Some older persons have families that are supportive and provide informal care whilst other families fail to provide any support or care (Nay & O’Donnell, 2008). By 2011 the main type of family amongst older persons will be couples with no children, and if there is no support system the risk of isolation will increase (Bartlett, 2003). Services supplement family support and therefore those older persons without support will have difficulties remaining at home and will need alternative accommodation (Kendig & Duckett, 2001; Nolan, et al., 2002). These changes in family structure are important to understand as they influence the availability and provision of support provided by families to assist older persons to remain living at home.

Further to family structure, income influences the capacity of older persons to purchase services and have supportive accommodation (Barkway, 2009; Kendig & Duckett, 2001). In Australia, there is great diversity in income amongst older persons. For some people income inequalities increase as they age (Heywood et al., 2002). In particular, women acquire less wealth and retirement provision through their working lives, and therefore have less as they age.

The Age Pension and home ownership provide a minimum standard of wellbeing for older persons in Australia (McCallum & Geiselhart, 1996). Currently, the major source of income for persons over 65 years is the government pension. According to the AIHW (2007) in 2006, 66% of men over 65 years and women over 63 years received the Age Pension. However, a shift in social policy has seen a promotion of
individual responsibility and the push for superannuation. Instead of a reliance on the social security system of tax funded Age Pension, individuals are now encouraged to save to provide their own financial support in retirement (AIHW, 2007; McDonald, 1997).

There is evidence of a relationship between the level of income and health (ABS, 2006b; Barkway, 2009). As per the general population, older persons who have low incomes generally have poorer health and higher levels of disability and chronic illness. Older persons with low incomes often postpone obtaining medical assistance and use less preventive and after care services. At the same time, they have poorer nutrition and housing, and higher rates of hospitalisation (Bishop, 2000). Income therefore has implications for the experience of ageing at home, in particular, the ability to afford food, health care, adequate housing and other services.

Similar to income, changes in workforce patterns affect older persons. In the general population, there has been a decrease in workforce participation of men and a large increase from 19% to 68% between 1961 and 1998 of women (Bishop, 2000). Other trends include an increase in part-time work and the popularity of early retirement.

Currently, older persons are encouraged to remain in the workforce longer and there has been an increase in the workforce for those over 65 years. In 2006, the percentage of people aged 65 years and over employed was 4.4% for women and 13% for men. These rates have increased by 2.7% in the last decade (AIHW, 2007). Retirement has a significant impact on the ageing experience, and as there is no compulsory retirement age in Australia today, it is a more gradual rather than sudden process (AIHW, 2007). The age of eligibility for retirement benefits is currently being increased from 65 years to 67 years.
Many older persons undertake unpaid work, including volunteer and voluntary work, caring for other older persons and grandchildren. In 2003, 113,100 older persons were the primary carers of another person, with the majority caring for a partner at home (AIHW, 2007). Whilst this unpaid work contributes to the economy, unfortunately it is only valued to a small extent (Donald, 2005).

3.1.5 Health and social services

Older people are major users of health services and with increasing numbers of older persons it is anticipated demand for health and social services will increase (Donald, 2005; Kendig & Duckett, 2001; Swerissen, 2009). In Australia, Commonwealth and State Governments fund and provide health services and aged care. A major preventable cause of health breakdown may arise from ignorance of community care services such as home help and home modification. Most older persons live independently and can continue to do so by knowing how to access services when they need them (Bishop, 2000). One service commonly utilised by older persons is the General Practitioner (GP).

Role of the General Practitioner

Many older persons in Australia receive health care from their GP (AIHW, 2007; Bishop, 2000; Wells et al., 2009), and general practice is the entry and navigation point of the health system for most Australians (Cheek et al., 2005a). General practice is funded nationally and Australians have access to GPs through the Commonwealth Medicare Benefits Schedule (MBS) (AIHW, 2007). The use of GP services increases with age and the most common reasons for GP appointments are to get prescriptions, test results or to have a check up (AIHW, 2007).
GPs are now responsible for the implementation of management programs for chronic disease, and education for self-management of chronic conditions, such as diabetes and cardiovascular disease (Taylor, 2008). As the incidence of chronic disease increases with the ageing population and there is a requirement for more support and services (AIHW, 2010), the role of the GP in assisting the older person to stay living at home will continue to be very important. Currently, GPs in Australia are responsible for referral to secondary and tertiary health services. This includes referral of older persons to the Aged Care Assessment Program (ACAP) for assessment to receive community services to remain living at home or for residential care placement. However, it is believed that better coordination between GPs and community care is needed to reduce fragmentation and inconsistency of services, resulting in improved care for older persons (Wells et al., 2009).

3.1.6 The community care and residential aged care system

The World Class Care Discussion Paper (1999) points out that maintaining frail older persons at home is a cost effective measure (Bishop, 2000). To achieve this, the majority of frail older persons receive support from their family, friends and neighbours. To complement this informal support, the community care system provides additional support for older persons to remain at home and assist them and their families with services when required (AIHW, 2008; Bishop, 2000; Cheek et al., 2005a).

Currently, less than 20% of older persons aged 70 years or over receive residential or community care services. Of these, the majority live in their own homes and receive community care provided by Home and Community Care (HACC) and CACPs (Bishop, 2000).
Despite the availability of these services, there is criticism that community care is based on a model of dependency and requires a new focus relating to successful ageing and self-management (Wells et al., 2009).

**Aged Care Assessment Program**

The increasing numbers of older persons living in the community has led to many older persons requiring assistance to remain living at home. In 1987 under the ACAP, multidisciplinary Aged Care Assessment Teams (ACAT) were developed to assess and advise the provision of services and health and social support required for older persons to remain living at home. Prior to the introduction of this program, GPs were responsible for the assessment of frail older persons and determining the services or care required (McCallum & Geiselhart, 1996).

Besides organising support and care at home, multidisciplinary teams made up of health professionals including geriatricians, GPs, nurses, social workers, occupational therapists and physiotherapists also determine relocation to a hostel providing low level care or to a nursing home for high level care. The introduction of the ACAT to assess and approve entry into nursing homes (Kendig & Duckett, 2001) has led to changes in nursing home admissions. Initially, there was a 50% reduction in nursing home admissions (Bruen, 2005), and now as the majority of older persons want to remain at home with support (AIHW, 2008) nursing homes provide high level care only (Bruen, 2005). The ACAP has assisted in keeping older persons out of residential care and supporting them at home with the provision of home and community care (Bruen, 2005; Wells et al., 2009).

However, it is important to recognise that although multidisciplinary health care teams have become common in Western countries (Mellor & Solomon, 1992;
Robinson & Drinkwater, 2000) and have been successful in reducing nursing home entry, there is still variation in assessment and recommendations throughout teams in Australia (Kendig & Duckett, 2001). This inconsistency in referral has implications for the amount and type of community care received by individuals at home. Reforms are needed to employ a new model that has better processes to improve assessments through the use of continual, more holistic assessments, and one that fosters communication and continuity of care across different health contexts (Wells et al., 2009).

Home and community care
The Home and Community Care (HACC) program implemented in 1985 is a joint Commonwealth and States and Territories funded program providing a range of assistance to older persons living in the community (Taylor, 2008). Some of the services provided include home help, personal care, meals on wheels (Chater, 2002; Taylor, 2008; Wells et al., 2009), respite care, home maintenance and modification, transport and community nursing (Taylor, 2008; Wells et al., 2009). Other support services are provided by the Department of Veterans affairs (Bishop, 2000; Taylor, 2008), including Homefront, which assesses the home environment and assists with modifications to prevent falls so that older persons can remain living at home (Bishop, 2000).

More recently, since 1992 CACPs are available for people with complex care so they can stay living at home (AIHW, 2008; Kendig & Duckett, 2001; Taylor, 2008). The introduction of high level care packages, known as Extended Aged Care at Home packages (EACH) in the home in 1998, assist older persons requiring greater support to stay living at home (Taylor, 2008). In recent times, this has led to the introduction
of high level care packages for older persons with dementia, known as Extended Aged Care at Home dementia (EACHd) to stay living at home (AIHW, 2008).

According to the AIHW (2008), 64% of those receiving CACPs are 80 years and over, and of these 71% are women and 55% live alone. As previously mentioned, referral for these services is made through the ACAP. As a major role of the ACAP is to keep people at home with support, it is therefore not surprising that over the last few years, the demand for HACC services has been rising (Wells et al., 2009) with the number of high level care packages increasing rapidly (AIHW, 2008). Despite the provision of high level care packages, some older persons eventually need to relocate to residential care. The AIHW (2008) reports that the most common reason for discontinuing a CACP was to move to residential care, with those receiving an EACHd package more likely to move (AIHW, 2008).

Residential Care
Older persons assessed by the ACAP and unable to continue to live at home currently have two options in residential aged care. These include placement in hostels to receive low level care, and in nursing homes for those requiring high level care.

Government reports reveal the use of residential care increases with age and is higher for women (ABS, 2006a; AIHW, 2007). Currently, only 5% of older persons live in residential care (ABS, 2006a). Of these, only a small percentage move into a nursing home and their length of stay is not long. As they enter with high level dependency requiring high level care (Kendig & Duckett, 2001), the average length of stay for women is 3.5 years and 2.3 years for men (Cullen, 2007). It is therefore not surprising that, as entry into a nursing home brings the older person closer to the end
of meaningful life, generally they try to avoid relocation to a nursing home and prefer to remain at home with high levels of support. Furthermore, memories of poor standards of care and family abandonment in nursing homes in the past, influence older persons to avoid nursing home placement (Kendig & Duckett, 2001; McCallum & Geiselhart, 1996). Although the rates of older persons moving to residential care have been increasing each year over the past 10 years (AIHW, 2008), this increase is more than likely a result of population ageing.

3.1.7 Summary of older persons in Australian society

In summary, this section has provided an overview of the demographic data describing population trends and the health and social characteristics of older persons in Australian society. These data demonstrate increased longevity has led to greater numbers of older persons living in Australia with various health and social needs.

These trends have influenced decisions about past and current policies on ageing as they inform the context in which policies are developed. The following section examines ageing from a policy perspective and describes international and national policies formulated during the latter part of the 20th century and early 21st century, and their influence on supporting older persons to sustain their living at home today.

3.2 Policy perspectives

Policy perspectives provide a context to explain current services available for older persons. History is important to understand current policies (Kendig & Duckett, 2001), and therefore this section of the literature review relating to older persons in Australia provides an overview of the evolution of international and national policies relating to ageing at home since the mid 20th century.
International and national policies have been influenced by demographic change (ABS, 2004b), the implications of population trends and beliefs about ageing (Kendig & Duckett, 2001). Some scholars however, believe policies have been driven more by the changing political philosophies and the economic context than in response to demographic change (Howe & Healy, 2005; Kendig & Duckett, 2001).

In Australian society, despite the fact ageing indicates a healthy society, the consequences of an ageing population have been thought of as a burden. Past policy was constructed by politicians and policy makers largely influenced by the biological perspective with its focus on dependency. In the past, older persons were seen as being dependent on resources and policies addressed the needs of the dependent frail aged, and the impact of this on society’s economic, health and social resources. Consequently, there was particular concern for the health sector to cope with an increasing demand for services from older persons. Overall, ageing was viewed negatively and the voices of older persons were not included in policy formulation.

Policy did not address healthy ageing (Heywood et al., 2002) and government policies were directed towards aged care with a focus on residential care.

In contrast, in the current climate of demographic and political change and attempts to shift negative views on ageing to a more positive approach, policy is directed at promoting independence and avoiding admission to nursing homes through the provision of care and services at home (Heywood et al., 2002; Wells et al., 2009). In addition, government policy relies heavily on families to provide informal support for older persons to remain living at home, as this reduces government expenditure.

Presently, older persons are part of the debate about policy and this is seen through the discourse on healthy ageing. Older persons themselves identify what they require to stay at home and policies should recognise this and address these resources.
3.2.1 International perspectives on ageing

The international response to the global ageing population began in the early 1980s with the introduction of policies from the United Nations (UN) to guide countries in developing their national policies to assist older persons to age successfully. The focus of these policies was to determine how older persons will be cared for, as ageing at the time was viewed as dependence. These UN policies included the International Plan of Action on Ageing titled the Proclamation on Ageing in 1982, the United Nations Principles for Older Persons to internationally create a society for all ages in 1991 and the International Year of Older Persons in 1999 (UN, 1999a).

The UN articulated Principles for Older Persons included independence, participation, care, self-fulfilment and dignity (UN, 1999b). The importance of these principles is found in the conditions they set for ageing, and their impact on QoL and wellbeing through the provision of a framework for the delivery of services and care. In particular, the independence principle and the right for older persons to live in safe environments they can adjust to suit their changing abilities (UN, 1999b), supported policy addressing ageing at home.

Concerned with the financial implications of population ageing, the OECD countries in 1994 agreed policies should be directed at sustaining older persons in their homes for as long as possible and providing care and support required (OECD, 1994). Later in 1998, the OECD enacted Maintaining Prosperity in an Ageing Society 1998 (OECD, 1998). This response to population ageing proposed dividing the responsibility between government, private and voluntary sectors, and individuals (Howe & Healy, 2005). Echoing this concern with population ageing and the implications for less economic growth and decreasing family and community
support, the World Bank since 1994 has pushed population ageing as an issue for developing countries (World Bank, 1994).

Later, in 2002 the WHO policy on active ageing expanded on the five UN International Principles for Older Persons for healthy ageing for all persons regardless of the setting, that is, residential care or in the community (McKenzie, Naccarella, & Thompson, 2007; WHO, 2002), to promote factors to keep people healthy. According to the WHO, active ageing describes “optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002, p. 12). The WHO’s objective is that healthy older persons remain a “resource to their families and communities” (WHO, 2002, p. 9).

Internationally, demographic change has led to continual adjustments in policies and the international response to population ageing has been to address the financial implications of the provision of support and services. This international context has had a large influence on Australian policy perspectives.

3.2.2 National frameworks for ageing
Australia has attempted to translate and implement international policies relating to older persons. As Australia has ties with the UN, the OECD, and the WHO, the framework for Australian policies is set in response to the international context of ageing. As the UN and the WHO policies now promote healthy and active ageing, this positive view of ageing has influenced policies in Australia (ABS, 2004b; McKenzie et al., 2007), and Australian governments have put strategies in place to support these priorities (DOHA, 2000).

The impact of an ageing population and the implications of international policies have brought about continued development and review of policy in Australia. Since
the 1980s policy has focused on the social and economic consequences of population ageing (Andrews, 2005; Howe & Healy, 2005). This has led to Australian governments addressing issues, such as the need for aged care, retirement, workforce, intergenerational issues, the promotion of healthy ageing (Byles et al., 2006), infrastructure and pensions (Andrews, 2005). In addition, changes in political climate at Commonwealth Government level have brought about changes in aged care policy.

These changes have led to government expenditure for older persons in income support through the provision of the aged pension, health care including medical, hospital and pharmaceutical benefits; and the provision of health and social services, such as community care and residential care (AIHW & DOHA, 2002). Further, changes to policy relating to provision of the aged pension have led to the encouragement of older persons to remain longer in the workforce.

The impact of an ageing population, conditions for healthy ageing, and factors which promote increasing functional capacity, independence and QoL have become a focus for current researchers (Sims et al., 2000). Research has shown older persons want to remain living at home, and the Australian government has adapted policies to support older persons to age healthily at home and postpone a move to residential care (ABS, 2004b; Fine & Thomson, 1993; Nay & O’Donnell, 2008). Thus, the focus of this study is to investigate more closely what factors are needed to assist older persons in this endeavour.

**Pre 1980s policy on ageing**

Prior to the early 1980s, Australia lacked specific policy on ageing and national policies relating to work, health and housing focused on young families (Kendig &
Duckett, 2001; Pfeffer & Green, 1997). In the 1950s and 1960s, ageing did not attract major social policy and attention was paid to the baby boom and migration. In addition, political conservatism at the time was not favourable to policies on health or welfare (Kendig & Duckett, 2001).

Policies throughout the late 1960s and 1970s in Australia focused on the provision of care for the frail aged, and the nursing home owned by private providers was the only service providing care. These policies concentrated care in the residential sector and away from the community sector. From 1975 to 1988, policy concentrated on nursing homes (Howe, 1997) and there was some policy development for funding increases in hostels and nursing homes. However, major policy advantaged all individuals as it included the Age Pension, Medibank and public housing (Kendig & Duckett, 2001).

Post 1980s policy on ageing
Since 1980 the development of policy in three areas has created the current system of aged care. Policy was influenced by a change in national government from Labour to Liberal Government in 1996-97; a shift in service provision and funding concerning residential and community care; and continued demographic trends and policy change (Howe & Healy, 2005). These changes have led to three developments in aged care comprising: the introduction of ACAP which has given options for older persons to stay at home with support; the expansion of community care, enabling more older persons to stay living at home; and the introduction of standards, monitoring and reporting to ensure quality in residential care, and more recently in community care (Bruen, 2005).
It is also acknowledged that the influence of the women’s movement throughout the 1980s for women in the workforce and recognition for women as family carers has contributed to policy on aged care and the development of community care. In addition, the voices of older persons through the Combined Pensioners Association (CPA) and the Council on the Ageing (COTA) (Kendig & Duckett, 2001) have further influenced government policy.

National Aged Care Reform Strategy

Between 1982 and 1992, in response to the UN International Plan of Action on ageing, policy attention in Australia was directed to ageing (Pfeffer & Green, 1997) and the focus moved from residential care to community care (Howe & Healy, 2005). These policy changes in services and support were known as the national Aged Care Reform Strategy (1986-1996). The impetus for this change in policy direction was the mistreatment of residents in nursing homes, inappropriate nursing home entry, concerns for residential care expenditure, and the desire of older persons to stay living at home (Pfeffer & Green, 1997). The aims of the reform strategy were to shift the balance in residential care between hostels (low level care) and nursing homes (high level care), and to change the balance of care between residential care and community based care by increasing the independence of older persons living in the community and decreasing admissions into residential care (ABS, 2004b; Howe, 1997; Leveratt, 1999).

These changes led to three changes; 1) the restructuring of nursing homes and hostels which were funded under separate policies (Kendig & Duckett, 2001); 2) the implementation of HACC as an alternative for the expense of nursing home subsidies (Russell & Kendig, 1999), and 3) the provision of support for families unable to
provide total care for older persons to stay living at home (Fine & Thomson, 1993; Kendig & Duckett, 2001). As a result of these changes, the level of dependency for persons entering nursing homes has increased, and less dependent people who would have been admitted to nursing homes in the past are living at home with services, support and care (ABS, 2004b).

Policy on aged care since the 1980s involving moving care from the nursing home to the home has given older persons and their families’ QoL and options through aged care assessment and community care (Bruen, 2005). Through the reform strategy, older people have gained a voice and there is a greater focus on older persons in relation to acute care and housing (Howe, 1997). Despite this, Kendig and Duckett (2001) caution the assumption underlying the policy was that it was preferred by older persons and helped maintain their independence and autonomy. This highlights the need to take individual views and differences into account.

During the 1990s community care moved to providing more complex support as well as maintaining a low level of support (DOHA, 2003). However, the community care system was a complex, fragmented system causing confusion as services were funded and delivered separately. This was largely due to the need to cater for a diverse population, different funding sources and different lines of accountability. In response to the fact older persons prefer to stay at home (Kendig & Duckett, 2001) and in an attempt to achieve a more integrated system, the consultation paper A New Strategy for Community Care, proposed a number of reforms including the 1992 implementation of CACPs and in 1998 the EACH package (DOHA, 2003). These reforms further replaced residential care by providing high level care in the home (Kendig & Duckett, 2001). However, it is recognised this system of support relies heavily on informal carers who are usually family and female (AIHW, 2007).
Response to these reforms has led to the provision of carers respite and financial support for carers (Bruen, 2005; Leveratt, 1999).

In 1998, the Commonwealth Government implemented the *Staying at Home-Care and Support for Older Australians* package to provide support for community care for older persons with dementia and their carers (Kendig & Duckett, 2001). These high level care packages were designed to provide support to enable frail older persons to stay living at home. According to COTA (2002), these were significant policy initiatives for those with dementia and their carers.

*A New Strategy for Community Care, The Way Forward* (DOHA, 2004), a reform process for community services further highlighted the complexity and duplication within community care (Taylor, 2008). Managing payment for community care will be the topic for future debate as demand for community care will increase as more older persons will want to stay living in their homes (Bruen, 2005). Providing care at home will also require more support for carers and better housing in the future. A focus on the environment needs and other structural factors preventing older persons from living at home may be better than only assessing the functional limitations of older persons.

*The Aged Care Act*

Australia’s *Aged Care Structural Reform Package* introduced in 1997 with its agenda on ageing in place has led to major reforms and change in the delivery of residential aged care services (Chandler, 2007; DOHA, 2002a). This attention to policy for care of older persons in nursing homes came about due to allegations of low standards of care and incidents of abuse (Shotton, 2003). The *Aged Care Act* in 1997 was a set of laws and mechanisms designed to protect frail older persons in Australia, and

The restructuring of residential care aimed to have further integration of nursing homes and hostels, and included the implementation of a common funding instrument, accommodation bonds and an accreditation system (Howe & Healy, 2005; Kendig & Duckett, 2001). However, this system has been criticised for its high administrative requirement and has removed the time staff spend on care away from the residents (Kendig & Duckett, 2001). The ageing in place policy influenced the delivery of residential care services and assisted in keeping the older person in their place of residence with services delivered to them.

A review of this reform was conducted in 2004, with some policy responses in 2007. A major outcome from the review was a new funding instrument for residential care which does not require the high administrative record-keeping mentioned previously (Hogan, 2007). Other outcomes included a greater commitment to community care rather than residential care, and an increase in aged care places for community care. However, Hogan (2007) claims this commitment will place greater demands for residential respite care due to the number of older persons living in the community with dementia.

National Strategy on Ageing

The Australian Commonwealth Government’s key policy response to the 1999 International Year of Older Persons (IYOP) was the development of the National Strategy for an Ageing Australia in 1998 (Kendig & Duckett, 2001). The National Strategy focused on the personal and economic benefits of having healthy older persons living in the community (Byles et al., 2006). It values independence and self-
provision, and involved putting policies into place that encourage older persons to participate and contribute to society.

Major elements in the National Strategy for an Ageing Australia include self-provision, cost-effectiveness, and support for housing choices (Gardner et al., 2005). These elements are considered under four themes; Healthy Ageing with the focus to extend health gains through health prevention and promotion to maintain function and enhance QoL, Independence and Self Provision involving workforce participation and income support, World Class Care delivered through aged and health care systems, and Attitude, Lifestyle and Community Support including community attitudes, safety, housing, transport and recreation (DOHA, 2002b).

The National Strategy for an Ageing Australia recognised population ageing and provided a framework for the development of new policies and programmes (Bartlett, 2003; DOHA, 2002b). However, to sustain older persons in their homes with community services, housing that provides a safe standard of living is required (Kendig & Duckett, 2001; McNelis, 2007). One of the criticisms of the National Strategy for an Ageing Australia is that it fails to provide an approach to older persons and housing (McNelis, 2007).

Current policy focus
Key policy themes for the last decade have been set around independence and ageing in place. Policy has focused on supporting healthy ageing through services and reducing the impact of chronic disease (McKenzie et al., 2007). According to Bartlett (2003), policy addressing the various issues of population ageing has been emphasised in national papers including *The Intergenerational Report* in 2002 and a
report by the *Prime Minister’s Science, Engineering and Innovation Council* in 2003 promoting healthy ageing in Australia.

Australia’s aged care system continues to be structured under two forms of delivery of care, residential care and community care. The Australian government subsidises both residential aged care places and community care packages (Wells et al., 2009). The community care system has provided flexible packages for older persons, Carer Payment (asset/income tested) and Carer Allowance (Kendig & Duckett, 2001). In particular, dementia has become a main focus of policy due to the demand for care and the expectation of an increase in incidence (Andrews, 2005).

The sharing of responsibility between the Commonwealth and States in Australia has created complexity and barriers to providing care. In addition, a lack of funding means providers do not attract good, skilled practitioners. The current system has problems with insufficient places for residential care and there are long waiting lists for community services (Wells et al., 2009). This has resulted in low level residential care becoming the highest provider of care to high level residents. The policy of ageing in place creates a greater strain on the system as there are more levels of care and cost, and legislation for the provision of care (Chandler, 2007). Although community care has reduced the numbers of older persons entering residential care, at the same time it has placed more of the onus of care on families to provide informal care (Kendig & Duckett, 2001). Attention to these issues relating to care in the community and housing will be necessary in future policy if older persons are to remain living at home.

Recently, a *National Primary Health Care* strategy, emphasising a national approach to aged care from home care to nursing home care, has been instigated by the
Australian government. Its agenda is to provide a model of integrated primary
community care and collaborative support for future health care service delivery to
accommodate the rapidly increasing baby boomer generation (DOHA, 2010).

*Future policy focus*
There are many issues associated with population ageing in Australia, and the
involvement of older persons and the wider community is necessary to inform future
policy on ageing. Future policy should focus on disease prevention and health
promotion and the promotion of successful ageing in middle-age (Bowling &
Dieppe, 2005).

Past policies relating to work and income are inappropriate and new models in
retirement, leisure and aged care are now required. With policies directed at older
persons remaining in the workforce and living at home, services that are more
accommodating to the diverse needs of older persons are required in the future
(Bartlett, 2003).

Public policy is shaped by older people’s expectations and public attitude (Kendig &
Duckett, 2001). While policy is written for large sectors of the community, it must
support older persons to achieve their own goals and enable service providers to have
flexibility in service provision (Kendig & Duckett, 2001). In addition, many
individuals have responsibility for providing assistance or care for their older parents
and this “is by no means universal, unequivocal or without qualification” (de Vaus,
1996, Summary section, para. 2). This suggests that policy relying on family support
and care for older persons in the future may be unsuitable (Bartlett, 2003).
3.2.3 Summary of policy perspectives on ageing

In the past, policy in Australia was based on a negative view of ageing and a concern to manage the growing numbers of older persons and increased dependency on health and social resources. Policy focused on aged care, and residential care was the only health service paradigm available for the provision of care for the frail aged. More recently, Australia has responded to the positive approach of international policy to ageing and national polices have shifted to include the promotion of independence, ageing in place and the provision of support and care through community services. Policy on aged care in Australia has focused on three areas which include the introduction of the ACAP, HACC and standards and monitoring for residential and community care.

The current focus of policy in Australia is on work, income, leisure and the capacity of the older person to age well and remain living at home. These policies have been successful in providing alternatives for older persons and encouraging participation in society. Consequently, older persons are encouraged to remain living at home with the provision of informal and formal support, and care if required. Care in the nursing home has been moved into the home and low level residential care has been replaced with high level community care. However, in the future policy may need to be reshaped to accommodate further development of community care, improved funding for residential care, and address the demand on informal care at home.

3.3 Chapter 3 summary

The demographic characteristics and health and social experiences of older persons presented in the first section of this chapter demonstrate they are varied and influenced by many factors. As older persons are living longer and the population is
ageing, Australia has made some positive attempts to address requirements for health services and social support.

Policy perspectives presented in the second section of the chapter demonstrate that since the 1980s, international and national policies have responded to changing demographics, and the political and economic circumstances of an ageing population. International polices have been introduced by the UN, WHO, OECD countries and the World Bank. In response to these policies, Australia has implemented policies on ageing and aged care, including the National Strategy on Ageing and a reform process for aged care.

Empirical evidence demonstrates heterogeneity amongst the older population and this suggests many older persons are living at home with varying capacities. Knowledge on ageing and home is important for understanding the experiences of older persons as they age, as it provides the context in which they make their daily decisions. However, it does not increase the understanding of what older persons do in their daily lives to sustain their living at home.

The next chapter presents the research methodology. It examines the methodological approach guided by post-positivist grounded theory and explains the research methods used to explore and describe the processes older persons use to stay living at home.
In this chapter, the research methodology used to explore aspects influencing the older persons’ everyday living is discussed. It begins with a discussion of the study approach including the epistemological and theoretical underpinnings, origins and approaches of grounded theory, as well as the rationale for choosing grounded theory as a methodology. This section is followed by an explanation of the grounded theory study methods used and includes the setting, sampling approaches and criteria, and participant recruitment and profile. The chapter also includes a discussion of the two methods of data collection, namely focus group discussion and individual interviews. In addition, the critical components of grounded theory analysis including constant comparison, theoretical and conceptual coding, memo writing, identification of the central category or process, theoretical sensitivity and theoretical saturation are described. The chapter concludes with a discussion of study rigour, ethical considerations and researcher reflexivity.

4.1 Study approach

Research is approached through different paradigms and there is a choice of paradigms for the researcher to study phenomena and discover new knowledge. A paradigm is the researcher’s way of viewing the world, and their philosophical basis and assumptions are encompassed by the paradigm of inquiry chosen (Denzin & Lincoln, 2008; Schneider, Elliott, Lo-Biondo-Wood, & Haber, 2003). Traditionally in designing research, researchers have identified a preference for a paradigm of
study to answer their research questions, as the researcher’s philosophical beliefs influence the research questions and method used (Annells, 1996).

A researcher takes a particular philosophical stance in order to answer questions regarding ontology, epistemology and methodology. Ontology relates to the researcher’s perspective on reality, epistemology addresses their perspective on the relationship between the researcher and knowledge, and methodology is concerned with how the researcher should go about obtaining the knowledge (Denzin & Lincoln, 2008).

Historically, the most commonly used paradigm has been objectivism, taking a positivist stance. This paradigm is linked to empirical science laying claim to being objectively proven and that truth can be discovered (Crotty, 1998). However, over time it has been acknowledged that a positivist approach is not appropriate for all research questions. Hence, different philosophical positions have informed a range of approaches including post-positivism, constructivism and emancipatory approaches. In particular, the one of relevance to this study is termed post-positivism. The ontological position in post-positivism is that reality can only be approximated, as complete objectivity is not possible (Denzin & Lincoln, 2008; Polit & Beck, 2010). It argues probability not certainty and that the truth may not be entirely understood (Crotty, 1998).

Despite their own philosophical stance, researchers now commonly select an appropriate paradigm for the phenomenon to be studied. In this study, the researcher selected grounded theory as the appropriate methodology to answer the research questions. Grounded theory is a “way of thinking about data” and each time it is used it is modified to suit the research question and context (Morse, 2009, p. 14).
Specifically, the grounded theory approach outlined by Strauss and Corbin (1990, 1998) informed by a post-positivist theoretical perspective was chosen. The reasons for these decisions are presented below.

4.1.1 Origins of grounded theory

Grounded theory is a research approach originally developed in the 1960s by Glaser and Strauss (Grbich, 2007; Polit & Beck, 2010), who defined it as “the discovery of theory from data systematically collected and analysed” (Glaser & Strauss, 1967, p. 1). It was developed in response to the dominance of the positivist paradigm with the aim to generate theory (Glaser & Strauss, 1967).

As a methodology, it “is inductively derived from the study of the phenomenon it represents” (Strauss & Corbin, 1990, p. 23) and generates theory from the data (Borbasi, Jackson, & Langford, 2008; Charmaz, 2006; Glaser & Strauss, 1967). Using grounded theory, the researcher attempts to understand meanings given to concepts in a particular context (Glaser & Strauss, 1967; Strauss & Corbin, 1990) and to develop a theory that describes and explains the phenomenon (Dey, 1999; Glaser & Strauss, 1967; Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007).

Grounded theory stems from two analytic traditions: the perspective of positivism and quantitative survey methods from the Department of Sociology, Columbia University through the influence of Glaser, and from the Chicago school perspective of symbolic interactionism which shaped the philosophical background of qualitative research conducted by Strauss (Cutcliffe, 2000; Dey, 1999; Eaves, 2001; Glaser & Strauss, 1967).
Symbolic interactionism, a sociological perspective of human interaction, originated in the University of Chicago through the work of George Mead in 1964 (Burns & Grove, 2009) and evolved later in research by Herbert Blumer (Speziale & Carpenter, 2007). Symbolic interactionism studies the concept of the self within the social world and it is believed that the individual and their context cannot be separated (Blumer, 1969). The emphasis is on meaning and interaction, and how meaning is derived in interaction with others, and changes as the context changes (Grbich, 2007).

Symbolic interactionism has three basic ideas, these being that people act towards symbols such as words, roles or objects as they have meanings for them, meaning is learned through social interaction, and meaning is fluid and changes as a result of interpretation (Annells, 1996; Blumer, 1969; Eaves, 2001; Polit & Beck, 2010).

When viewed from a symbolic interactionist perspective, in this study the meaning the older persons give to living at home may be shaped by the interactions they have with others, and these meanings may change over time as they become more accepting of their changing situations. Also, the actions and interactions used by the older persons to stay living at home may be mediated by their interpretations of their personal situation of ageing.

4.1.2 Approaches to grounded theory
Over recent decades grounded theory has evolved and been interpreted from different perspectives (Grbich, 2007; Morse, 2009; Schneider et al., 2007). When this research commenced, the two main approaches to grounded theory included Glaser (1978, 1992) and Strauss and Corbin (1990, 1998). These approaches have common characteristics and share the similar notion to generate theory that is grounded in
data. However, they have procedural differences (Annells, 1997a; Grbich, 2007; Strauss & Corbin, 1990, 1998). At the commencement of this study, Clark’s situational analysis and Charmaz’s constructivist approach to grounded theory were evolving (Morse, 2009).

The original approach to grounded theory was developed in the USA in 1967 by sociologists Barney Glaser and Anselm Strauss (Kennedy & Lingard, 2006; Schneider et al., 2007; Strauss & Corbin, 1998). It was immersed in positivism and according to Glaser and Strauss (1967) emphasised a process of induction and deduction. In using this approach, the focus is on generating grounded hypotheses on a substantive area and the emphasis is on emergence, including the emergence of a grounded basic problem, grounded questions and a basic social process (Annells, 1997a). Glaser (1978, 1992) has continued to follow this approach.

Another approach developed later by Anselm Strauss and Juliet Corbin in 1990 and further defined in 1998 involved procedural differences to the original approach and moved grounded theory to a post-positivist paradigm (Annells, 1996; Kennedy & Lingard, 2006). This approach is considered post-positivist because methodologically it involves a systematic examination of data bringing the researcher closer to reality (Kennedy & Lingard, 2006). Furthermore, epistemologically it gives voice to the participant and represents the participant “as accurately as possible” (Charmaz, 2000, p. 510). The relationship between the researcher and participant is subjective because it acknowledges the influence of the researcher in analysis with the data (Strauss & Corbin, 1998), and therefore the researcher and the participant create the theory (Annells, 1996; Annells, 1997b).
The approach focuses on a phenomenon relating to a problem or curiosity, and the development of an inductive grounded theory about the social processes of that problem or curiosity (Annells, 1997a). These processes explain the change, and the theory is applicable to managing the problem (Annells, 1996).

Strauss and Corbin (1990, 1998) argue their approach is systematic and allows the researcher to capture complexity of the individual’s reality. Charmaz (2000) believes Strauss and Corbin’s approach is more prescriptive for data collection. Annells (1997a) and Denzin and Lincoln (2000) argue that the approach described by Strauss and Corbin (1990) is helpful in developing theory that is practical.

Nationally and internationally, nurses have used grounded theory in their studies. For example, Backman and Hentinen (1999) developed a model for self-care of the home-dwelling elderly in Finland. Fenwick, Barclay, and Schmied (2001) examined the experiences of mothering a preterm infant in Australia. Lee (2001) looked at the perceptions of Hong Kong elders on adjustment to residential care.

4.1.3 Rationale for using grounded theory

Grounded theory was considered to be the most appropriate methodology for this study for three reasons. Firstly, the research questions in the study address the strategies the older persons use to remain at home from their perspective. This has received little attention to date and there is not much known about the processes people over the age of 65 years engage in to stay living at home. Glaser and Strauss (1967), and Strauss and Corbin (1990) claim that grounded theory has been particularly useful in understanding phenomenon where there has been little theoretical development. As the focus is on the context where daily interactions take place, grounded theory is suitable for the exploration of interaction to study social
processes (Dey, 1999; Glaser & Strauss, 1967). Furthermore, grounded theory is useful to explore individual experiences, particularly micro activity (Grbich, 2007).

Secondly, in grounded theory, theory is inductively and deductively derived and developed from the data, and not imposed on the data collected (Glaser & Strauss, 1967; Speziale & Carpenter, 2007; Strauss & Corbin, 1990). The study did not set out to verify or test existing theories about living at home but the intention was to develop a theory. Grounded theory was developed as a methodology to enable the researcher to generate theory (Glaser & Strauss, 1967) providing a new perspective for looking at the situation.

Thirdly, grounded theory gives rigour through a systematic process of data collection and analysis (Strauss & Corbin, 1990). Following discussions with colleagues and supervisors, the decision was made to use the systematic process described in detail by Strauss and Corbin (1990, 1998). This approach was used as the methodological framework for this study and guided decisions about methods of data collection and analysis.

4.2 Study methods

The study methods informed by a post-positivist grounded theory approach provided a means to collect and analyse data. This study used purposive and theoretical sampling and two methods for data collection, namely, focus group discussions and individual interviews. The focus group discussions provided a means to explore the breadth of the older person’s experiences collectively, whilst the individual interviews enabled a theoretically sampled, more in-depth exploration of the concepts generated in the focus groups and preceding interviews.
4.2.1 Study setting

In addition to the way data are collected and analysed, methodology determines what type of setting would be used. In this grounded theory study, past experience directed the researcher to find a setting where a sample of older persons experiencing the phenomenon of sustaining their living at home could be found. The setting chosen to conduct the study was a Seniors’ Leisure and Learning Centre located in Western Sydney, NSW, Australia.

This was a fairly typical local government centre offering a standard program of activities. Demographics of the local government area (LGA) included that in 2006 women comprised 56.6% of the population over the age of 65 years and 58.1% of older persons were Australian born (ABS, 2007a). Of these, 65.4% lived in a house, 19.7% lived in a unit, flat or apartment, 14.4% lived in a townhouse or semi-detached house and 2% lived in other dwellings (ABS, 2007b).

The centre is administered by a local council in a LGA of Western Sydney for people over the age of 50 years to engage in educational, recreational and social activities. Examples of activities conducted at the centre included English, colonial and Australian history, computing, cooking, singing, exercise, dance, line dancing, bowls and yoga. In addition to conducting these activities, the centre provided lunch and transport for members when required. At the time the study was conducted, the centre operated between 9am and 5pm Monday to Friday. There were approximately 250 members at the time of participant recruitment, aged between 50 and 97 years.

The centre was chosen as it had a large membership of regular attendees from which to obtain a volunteer sample satisfying the recruitment criteria for the study (see below). Also, the centre catered for both genders that were likely to be living
independently in their own homes. As participants regularly attended the centre, it provided them with a familiar non-threatening environment.

4.2.2 Study sampling
Guided by grounded theory, sampling encompassed both purposive and theoretical sampling, sampling criteria, processes for participant recruitment and collection of the profiles of the older persons who volunteered to become participants. The aim of sampling in this study was to collect rich information, that is, according to Borbasi et al. (2008) information from people experiencing the phenomenon. This was necessary to answer the two research questions exploring the experiences of older persons living in their homes and how they continue to stay living at home.

Purposive and theoretical sampling
Following the practices of grounded theory, purposive and theoretical approaches to sampling were used in this study. In grounded theory, sampling usually commences with purposive sampling based on the researcher’s knowledge and experience of the topic (Dey, 1999; Polit & Beck, 2010; Strauss & Corbin, 1990), and the practicality of recruiting participants who have the knowledge or experiences the researcher seeks (Schneider et al., 2007).

Following purposive sampling, further sampling then became theoretical, and was guided by the emerging theory (Cutcliffe, 2000; Glaser & Strauss, 1967; Polit & Beck, 2010; Strauss & Corbin, 1990). Theoretical sampling is where data collection and analysis occur concurrently, with the researcher using the analysed data to determine where to collect the next data to obtain the best information to develop the theory (Glaser & Strauss, 1967; Kennedy & Lingard, 2006; Schneider et al., 2007; Strauss & Corbin, 1990, 1998). Sampling cannot be predetermined and decisions
about sampling are made as the study progresses (Cutcliffe, 2000; Kennedy & Lingard, 2006; Speziale & Carpenter, 2007; Strauss & Corbin, 1998). Theoretical sampling gives the researcher flexibility to develop the theory guided by the new emerging concepts (Glaser & Strauss, 1967; Strauss & Corbin, 1990). In this study, data generated from the focus group discussions and the interpretation of these concepts guided theoretical sampling and questions in the subsequent individual interviews.

Selection of participants for the individual interviews differed from that of the focus groups. In this study, based on the concepts emerging from the analysis of focus group data, nine older persons were interviewed. These nine participants were selected because they reflected a range of and variability in strategies used, and they had various levels of good health and support which allowed for maximum exploration of the processes used by the older persons.

During the individual interviews participants were asked questions to develop the categories and determine variations among the concepts developed from the focus group data, an approach guided by Strauss and Corbin (1998). Data were collected, coded and analysed to determine where to next collect data. Theoretical sampling enhanced the researcher’s understanding of the processes used by this group of older persons, both individually and collectively as it enabled more focused interviewing. Theoretical sampling continued until the theory was developed and theoretical saturation was reached.
Sampling criteria

The sampling criteria used to select a purposive sample were:

- **Aged 65 years of age or over.** At the commencement of the study there were variations in the literature regarding the age used as a baseline to determine an older person. The decision to use age 65 years in this study was influenced at this time by the Australian government policy regarding compulsory retirement age and eligibility to receive an aged pension for men (AIHW, 2007);

- **An urban resident in Western Sydney, NSW, Australia.** As there are different considerations between urban and rural settings in Australia, it was decided to focus the study on older persons living in an urban setting only;

- **A member of the Seniors’ Leisure and Learning Centre.** Membership of this centre was essential as the centre was designed for members to take part in activities and not for the purpose of day care. In this way, participants attending the centre were likely to be living independently and would be well suited to describe their experiences of living at home;

- **Currently living in their home for at least 12 months before the study.** Twelve months living in the current home was considered to be the minimum time necessary for a participant to be conversant with the experiences the study intended to capture;

- **English speaking.** As the research was conducted in English, it was determined that participants would be included in the study if their understanding of English was adequate without interpreters.
4.2.3 Participant recruitment

After obtaining ethics approval from the University of Western Sydney Human Research Ethics Committee (UWS HREC) and meeting with the centre coordinator, the researcher was invited to attend a forum held for members of the centre every three months. In order to recruit participants, at the conclusion of the forum the researcher was given a short time to explain the details of the study and specifically what participant involvement entailed. The researcher used this time to discuss an interest in exploring the processes used by older persons to remain living at home, stereotypes that exist in society in relation to ageing and the positive ageing focus of the study. Following this explanation, the older persons were invited to ask questions about the study. After addressing these questions, which were few and dealt mainly with procedural issues, the majority of older persons in attendance expressed their interest in participating.

In attendance at the forum were members of the University of the 3rd Age (U3A) and those who were not members. Because of what appeared to be some tension between these two groups, and mindful of the group dynamics it created, there was deemed a need to prevent issues relating to this tension from possibly affecting recruitment and data collection. Therefore, the researcher deliberately recruited for the composition of the focus groups from selected activity groups attended by older persons with similar interests. In this way, the tension that may have arisen from the perceptions of intellectual inequality between the two groups was avoided by the selection process that identified specific activities where there were dispersed numbers of U3A members in each class.

Recruitment for the first focus group followed the line dancing and gentle exercise classes. Participants for the second and third focus groups were then recruited from
the indoor bowls class and English class respectively. These were the four most common classes conducted at the centre at the time of recruitment, and had the largest attendance. This part of the recruitment process for the focus groups was informed by the work of Krueger and Casey (2000), highlighting the importance of linking recruitment to times when the participants are together for another purpose. The older persons who volunteered to participate were personally contacted via telephone over the following two days to confirm a date and time to participate in a focus group.

Recruitment for the individual interviews occurred at the conclusion of each focus group when all participants from the three focus groups were invited to be interviewed individually. At this point, participants were informed that not all volunteers could be interviewed. In total, 17 out of 20 focus group participants volunteered to participate in the individual interviews. One other older person who was unable to attend a focus group also volunteered to be interviewed. Therefore, of the 21 people who agreed to participate in the study, 20 consented to participate in the focus groups and 18 consented to participate in individual interviews at a later time.

4.2.4 Participant profile
Participants were drawn from a sample of English speaking persons aged 65 years and over who reside in their homes and were members of a seniors’ centre. Personal details were collected on the Participant Personal Profile Form (see Appendix C) from all participants prior to the commencement of data collection. The form collected information about personal characteristics, education, occupation and retirement, income, housing and living arrangements, and support. Collection of this biographical data was used to confirm that each participant satisfied the selection
criteria, and as background information to increase the researcher’s theoretical
sensitivity in interpreting data collected. A summary of the participants’ biographical
data collected on the Participant Personal Profile Form is presented in Appendix G.

There were seven male and 14 female participants and their age range was from 66 to
97 years of age. Countries of birth included 15 from Australia and one each from
New Zealand, England, Uruguay, Indonesia, Sri Lanka and Egypt. Languages spoken
at home were English, Spanish, Dutch, Tamil and Arabic. The marital status of the
participants included seven married, 12 widowed, one never married and another
who was divorced. Nineteen participants had living children (ranging from one to
seven children) and two participants had no children.

Twelve participants lived in a house, six in a unit and the other three in a town house,
a retirement village and a duplex. The length of time participants had lived in their
current dwelling ranged from 2½ years to 74 years. Almost all participants had lived
in their current homes for at least 10 years and some had lived there for more than 40
years. The household composition included 12 living alone, five lived with a partner,
two lived with their children and two lived with a partner and their children.

In terms of education, six participants had completed primary school education only,
10 high school education, two the equivalent of Technical and Further Education
(TAFE) and a further three had completed other forms of Tertiary Education, that is,
overseas degrees, and a teachers college qualification. Thirteen participants had been
employed in blue collar occupations\(^1\) and four participants had been employed

\(^1\) Blue collar occupation is defined as “belonging or relating to workers involved in some sort of
manual labour, as distinct from clerical or professional workers” (Butler (Ed.), 2010).
previously in white collar occupations\(^2\). Another four participants described their previous occupation as undertaking home duties. All participants were retired and did not formally engage in employment. Overall, 12 participants had a household income below AU$30,000 per year, with nine of these participants having a household income below AU$15,000 per year. Almost all participants relied on the aged pension as their only income.

When asked who would be their immediate support person if required, 14 participants said they would rely on their children or grandchildren, five would rely on their partner, one would rely on her nephew, and one participant who was divorced, had no children and lived alone would rely on a neighbour. Most of the participants stated they would rely on their neighbours if they could not obtain assistance from their family.

### 4.3 Data collection

This study utilised a grounded theory approach to data collection and analysis. Consistent with grounded theory, the process of data collection and analysis was not linear and although described in a linear format in this thesis, it was an iterative process that moved backward and forward and from one level of analysis to another.

Data collection commenced with a generalised approach through focus group discussions to explore and obtain a group view of the experiences of the participants living at home. As the study progressed, data collection and analysis became more focused through the individual interviews where the researcher could collect

\(^2\) White collar occupation is defined as “belonging or relating to non-manual workers, as those in professional or clerical work, who traditionally work a suit, white shirt and tie” (Butler (Ed.), 2010).
individual perspectives to understand and further explain the experiences through the developing theory. According to the literature, two of the most successful methods used in combination to obtain data have been the use of focus group discussions and individual interviews (Lambert & Loiselle, 2008). Halcomb and Andrew (2005, p. 80) suggest that using two methods can give data “completeness and confirmation” and Duffy, Ferguson, and Watson (2004, p. 74) indicate that using more than one method can ensure the theory is “‘grounded’ in the data.”

The time taken for data collection was extended over 24 months. This included 16 weeks to conduct and analyse the three 1-hour focus groups. Following analysis of data within and across the focus groups, the concepts generated were then used as the basis for the questions in the individual interviews. The researcher returned to the centre for eight weeks and again at a later date for a further two weeks to collect and analyse data to understand emerging concepts in greater depth and work towards developing the theory. The decisions made and specific procedures followed for data collection and analysis in the focus groups and individual interviews are discussed in the following section. Figure 1 on p. 115 displays the process of data collection and analysis in this study.
Figure 1  Process of data collection and analysis

Focus Group A
Focus Group B
Focus Group C
Interview Sarah
Interview Anne
Interview Irene
Interview Rose
Interview Mark
Interview Maree
Interview Ellen
Interview Irene again
Interview Tim
Interview Marjorie

Data collected and analysed ➔ Data collected and analysed ➔ Data collected and analysed
4.3.1 **Focus group discussion data collection**

The focus group discussions were used in this study to explore and describe the experiences of living at home and the meanings given to them through a collective perspective. The purpose of using focus groups as the initial method of choice was to obtain a range of ideas (Krueger & Casey, 2009). The idea of the study was not to generalise about the population of older persons but to describe and understand how this group of older persons remain living at home. Using the focus groups as a method to collect data developed the researcher’s theoretical sensitivity to the topic and assisted in establishing a relationship with the older persons to be interviewed later.

According to the literature, data collected from focus group discussions can give information that is rich about the experiences of the participants (Lambert & Loiselle, 2008; Speziale & Carpenter, 2007). In focus groups, individuals are influenced by others and they also influence the others in the group discussion. Through participating in focus groups, people hear what others are saying and then form their own perspectives (Krueger & Casey, 2009).

Focus group discussions assist in the identification of patterns of ideas and achieving a greater scope (Krueger & Casey, 2009). In this study, they provided a range of experiences relating to living at home. As focus groups are homogenous groups (Krueger, 1994; Krueger & Casey, 2009), the older persons invited to participate in this study had common knowledge and experiences about the phenomenon as they were living it at the time; initially all participants were over 65 years, lived in their home and were members of the same centre. Being a member of the centre meant that the participants knew each other, and according to Lambert and Loiselle (2008, p. 229) interactions within groups can emphasise the group “members’ similarities.”
It is believed people disclose more about themselves to people who they think resemble them in various ways (Krueger & Casey, 2009). However, one of the disadvantages of focus groups is that they may restrict some participants from open discussion, as some people may be influenced by more dominant participants (Krueger & Casey, 2009; Speziale & Carpenter, 2007). The composition of the focus groups in this study was organised to minimise this disadvantage. This is explained in the following section.

4.3.2 Focus group formation and composition

Although all participants in the focus groups were aged over 65 years, lived in the same LGA with similar demographic characteristics and took part in similar activities at the centre, all three focus groups were different. Each group varied in size and composition. Despite these differences, each focus group discussion provided valuable information on the topic and the older persons gave the impression that they enjoyed being involved, as they appeared relaxed and comfortable to talk about the processes they used and to share them with each other.

The number of focus groups to be conducted was not predetermined as the study was emergent. Glaser and Strauss (1967) describe data collection in grounded theory is not based on a preconceived theoretical framework. However, prior to the study commencement the decision was made that a minimum of three groups would be conducted. After the third focus group it was determined sufficient breadth of data were collected as there were no new concepts emerging in the ongoing analysis.

In this study, the number of participants in each focus group varied. Group numbers were guided by the literature and made up of the number of older persons volunteering to participate. According to Burns and Grove (2009) and Speziale and
Carpenter (2007), the ideal size of a focus group ranges from six to 10 participants. It is believed groups larger than 12 restrict the participants’ chances to discuss their experiences (Krueger & Casey, 2009; Speziale & Carpenter, 2007).

In total, 20 older persons, seven males and 13 females were divided into the following groups:

- Group 1 consisted of three males and seven females. This group was made up of mixed genders as it is believed the topic may be experienced differently on the basis of gender (Krueger & Casey, 2009).

- Group 2 consisted of six females.

- Group 3 consisted of four males.

Same gender groups such as those in groups 2 and 3 were used as it is believed that participants with similar experiences may speak more freely (Burns & Grove, 2009) and that in mixed gender groups some males may speak with more “authority,” annoying some of females in the group (Krueger & Casey, 2000, p. 73).

4.3.3 Focus group discussion procedure
Prior to conducting the first focus group, the researcher attended the seniors’ centre on two occasions to scout out the location of a suitable room to conduct the focus groups. This assisted in determining if factors were present that would interfere with the group discussions. During these visits a small quiet room was selected that was free from visual and outside distractions to the participants, and there was no traffic flow through the room at that time of day.
The same procedure was followed for each of the three focus groups. Before commencing all three group discussions, chairs were arranged around tables so they were equally spaced with participants facing each other. In this way, each participant was able to maintain eye contact with every other participant in a relaxed setting (Burns & Grove, 2009). The decision to place tables in front of the chairs was made as it was thought participants could lean forward on the tables if they became tired, and that tables would be of benefit to those participants who were self-conscious. As all focus group discussions were audio recorded, prior to each group the recorder was placed in the centre of the tables and the equipment was tested to determine that it was functioning and could receive sound clearly from different parts of the room. To facilitate a relaxed and social atmosphere, morning tea was made available.

A major decision made prior to data collection was for the researcher to conduct all focus groups. It was thought that individual styles in conducting the focus groups may alter the type of data collected and therefore the use of one moderator only would provide consistency in data collection across the focus groups. This approach is referred to as equivalence and provides reliability (Speziale & Carpenter, 2007).

On commencement of each focus group, after the collection of biographical data (see Appendix F) from each person and issuing a name tag coded with a participant number, the participants were welcomed and an introduction about the purpose and details of the study was given. Following this introduction, ground rules for the discussion including respecting the privacy of other participants and not speaking when others were speaking were set. This part of the procedure was informed by the work of Krueger and Casey (2000) and Morgan (1997) who claim ground rules are essential to set in focus groups as participants share their personal information.
To further assist in making the older persons feel comfortable, each participant was then asked to: “Introduce yourself and explain where you live and why you like living there.” This question was used as it was an easy question for all participants to answer and therefore would assist the older persons to feel relaxed and confident to participate in the group discussion. During the analysis of the focus group discussions, the responses to this question assisted with understanding the meaning of home as the older persons discussed why they wanted to stay living in their homes. Following this introduction, the focus groups then led with a general question: “Tell me about your experiences that make it possible for you to remain living in your home?” This general question was used because grounded theory starts with a general question that everyone can answer (Dey, 1999).

When preparing to conduct the focus groups, consideration was also given to the issue to use a topic guide format or develop set questions to be discussed. A topic guide was chosen as according to Krueger (1994) a topic guide allows the discussion to flow. The topic guide (see Appendix D) consisted of a list of topics taken from a brief review of the literature. Throughout each of the focus groups, the same topic guide was used as required when the topics were not covered by the participants.

During each group discussion, the main topics discussed were listed on butcher paper by the researcher. At the conclusion of each focus group discussion, these topics were fed back to the group to verify they were the main topics that were discussed. Informed by the work of Krueger and Casey (2000, p. 46), a closing question, “Have we missed anything?” was used to seek final comments from the older persons.

Each focus group lasted approximately 1 hour in duration. Generally, focus groups last from 1-2 hours (Burns & Grove, 2009). Prior to data collection, it was assumed that there might have been some challenges, both physical and psychological with
understandings, but these were not experienced with the three focus groups. The older persons appeared relaxed, no one complained of being unable to hear the discussion and all confirmed they were comfortably seated throughout the group discussion.

By the conclusion of the 3rd focus group, 7 males and 10 females had volunteered to participate in an individual interview and completed the Individual Interview Consent Form (see Appendix B). Of these 17 volunteers, 8 were interviewed. One other person who was unable to participate in a focus group volunteered to be interviewed. The rationale for the decisions made about individual interview data collection is described in the following section.

4.3.4 Individual interview data collection

Individual interviews were selected as the other method for data collection. The main objective of conducting interviews in this study was to test theoretical thinking to gain an understanding of the individual meanings related to the experiences of the older persons. Additionally, the individual interviews served to clarify the focus group data collected, and facilitated the exploration of missed opportunities and areas that were difficult to discuss in the focus groups for example, personal finances and health. In grounded theory, interviews complement other methods, they are focussed and intensive and participants construct meanings related to their experiences through the information they give (Charmaz, 2006). Furthermore, interviews can provide more in-depth information about experiences and events impacting on participants when compared with focus groups (Burns & Grove, 2009).

Interviews vary according to their amount of structure and can be highly structured, semi-structured or open-ended (Schneider et al., 2007). Semi-structured interviews
provide a degree of structure as the same questions are asked but they give flexibility to the order in which they are asked (Duffy et al., 2004). Studies using a grounded theory approach typically use focused, open-ended interviews and a semi-structured format (Duffy et al., 2004; Glaser, 1992; Glaser & Strauss, 1967). The range of interview topics becomes narrow as they become more focused on the specific topics throughout the study (Dey, 1999). Use of focused open-ended interviews in this study enabled the researcher to have some flexibility to explore the older persons’ experiences as they described them.

The number of interviews conducted was not predetermined as the design was emergent with the developing theory. As theoretical sampling was used, each interview gathered more data on the developing categories and the questions became more focused to saturate the developing categories. As previously mentioned, in addition to the three focus groups, 10 interviews were conducted to develop the theory explaining the process a group of older persons engaged in to remain living at home. Another aspect relating to individual interviews in this study included theoretical selection of older persons to interview.

4.3.5 Individual interview participant selection
Using theoretical sampling described by Strauss and Corbin (1998), the selection of participants to be interviewed was determined by the concepts, categories and development of the theory emerging from the analysis of data. In keeping with theoretical sampling, data were sampled, not persons. In this way, sampling in the individual interviews was determined by the need to use the older persons who would provide the information required to develop the theory. Theoretical sampling ceased when theoretical saturation was reached after the 10th interview.
In this study, selection of the older persons to interview was based on the data from the focus group participants who appeared to have put into place many different processes. The researcher was most interested in the processes used when changing conditions impacted on everyday living. Nine participants were interviewed, with one interviewed twice due to her changing circumstances between interviews. In the first five interviews, four females over the age of 75 years living alone, and one male living with a family member were chosen to interview as data showed these participants had already put a number of processes into place to stay living at home, and they were continually renewing these processes in response to change. In the second group of five interviews, the older persons selected for interview were chosen because their individual circumstances had changed significantly and become more complex due to deteriorating health. These five participants had either moved out of their home into alternative accommodation or were now living at home with higher levels of support.

As mentioned previously, not everyone who volunteered was interviewed. Four females who had volunteered to be interviewed were not interviewed as one had died, two were not available at the time of the interview and the other person’s circumstances remained unchanged. Also, five males who volunteered were not interviewed, as one had died and the circumstances of the other four had not changed.

4.3.6 Individual interview procedure

After data were collected and analysed from the three focus groups, nine participants were given the choice to be interviewed in their home or in a quiet room at the centre. Of these nine participants, two chose to be interviewed in their own homes and one in the hostel. Another participant chose to be interviewed via telephone at
the retirement village. The remaining interviews were conducted at the centre. All interviews were audio recorded and conducted at a time convenient to the older person. With the exception of the telephone interview, during each interview the participant and researcher sat facing each other and the recorder was placed on an adjacent table. Throughout the interviews, no participant indicated the recorder was a problem or distraction and the presence of the recorder did not appear to interfere with the interviews in any way. In this way, a positive interview environment was ensured (Burns & Grove, 2009).

The concepts generated from the three focus groups were used to develop a topic guide of interview questions (see Appendix E) to focus the individual interviews on the research questions. Use of this guide facilitated discussion of the processes used to stay living at home as they related to the individual. Topic guides are useful to guarantee all topic areas are explored (Polit & Beck, 2010). The open-ended questions in the topic guide were used at times during the interviews as a guide to encourage participation when the participant was having difficulty talking or keeping focused on the topic. These questions were not asked in a specific order as the interview was directed by what the older person had to say. These prompts facilitated free flowing conversation guided by the participants’ discussions of their experiences. In addition, they were useful to confirm and expand upon concepts already explored in the focus groups.

During the interviews participants were asked to explain their understanding of the meaning of continuing to live at home and discuss the strategies they used. The discussion included what facilitated and what were the barriers to this process, what changes occurred and how each person had prevented or managed these changes. All 9 older persons interviewed did not need encouraging and generally were open with
their responses. However, at times the researcher probed for clarification of what
they were saying or asked them to expand on what they were saying.

The length of each interview was dependent on the older person, and the researcher
was always conscious of the time taken for interview. At the end of the interview, a
final question: “Is there anything else?” was asked to elicit any information the older
person wanted to add. Each interview concluded when the older person felt they had
nothing more to say. The duration of all interviews was approximately 60 to 90
minutes. Schneider et al. (2007) suggests that interviews should be limited to 1-2
hours to prevent fatigue. At the conclusion of each interview all older persons were
thanked so they had a sense of closure. Guided by grounded theory data collection
and analysis, all interviews were transcribed verbatim and analysed as soon as
possible after each interview, prior to conducting the next interview.

4.4 Data analysis

As mentioned, the grounded theory procedures described by Strauss and Corbin
(1990, 1998) were followed to inform and direct data collection and analysis. In this
way, data collection and analysis inform each other (Glaser & Strauss 1967; Strauss
& Corbin 1998). Data analysis involved a process of inductive and deductive
thinking (Strauss & Corbin, 1990) and the purpose was to develop a theory through
interpretation of the data.

The critical components of grounded theory used in data analysis are described in the
following section. These components include constant comparison, theoretical and
conceptual coding, memo writing, identification of the central category or process,
theoretical sensitivity and theoretical saturation (Annells, 1997b; Glaser & Strauss,
4.4.1 Constant comparison

Constant comparison is fundamental to generating grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). It is described as the systematic process of comparing pieces of data in data collection and analysis to discover relationships and generate categories (Borbasi et al., 2008; Cutcliffe, 2000; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998). In this study, constant comparison was used when collecting and analysing data. All new data were coded and compared with previously collected data. Following comparison, the concepts in each category were compared with each other for similarities and differences and categorised according to their properties. Strauss and Corbin (1990) state it is the groups of concepts together that give categories conceptual power. Following the work of Strauss and Corbin (1998), categories were then compared with other categories and linked through their relationships.

4.4.2 Conceptual and theoretical coding

Coding is a critical component in grounded theory and involves processes of analysis where data are “broken down, conceptualised” and reassembled to form theory (Strauss & Corbin, 1990, p. 57). According to Charmaz (2006) coding is a focused way of seeing the data and is described as giving a short label to describe sections of data. It is a flexible, emergent process and demonstrates how the researcher analytically sorts data to have an understanding of “what is happening” (Charmaz, 2006, p. 3).

Prior to data analysis, the decision was made to engage in the process of analysis without using computer assisted programs. Computer programs assist researchers to manage data, they do not analyse data (Liampittong, 2009). It was thought that engaging in the process manually would provide a way to learn about what was
happening to the data in analysis. Therefore, commencing with open coding, all data were coded manually on printed copies of files.

Open coding
In grounded theory, open coding is the first level of analysis and is described as opening up the data (Glaser & Strauss, 1967). Strauss and Corbin (1990, p. 61) refer to open coding as the “process of breaking down, examining, comparing, conceptualizing, and categorizing data.” In this study, open coding was performed immediately following data collection of each focus group and individual interview.

Open coding involved identifying and giving names to codes and possible categories. Transcribed data were formatted onto a template with four columns. The first column consisted of raw data; the second column was used for codes, that is, the labels given to raw data developed during line-by-line or section analysis, the third column was used for the grouping of codes into subcategories, and the last column was designed to denote the category.

During the process of open coding in all focus groups and individual interviews, the entire transcript was read first to get an overall picture of what the participants had said. Following this, data were broken down by examining words and phrases line-by-line in the transcripts and giving them codes. Strauss and Corbin (1998) refer to this process as microanalysis. Simultaneously the question was asked, “What is going on here?”

Throughout the process of coding other questions recommended by Glaser, and Strauss and Corbin were asked of the data. Glaser (1978, p. 57) suggests asking the questions: “What does this incident indicate?,” “To what category does it belong?” and “What is happening in the data?” to open up the data. In addition, Strauss and
Corbin (1990, p. 63) suggest asking: “What is this? What does it represent?” to open up the data and increase theoretical sensitivity.

Initially, a very long list of codes was developed which was later refined. The initial codes developed were descriptive as they were in-vivo codes, that is, the words of the older persons were used to name the codes (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Charmaz (2006) and Liamputtong (2009) suggest using in-vivo codes in initial coding to keep the meanings intended by the participants. Later in analysis, codes were conceptualised and initial in-vivo codes were changed and reworded to develop categories and the theory.

As data were already available for comparison in the individual interviews, a few paragraphs at a time were coded rather than line-by-line coding. Importantly, the same questions were asked of the data. Once concepts were coded they were compared with the other concepts already identified and then similar concepts were grouped together and developed into categories. Furthermore, diagrams were constructed throughout open coding to help link the concepts as they emerged. Table 1 is an example of open coding from the study.
### Table 1  Open coding example

<table>
<thead>
<tr>
<th>Data</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>“They’re [children] always at the end of the ‘phone if you need them.”</td>
<td>Having others there</td>
</tr>
<tr>
<td>“I have got them [friends and family] there as I need them.”</td>
<td></td>
</tr>
<tr>
<td>“We [people at the centre] always help one another.”</td>
<td>Helping each other out</td>
</tr>
<tr>
<td>“I feel I can help her [neighbour] a bit and she helps me a bit.”</td>
<td></td>
</tr>
<tr>
<td>“Having someone to talk to.”</td>
<td>Sharing with others</td>
</tr>
<tr>
<td>“You have got to mix with people.”</td>
<td></td>
</tr>
<tr>
<td>“The boys are not as attentive but I just say I want this done.”</td>
<td>Outsourcing work</td>
</tr>
<tr>
<td>“I have a chap mow the lawn.”</td>
<td></td>
</tr>
</tbody>
</table>

**Axial coding**

Guided by Strauss and Corbin (1990), following open coding and prior to selective coding, coding was developed to a second level to include axial coding. Strauss and Corbin (1998) argue the purpose of axial coding is to rebuild data broken down in open coding and relate categories by examining the relationships between categories and subcategories. Charmaz (2006, p. 60) asserts that during axial coding “the properties and dimensions of a category” are determined.

Throughout the process of axial coding in this study, the paradigm model developed by Strauss and Corbin (1990) was used. This model assists in the identification of whether the concepts and categories identified through the analysis represent the central phenomenon or are causal conditions, intervening conditions, context, action/interaction strategies or the consequences of the strategies. The paradigm model is used as a coding framework to break down data and put it back together under categories. Use of the paradigm model is particularly helpful to explore and
explain the relationship among categories (Polit & Beck, 2010). In this study, a template consisting of columns using these six headings within the framework and an extra column to answer questions was used.

During the process of axial coding questions were continually asked of the data, diagrams were constructed and memos were written to assist with theoretical conception. Strauss and Corbin (1998) argue asking questions such as: “who, when, where, why, how and with what consequences” at this level adds descriptive depth. Asking questions of the data, such as: “What is the meaning of home?” will according to Charmaz (2006), help understand the meanings given by the participants. It was the use of these questions that increased the understanding of why the older persons wanted to remain living at home, and facilitated the development of the theory to explain the processes they use. Table 2 is an example of category development.
Table 2  Category development example

<table>
<thead>
<tr>
<th>Data</th>
<th>Code</th>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>“They’re [children] always at the end of the ’phone if you need them.”</td>
<td>⇨ Having others there</td>
<td>⇨ Being there for each other</td>
<td>⇨ Connecting with others</td>
</tr>
<tr>
<td>“I have got them [friends and family] there as I need them.”</td>
<td>⇨ Having others there</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“We [people at the centre] always help one another.”</td>
<td>⇨ Helping each other out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I feel I can help her [neighbour] a bit and she helps me a bit.”</td>
<td>⇨ Sharing with others</td>
<td>⇨ Positioning self</td>
<td></td>
</tr>
<tr>
<td>“Having someone to talk to.”</td>
<td>⇨ Sharing with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“You have got to mix with people.”</td>
<td>⇨ Outsourcing work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“The boys are not as attentive but I just say I want this done.”</td>
<td>⇨ Outsourcing work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I have a chap mow the lawn.”</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Selective coding
The third level of analysis performed after axial coding was selective coding. Other approaches to grounded theory describe this level as theoretical or focused coding. As the Strauss and Corbin (1990, 1998) approach to coding was used to guide coding in this study, the term selective coding is used in this thesis. This is the level of analysis where categories are integrated to form a theory (Glaser & Strauss, 1967; Grbich, 2007) and the theory is refined (Strauss & Corbin, 1998).

Guided by the Strauss and Corbin (1990, 1998) approach, a storyline was written to explain the central category and process, and the relationship of all categories by the use of the paradigm model. The storyline described each category and subcategory, the conditions that give rise to it, the processes used within the context and the positive and negative consequences of the actions and interactions used. In this way,
a central category, process and theory was developed that remained grounded in the data.

Throughout this thesis subcategories are italicised in bold (e.g. *keeping well*), major categories are italicised in bold and inverted commas (e.g. ‘*protecting self’*), characteristics of the central process can be seen in bold lower case (e.g. *persisting*), and the central category and process appears in lower case, bold and inverted commas (‘*holding momentum: sustaining living at home*’).

4.4.3  *Memo writing*

Memo writing is a critical component of the process of analysis in grounded theory (Glaser 1978, 1992; Strauss & Corbin, 1990, 1998). According to Strauss and Corbin (1998), memos are used in two ways in grounded theory; they are used to record the researchers’ analysis and interpretations; and they are used to record methodological decisions, such as where to sample next.

In this study, writing memos at each of the three levels of coding assisted the analysis of data through the expression of ideas and answering questions about codes, properties and their relationships to each other. Writing memos further assisted reflection and recording about what was happening in the data, as it was clearer to see thoughts on paper. Memos therefore enabled a closer connection with the study and this relationship increased the researcher’s theoretical sensitivity to the analysis.

Throughout the analysis process, memos became more refined and a collection of memos then became the basis for the storyline in Chapter 9. The researcher found memos were also useful to go back to recollect ideas, in particular looking at the relationships of each category assisted the researcher to identify the central category.
and process, and construct the theory ‘**holding momentum: sustaining living at home**.’ As all memos were dated and titled they proved useful as an audit trail.

Birks, Chapman and Francis (2008) claim the most practical use of memos is to use them as an audit trail.

In addition, the researcher found the process of drawing diagrams as part of the memo assisted in conceptualisation and connection of the relationships amongst categories more easily. Schneider et al. (2007) suggest that diagrams provide a different way of seeing the data. Table 3 is an example of a memo.

**Table 3  Memo example**

<table>
<thead>
<tr>
<th>Memo: Focus Group A – Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall these older persons are healthy. That is, healthy in terms of the World Health Organization definition of health. They know what they need to do to satisfy their needs. For these participants, health is a resource for sustainability that involves the utilisation of their other personal resources. They work with their families and friends and others in the local community. They realise their potential and constantly re-examine it, making the necessary adjustments.</td>
</tr>
<tr>
<td>Home is a place where they go to rest and relax and do chores. The community is the place where they go to live. They achieve a balance through utilising resources and their learned strategies. Home is a supportive place for sustaining their health and wellbeing.</td>
</tr>
<tr>
<td>The older persons participate at the centre and some have membership at other clubs. These are their links with the broader community. They care for themselves, and friends or neighbours when needed. This involves a negotiated and/or reciprocal assistance.</td>
</tr>
</tbody>
</table>
Staying at home is linked with independence (having resolve) and is about doing what you want to do, not what others want you to do (creating own work). Time is your own to manage (setting own pace) and there is no one to interfere (creating own work). There are no strict orders or regulations determined by others at home (meaning of home) as there would be if you moved out of your home and into a nursing home or some other accommodation (consequence). The older persons know other people who have moved out of their home (depending on past experiences). At the present time they are not interested in moving (meaning of home), but realise they might have to change if they can’t look after themselves in the future (future awareness).

Why are they not willing to move? Is it because they can’t change because they are so independent? Is it about settling in? Adapting to change? Why not plan ahead? Why not change now before the decision is forced and there may be less control over the decision?

If you are independent (having resolve) it is hard to change. Being independent for so long means they have become used to doing things themselves (creating own work). They have time to try to help others (helping others) to be independent. They help each other at the centre (reciprocal assistance/connect with community).

?Independence does not facilitate adaption. It appears to make it harder to adapt to change.

4.4.4 Identifying the central category or process

The central category or process is another critical component of grounded theory analysis. According to Strauss and Corbin (1990), it is the central concept around which all categories are related as it puts together all parts of the theory. The central category is otherwise referred to as the core category and explains rather than describes the main curiosity or problem of the research (Strauss & Corbin, 1998). In addition, the central category accounts for variation in the data (Glaser, 1978, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998) and has analytical power as it draws all categories together to explain the phenomenon (Strauss & Corbin, 1998). Glaser argues the central category can be a basic social process that has two or more clear stages and accounts for change over time and gives the theory explanatory power (Glaser, 1978, 1992).
To identify the central category in this study, a storyline was written about the central phenomenon and its properties to show how each category relates to the central category. In this study, the central category was not determined until an advanced stage in the coding process. This category, determined to be a process ‘**holding momentum: sustaining living at home**,’ appeared at all levels of analysis.

4.4.5 *Theoretical sensitivity*

Another critical component of grounded theory is theoretical sensitivity. Theoretical sensitivity refers to the researcher’s ability to use knowledge and experiences, and the literature to see data in new ways (Strauss & Corbin, 1990; 1998). In this study, the literature was a source of data and enhanced theoretical sensitivity.

In grounded theory, debate exists as to the timing of the literature review. Glaser argues literature should not be reviewed until after analysis of data as it influences the interpretation of the data (Glaser, 1978, 1992; Glaser & Strauss, 1967). In contrast, Strauss and Corbin (1998) support increasing theoretical sensitivity by conducting a small literature review at the commencement of the study to identify what literature had previously been written on the topic and another more focused literature review during analysis to verify the theory.

As data collection and analysis for this study was guided by the work of Strauss and Corbin (1998), a small literature review was conducted at the commencement of the study to increase sensitivity to the topic and determine what had been written before about the topic. This review of the literature assisted with the development of the research questions and provided background information to the study. It also assisted in the development of a topic guide (see Appendix D) used to collect data in the three focus group discussions.
According to Glaser and Strauss (1967), theoretical sensitivity develops throughout the research. Theoretical sensitivity enables the researcher to recognise concepts during analysis, and understand and give meaning to data to develop the theory (Glaser, 1992; Strauss & Corbin, 1990, 1998). Throughout the study, knowledge of the phenomenon was further developed through exploration of data collected from focus groups and individual interviews. After concurrent data collection and analysis of the focus groups and individual interviews, a more comprehensive literature review was conducted based on the concepts that had emerged from the data. This detailed review facilitated a comparison of the developing theory with existing literature for verification, described in Chapter 10.

Overall, the ability to understand and give meaning to data, think conceptually and develop the grounded theory ‘holding momentum: sustaining living at home’ increased throughout the study with the ability to recognise concepts emerging from the data.

4.4.6 Theoretical saturation

The decision when to stop collecting data was guided by Glaser and Strauss (1967). In their work, they describe theoretical saturation is the criteria used by the researcher to determine when to stop sampling and occurs when no additional data can be used to develop the properties of a category (Glaser & Strauss, 1967). Without theoretical saturation, the theory is inadequate (Strauss & Corbin, 1990) and lacks density (Strauss & Corbin, 1998).

In this study, when all categories including the central category were developed and no new categories relating to the central process could be developed by collecting more data, it was determined there was no further need to continue sampling. At this
point, it was believed saturation was achieved in the context of this group of older persons living at home and attending the centre.

4.5 Study rigour

Maintaining rigour is vital to any research, as it is on this criterion that the reader is persuaded that the findings are trustworthy and scholarly. Following the work of Lincoln and Guba (1985), and Chiovitti and Piran (2003), concepts relating to credibility, dependability, transferability, and confirmability of the data are used to demonstrate trustworthiness in this study.

The credibility of a study relates to the study’s findings and representation of the phenomenon (Chiovitti & Piran, 2003). Credibility of the findings and theory in this study was ensured by accurate representation of what the participants were saying about living at home. To ensure credibility, as suggested by Chiovitti and Piran (2003), excerpts from transcripts using the words of the participants have been used to confirm that the categories reflected what the older persons had said. Also to ensure the theory was credible and reflects the data, direct quotations from the transcripts were used in the explanation. In addition, credibility was demonstrated through the procedure of member checking (Borbasi et al., 2008; Speziale & Carpenter, 2007) when the researcher read back the main points during and after each episode of data collection and the participants confirmed the researcher’s interpretation of the content. Furthermore, to strengthen credibility, the individual interviews were used to clarify concepts emerging from the relevant focus group discussion.

Dependability is concerned with the authenticity of the data. Chiovitti and Piran (2003) describe dependability as auditability. This aspect of trustworthiness was
ensured by following a clear research procedure. In this study, dependability can be seen through the decision trail (Borbasi et al., 2008) demonstrating participant criteria and recruitment (Chiovitti & Piran, 2003). This aspect included audio recording in focus group and interview data collection to give verbal accuracy, and transcribing the focus group discussions and interviews verbatim. It also included checking for accuracy with the participants after each focus group discussion and interview, when the main points of the discussion were summarised by the researcher for the older persons to confirm that data were accurately interpreted and complete. Dependability also incorporated the consistent use of the paradigm model described previously in the section on data analysis, as a framework for coding. After analysis of each transcript, checking for accuracy was achieved through peer examination conducted by the researcher’s two supervisors. This was to ensure that interpretations of the transcripts and analysis had been understood by the researcher. Furthermore, key decisions made in relation to data analysis are demonstrated through the use of quotations and memos.

Transferability is concerned with the generalisability of the findings for others wanting to use them (Polit & Beck, 2010). It is also referred to as fittingness and ensures that the findings will have meaning in similar settings or groups (Borbasi et al., 2008; Chiovitti & Piran, 2003; Speziale & Carpenter, 2007). In this study, transferability of the findings was achieved through a clear detailed description of the study setting, and the participant selection criteria and characteristics. Connecting the interpretation of the data and the theory to the demographic data and other literature has also demonstrated transferability as it enabled the findings of other research to be compared to the findings of this study.
Confirmability demonstrates trustworthiness through credibility, dependability and transferability of the findings. In this study, examining the contribution of possible researcher biases and assumptions in explaining reflexivity and theoretical sensitivity demonstrates confirmability. This includes the acknowledgement that the researcher was part of the research and influenced the findings. In addition, presentation of the methodology and findings by the researcher at a national conference and three College Research Colloquia for feedback demonstrates confirmability.

4.6 Ethical considerations

Permission to conduct the study was obtained through two different processes:

- The co-ordinator of the Seniors’ Leisure and Learning Centre

- Subsequently, from the University of Western Sydney Human Research Ethics Committee (UWS HREC).

The application for ethics approval required the identification of standards of practice in relation to conducting research with older persons, and included adherence to a number of ethical principles related to sampling, recruitment of participants, data collection and analysis. Polit and Beck (2010) contend that these principles involve standards of ethical conduct. In this study, these principles included obtaining permission to conduct the study, knowledge of risks or prevention of harm to participants, and finding volunteers who were informed about the study and aware of the impending request for them to disclose personal information. Others were obtaining consent to participate without coercion, participants’ right to withdraw from the study at any time, and their right to privacy, anonymity and confidentiality.
Although the term *vulnerable* is difficult to define, older persons may be considered a vulnerable group to research (Liamputtong, 2007, In press). Keeping this in mind, it was considered there were no other specific ethical issues relating to the conducting of research with older persons in this study. This group of older persons were members of a centre that was used for activities and not day care and there were no participants in attendance who were cognitively impaired and could not consent to participate.

Schoenberg (2002) argues that concern about conducting research with older persons is generally exaggerated. She states that concerns usually relate to cognitive impairment and consent, or the fact that the older person will get tired, have poor hearing or that those living in a residential care facility will be depressed or confused. Other concerns relate to the uneasiness of the researcher in exploring topics associated with everyday living in nursing homes. However, these concerns are overstated and conducting qualitative research with older persons has the potential to uncover the depth and fullness of their lives (Schoenberg, 2002). In their study, Cheek et al. (2005a) report successfully interviewing older persons using in-depth semi-structured interviews.

One of the requirements of ethics approval was to address what Polit and Beck (2010) and Schneider et al. (2007) refer to as the ethical principle of beneficence. This principle relates to protecting the participants from physical, social, emotional or financial “discomfort and harm” (Burns & Grove, 2009, p. 198; Polit & Beck, 2010, p. 121). Preventing or minimising harm included the assurance that participants would not be exposed to risk of harm or harm by participating. Although no risks to participants were expected, advice was sought from the Aged and Disability Community Development Worker in the LGA about an appropriate
contact person for referral if any of the participants became upset or distressed while talking about their past or present experiences, or revealed issues of elder abuse during data collection. Advice received at the time indicated that the ACAT social worker was the most appropriate person for referral if necessary. Fortunately, during the study no participants revealed any incidents of abuse. At times throughout the interviews, particularly when discussing the loss of a partner, family member or friend, some participants became uncomfortable or saddened. When this occurred the participant was asked if they would like to talk further about the issue. Generally participants did not want to talk about the topic further and appeared eager to move on to discuss a different concept. All participants were asked at the time if they wanted to discontinue the interview and/or talk to the ACAT social worker about how they were feeling. However, no participant wanted to discontinue the interview and all declined the offer for referral. Offering referral to the participants assists in preventing harm (Liamputtong, 2007, In press). The researcher ensured all interviews were concluded on a positive note by talking about a pleasant topic, such as a planned activity.

In relation to exposure to risk or harm, throughout the study the researcher maintained an awareness of the intrusion, albeit brief, into the participants’ everyday lives. Addressing this principle involved respecting participants’ time and willingness to express their inner thoughts and feelings. As a token of gratitude, morning tea was provided when collecting all data and an expression of thanks was given to participants for their time and support of the study. Reciprocity in giving something back to participants for their effort is important in conducting research as it decreases any inequality relating to power and some form of compensation for the time given by the participants demonstrates respect (Liamputtong, 2007, In press).
Furthermore, this expression of thanks eased the researcher to comfortably finish data collection without feeling emotions or leaving any burden for the participant. Subsequently, during data collection the participants gave their own thanks and commented that they were interested in the study and enjoyed having the opportunity to be involved in discussions with others attending the centre.

During participant recruitment, a verbal explanation of the details of the research was presented so that persons consenting to participate were adequately informed in advance of the details of the study, what was expected of their participation and that they would be asked to disclose personal information about their experiences of living in their home. Participants were also informed that all focus groups and individual interviews would be recorded, and of their right to withdraw from the study at any time. This information addresses the ethical principle of respect for human dignity and the right to full disclosure (Polit & Beck, 2010). Following this explanation, the request for interested persons to volunteer for a focus group discussion and individual interview was made. A Study Information Sheet and Consent Form (see Appendix A) were given to each of the potential participants. It was explained to participants that they were to initial the Study Information Sheet and complete the Consent Form before participation. To minimise the possibility of coercion, any persons interested in the study were first invited to take the Study Information Sheet and Consent Form away for one week to consider their consent. Not all older persons attending the forum consented to participate in the study, suggesting that recruitment was undertaken without coercion. Ensuring there was no deception or coercion, the researcher respected the participant’s autonomy and individual responsibility (Schneider et al., 2007).
On arrival at each of the three focus groups and all interviews, participants were given copies to keep of their initialled Study Information Sheet and signed Consent Form stapled together. At the commencement of all focus groups and individual interviews, the purpose and procedures of the research were explained to the participants. No participant withdrew from the study after its commencement.

Participants were assured of their right to confidentiality, where their identity could not be connected to the information they disclosed (Polit & Beck, 2010; Schneider et al., 2007). To maintain privacy and confidentiality in the focus groups, ground rules were set and participants were asked to respect the other participant’s experiences and agree that information disclosed in the focus groups was not to be discussed outside the focus group discussion. In addition, participants were informed that a coding system would be used in data collection and analysis to protect their identity and maintain confidentiality in the reporting of results. Participants were also informed that findings could be published in journals and in this thesis using pseudonyms to protect their identity.

To further address confidentiality, all audio recordings, transcripts, computer files and consent forms are kept in a secure location in a locked filing cabinet. Each participant had access only to the record of the focus group discussion they attended and their own interview(s). The transcripts have been seen only by the researcher’s supervisors. All computer data files are password protected and the passwords are known only to the researcher. To meet ethics requirements, all transcripts and audio tapes will be stored in a locked facility at the University of Western Sydney, NSW, Australia for five years from the publication of this thesis.
4.7   Researcher reflexivity

Qualitative research has been criticised for bias and lack of rigour. To develop quality in their research, qualitative researchers acknowledge their interests and assumptions through reflexivity (Barry, Britten, Barber, Bradley, & Stevenson, 1999; Primeau, 2003). Primeau (2003) claims that researchers’ being aware of their assumptions, values and biases provides a context to understand the interpretation of data. In discussing reflexivity, the researcher addresses their interests and how their position shapes the research (Charmaz, 2006; Smith, 2006). In so doing, they acknowledge their position in relation to the study, their role in the research, and that they are part of the phenomenon studied (Barry et al., 1999; Primeau, 2003). Therefore, through acknowledging the assumptions, values and biases of the researcher, reflexivity increases the trustworthiness of this research.

As this is a reflective account, the following section relating to researcher reflexivity is written in the first person.

4.7.1   Commencing the study

My assumptions about ageing and older persons at the commencement of the study have been outlined in Chapter 1 of this thesis. These were based on personal experiences with ageing family members and a substantial amount of professional experience gained through caring for older persons and teaching older adult nursing.

Other assumptions I had related to the research process. Being a novice researcher, I assumed that selecting the Strauss and Corbin approach to grounded theory would guide me through the research process and give rigour to the research. Also, I expected that there may be some difficulties associated with conducting research
with older persons relating to their hearing, sight or memory, which may lead to misunderstandings. However, these issues did not arise in this study.

4.7.2 Accessing participants

The participants were accessed from a seniors’ centre in Western Sydney. At the study’s commencement my first concern related to establishing a relationship with the older persons. I was concerned that because the members of the centre were an established group to which I did not belong, I would be perceived as an outsider. I assumed that this perception might make it difficult to recruit an adequate sample to conduct the study.

As an outsider, I was conscious that I was a visitor and that I wanted something from the older persons. I realised that I had to contribute something back to the group and I felt that by taking a personal interest and commenting on positive aspects of their demeanour, such as their clothes, level of activity and the validity of their experiences I was giving a little back. Also, as an outsider, I did not have insider knowledge and therefore spent time gaining access and trying to understand the culture at the centre. As I was not a current member of the group I had to work harder than an insider to establish rapport and trust. However, as an outsider I was more objective and open to what was said by the older persons. Furthermore, I was seen to be a researcher and therefore the older persons may have been more likely to tell me some things they would not disclose to an insider.

At recruitment, I felt uncomfortable because I was younger than the participants and I had limited research experience. I assumed that the everyday experiences of the older person would differ from my experiences, and as this was a topic that required the divulging of personal experiences, the older persons may not want to share them
with me. However, following a brief explanation at the conclusion of the forum I attended, I felt that I was accepted by the majority of the group because they indicated their interest in participating in the study. One older person told me that having someone young and friendly who was interested in the experiences of older persons motivated him to participate.

Attending the forum to recruit older persons for the study was informative as it enabled me to observe how the members of the centre were expected to act in this context and how they related to each other. After observing the group dynamics at the forum, I realised that there was some animosity within the larger group between those who were members of the U3A and those who were not members, and that this might affect the safety and comfort of the focus group environment. This knowledge influenced participant recruitment described previously under the study methods section.

4.7.3 Collecting and analysing data

When collecting data, I assumed that personal appearance was important to the older persons. I wore semi-casual clothing to look slightly professional but remain casual enough to maintain the interactions at a comfortable level. My assumptions were confirmed as I had noticed the majority of the older persons appeared to be very conscious of being appropriately dressed and well-groomed.

Prior to data collection, I assumed that the older persons would allow me to interview them in their own homes. I had intended to conduct interviews in the participants’ homes because I thought it would provide a rich context where they were engaged in the processes to stay living at home. However, it was not until the final stages of data collection before three participants invited me into their homes to conduct the
interviews. Possible reasons for not wanting to be interviewed at home could be that they had to undertake other activities, such as cleaning or preparing food if they were to invite me into their homes, or because they did not know me well enough to invite me into the privacy of their homes. I always accepted their decision.

Throughout data collection, my position as a nurse facilitated the trust of the participants who volunteered. Also, having a professional background as a nurse caring for older persons helped me communicate more easily. I was aware of the importance of establishing rapport with the older persons so they would trust me and share their personal experiences about living at home. I was friendly and wherever possible accommodating to individual needs. Liamputtong (2007) suggests researchers can establish rapport with participants by helping them to feel relaxed and comfortable. I engaged in small conversations or chat with many older persons each time I attended the centre. Engaging in general conversation helped me to understand the participants better, what they had to say, what was important to them, and become familiar with their idioms.

Each time I went back to collect data, the older persons made me feel welcome and attempted to include me in their day, as they asked me to join their group for lunch or participate in the activity. I could see they felt happy that I remembered little things about them. Towards the end of the study when I called in to visit the centre, the older persons recognised me and discussed what was going on in their lives.

Similar to criticism by Glaser (1992), I found rigidly adhering to Strauss and Corbin’s (1990) framework led to descriptive analysis and it was not until I acknowledged that I was part of the analysis that the analysis became theoretical.
However, I did find the framework useful to use and with experience would use it in a more flexible and less prescriptive manner.

At the conclusion of the study, I found it difficult to withdraw from the field. I enjoyed visiting the older persons and chatting about their everyday lives. I had developed a relationship with this group of older persons and maintained an interest in how they were managing at home. I was surprised at how many of the participants struggled in their daily living to achieve simple, often taken-for-granted tasks and how hard they were required to work so they could stay living at home. Developing the theory and writing this thesis has made withdrawing from the field easier as it enabled me to tell the older persons’ stories and acknowledge the precious time they gave to me.

4.8 Chapter 4 summary

In this chapter, the methodology that was to be used to understand the meanings older persons give to their experiences of living at home and elicit their responses to managing change has been explained. The decisions made about the best methods to answer the research questions and develop a theory explaining the processes used by 21 older persons to stay living at home have been described and justified. This included a discussion of the theoretical underpinnings of the emergent study through a post-positivist theoretical perspective using grounded theory methodology. The grounded theory approach (Strauss and Corbin, 1990, 1998) was considered the most suitable methodology because it enabled an exploration of what the experiences were and how older persons respond to these experiences.

The second section of this chapter described the study method, including the two methods of focus group discussions and individual interviews used to collect and
analyse data concurrently. In this section, the contextual setting, study sampling and participants were explained. This included identifying and justifying the rationale for using purposive and theoretical sampling, sampling criteria and participant recruitment. The critical components of grounded theory in relation to this study were described in the last section on data analysis. Study rigour supporting the research process has been addressed, and the researcher’s influence on the study has been explained through researcher reflexivity. Ethical considerations and were also described in this section.

The findings from the analysis of the three focus group discussions and 10 individual interviews are presented through four major categories and the central process in the following five chapters. The next chapter, Chapter 5 presents the major category ‘it’s home,’ examining the meaning of home described by the participants. It concludes with a presentation of the findings relating to the entry point into the process to stay living at home. Following this chapter, the major actions and interactions engaged in by the older persons once they enter the process to stay living at home are explained in Chapters 6, 7 and 8. The grounded theory ‘holding momentum: sustaining living at home’ developed though the exploration and description of the experiences of the older persons and interpreted through a storyline as both a central category and process is then presented in Chapter 9.
Chapter 5 – It’s home

The previous chapter described the research methodology and the methods used to collect and analyse the data to generate a grounded theory explaining the experiences of older persons remaining at home. This chapter and the following three chapters present the study findings revealing four major categories developed from the data, which are: ‘it’s home,’ ‘maintaining autonomy,’ ‘protecting self’ and ‘connecting with others.’

The first major category ‘it’s home’ is presented in this chapter. It describes the meaning of home as experienced by the older persons in this study and examines how the meaning of home influenced their experiences and capacity to achieve their goal to stay living at home. It describes the motivations and the context within which the older persons engage in actions and interactions to remain at home. The chapter concludes with the findings explaining the entry point into the process to stay living at home. Upon entering the process, the older persons implement the major actions which are described in the following three chapters.

5.1 It’s home

Living at home appeared to be critically important for all older persons, and to understand how they remain living at home required an understanding of why they wanted to stay living there. For the older persons in this study, home had meaning, as it anchored people giving them an identity, enabled them to be free from constraints
of others, provided physical and emotional comfort, and facilitated social contact.
The four subcategories presented under the major category ‘it’s home’ describing
what home means to the older persons in this study are: anchoring self, enabling
freedom, being comfortable and staying in touch.

5.1.1 Anchoring self
All older persons in this study were determined to remain living at home. Their
relationship with home was characterised by a number of aspects revolving around
the notion of anchoring self. Home to the older persons was so important, it
represented their past, present and future. Jane referred to this as: “But one’s life gets
locked into an area … your life gets locked up in the things you create.”

It was significant that almost all older persons had lived in their home for a long
time. This was illustrated in the responses of many, as John said, “I have lived in the
same place for 32 years,” and Sarah, “I have lived there for 74 years.” Despite some
variation in the length of time lived in the current home amongst the participants, it
appeared that living in the same home for a length of time created a strong and
significant connection, and as a result the older persons did not want to move out.
Sarah described how she felt firmly anchored at home and had “never ever thought
about” moving out of her home, and when speaking of the restrictions imposed on
daily living in other accommodation options she stated, “can’t imagine myself in a
[nursing] home.” Rose also talked about her reluctance to move out and said:

I couldn’t imagine being anywhere else …. I love my home and I lived there
when I was married and I’ve never had another home on my own …. I don’t
want to leave it and I can’t imagine going into a nursing home or anything or
a retirement village or anything like that because it’s just, I suppose, just
home to me.
A major reason for anchoring themselves to their home related to longevity of domicile. The older persons revealed home was a place where they had invested themselves and were determined to defend their right to remain living there. Irene was definite in her approach to staying at home and said:

Well, why give up a home when I’ve fought so hard to get it? I had to pay for the place myself .... I have lived in the house for 40 years and I don’t want to shift ... I don’t want to go into other homes ... I’ve said that all along .... I’ve been told enough about it but as far as I can look after myself I don’t intend to go .... I’ve been told for years I should give it up and go into a unit or something and I said no ... I’ve got no intentions unless I have to of leaving. Maybe I’m too determined. I think I'd die before leaving.

For many, the other major reason for anchoring themselves to their home related to identity. The continuity of living in the same home for a long period of time assisted the older persons to establish and secure an identity. This concept was illustrated when the older persons consistently made reference to their home as my home. When described in this way, the term my home implied a sense of identity through home ownership. When talking about their home, the majority of older persons described how they had invested everything into their home to achieve the status accompanying home ownership. Sally referred to her investment as: “It is my home because I own it.” Through home ownership the older persons were able to secure their place in the world, as Rose proudly said, “[I] live in my own home.”

Maintaining a close connection with their home over a period of time also facilitated the creation of an identity within the community. Living at home enabled the older persons to maintain an identity within their community as it conveyed messages about them to others. An identity linked to the community was particularly important when spouses die and other aspects of familiar life, such as the local corner shop,
start to disappear. Jane described her home as a place that gave her a social identity when she said, “Those people [neighbours] had known him [her husband] and that is very important to me, that I am not just me but that I was part of a double, part of somebody else.”

Living at home and investing the self into the home over time gave the older persons the opportunity to transform a house into their home, as Tom stated, “It’s not a house after a while, it’s a home.” Many older persons frequently made reference to the personal nature of this transformation, as Mark commented, “A home is what you make yourself.” Rose’s experiences support Mark’s comments when she said, “Home is what you make it.”

Some older persons described anchoring self as an investment of the self in the home, as a part of them had gone into building and creating a home, as Peggy said, “We built our house.” A few spoke of taking responsibility for creating their homes to define their own needs as they aged. When describing her recent experience of taking control of her environment to facilitate self-management of her chronic illness, Kathy stated, “Now I built a new home.”

For others, creating a home was as simple as keeping mementos around the home. In this way, home was a reflection of the self and facilitated self-expression. This aspect was illustrated when Ellen made reference to moving from house to house throughout her adult years and through decorating each new house with personal mementos, she created a new home. She expressed this as: “I can make a home anywhere …. Everybody has a few personal things that they dearly love … I put up two paintings. That was home.”
In summary, one of the most common meanings of home emerging from the responses of the older persons in this study was to describe home as a place where they anchor themselves to create and maintain an identity. The significance of living at home for a long time is that the older persons found it difficult to imagine living in alternative accommodation. Home was presented as an extension of the person and for the older persons in this study to move out of home meant leaving behind a part of themselves, losing their sense of self.

5.1.2 Enabling freedom

The meaning of home also encompassed a notion of being free from constraints. **Enabling freedom** was the second subcategory emerging from the responses of older persons as a reason for wanting to remain living at home. This subcategory describes one of the important characteristics of the meaning of home is that home symbolises freedom. The benefit of this characteristic was highlighted when Dan said, “Because I am sure that living in my home, definitely, [means] more freedom.”

Home offered the older persons a known territory and one of the most important benefits of living at home in a familiar environment was that they were able to determine how they wanted to go about their everyday living. Consequently, living at home afforded freedom to personalise activities and determine daily living, facilitating the self-management of everyday work and time. Rose described when living at home she could manage her daily work as: “Because it is home and I can do what I like.” Irene described being in control of her own time at home as: “Come and go when you wish … without someone wanting you to do this or that.”

Many older persons revealed that one of the advantages of having freedom at home was that home creates a work environment. Living at home gave a focus and a
purpose in life, and provided a good reason to keep busy and have daily work to do. Irene expressed this as: “I feed my cat and look after that, keep the house tidy in general and I see that the raking up’s done out in the garden.”

The older persons discussed that one of the critical aspects of managing their own work and time was that it enabled them to undertake daily activities themselves. Sarah expressed this as: “I do my own cooking and things like that …. I do all my housework myself.” Almost all older persons commented that doing tasks in their own time required only minimal effort. Frank said, “As far as I am concerned I have no problem at all attending to my work and I attend to my affairs.” For many, the freedom of living at home enabled them to extend their work into the community. Sally described this as: “I do all my own work, all my own shopping, do everything myself,” and Ellen stated, “We can still drive … and do our shopping.”

Although the participants varied in their capacity and their ability to do their own work, a range of benefits ensued from being at home, including gaining a sense of self pride and personal satisfaction through feelings of accomplishment. Many proudly expressed doing all their work themselves, as Anne and Rose both said, “I do all my own work.” Others expressed personal satisfaction through accomplishing daily activities themselves. This was described by Irene when she said, “I do all my own necessaries.” John stated, “I do everything for myself, washing, ironing, cleaning.”

In particular, those living alone described how they enjoyed living at home as they did not have to consider anyone else or contend with interference from others. Having freedom to do as they pleased at home, enabled the older persons to remain
autonomous and control the amount of interference of others in their planning of their everyday living. Rose described her experience as:

*I’m used to being on my own and when you’re on your own you can do what you like, you can eat what you like, you can go to bed and get up when you feel like it …. I like to be able to do things my way. If you’ve got me living with anyone they say well you do so and so and they might do it different to what I would do it …. I just feel happy living in my own home …. Doing what I want to do and doing it when I feel like doing it.*

**Enabling freedom** impacted positively on daily living, as the older persons’ lives were enhanced by their ability to maintain their independence and remain autonomous. Living at home and having freedom was seen by all older persons to be a critical factor to maintain their independence. The participants expressed an awareness of the loss of freedom and independence if they were required to move out of their home. Irene demonstrated this concern when she said, “*I’m too attached to my home …. I’m used to being independent and I don’t think I could confine down to regulations and rules.*”

In a later interview, Tim articulated his experience of moving into a hostel and compromising the level of freedom and independence he had attained when he was living in his own home. In the following example, he described consequences of moving out of his home are that he is now unable to determine his own daily schedule and is restricted to spending his time within the hostel. When talking about life in the hostel he said:

*Freedom of times and things, they have fixed meal times here, so you can’t wander down any old time, so I mean, on your own you might say, oh, I’ll have something early or I’ll have it later … and what I miss, I can’t go out.*
I’m used to sort of going out to the shops and do a little bit of shopping and now that’s a problem.

In summary, home as a place for freedom was one of the most important meanings of home emerging from the data. Enabling freedom was described by the older persons as having choice in making decisions about everyday activities. The older persons illustrated that having freedom through living at home and controlling interference from others facilitated their independence, resulting in great pride and personal satisfaction.

5.1.3 Being comfortable

A third subcategory emerging from the responses of the older persons as they described the meaning of home was that home was a source of emotional and physical comfort. Being comfortable was expressed through the benefits derived from living at home, such as happiness and contentment, good memories, a familiar territory providing peace of mind and stability, and a space for relaxation and restoration.

Emotional comfort was both a characteristic and a benefit of living at home. The majority of older persons reported having a sense of wellbeing derived from feelings of emotional fulfilment. For many, home facilitated feelings of happiness, as Peggy stated, “I have been there [home] for about 50 years now and I enjoy it.” Like Peggy, others described their feelings of satisfaction through living at home. Frank commented, “Older people … like to live in their homes. They are happy in their homes.” Laura added, “We are living there, very happy to live there.”

Living at home also provided a sense of comfort through contentment. Ellen exemplified this when she said, “It’s very comfortable. We’re here together … Our
home is very important to us … I think we’ve got everything we want in this house.”

Marjorie supported Ellen’s comments when she said, “I’ve got everything there that I want.”

Tim described an additional benefit of contentment when he was still living at home was the facilitation of independence. He stated, “I had all my stuff there, and it’s organised comfortably with comfortable chairs and a good bed and everything …. You’re independent there. After all you’ve got everything, when I’d arranged everything the way I wanted.”

Another major aspect of emotional comfort expressed by some older persons was their description of home as a peaceful place where they had their own space. When stating why she liked living in her home, Sarah commented, “It’s a nice quiet street and area.” When he was still living in his home, Tim expressed he liked living there because “there is plenty of space and fresh air and it’s nice and quiet.”

In addition to having their own space inside the home, others described having space within the outside boundaries of their home. Irene referred to the comfort she experienced by spending time in her back garden when she said, “I like space … would hate to live in a room. I like my backyard.”

Maree explained that having space at home influenced her decisions when relocating to the retirement village. She stated:

I wanted that extra room in case I, I’ve got friends who live in Melbourne and Adelaide, and if I wanted anybody then I could have them but I really didn’t. That wasn’t the only thing. I really wanted a two bedroom one for the extra room …. I didn’t want a one bedroom, no.
Almost all older persons described one of the other main characteristics relating to emotional comfort and a benefit of living at home is that home generated good memories. In this way, home was a place where the older persons could reflect on happy memories of life. Dan spoke of these pleasant memories when he said, “You cannot deny at our age, our memories, still there is a lot [of memories at] home … and everyone enjoys to see or to live or to tell about his memories.” Although Maree no longer resided in her home and was living in a retirement village, she described a feeling of contentment through the fond memories of her former home as: “Well it was a happy, happy home life and I felt that, how can I put it, I just felt that (-) [her husband] was there, although he died …. It was a happy household so I was quite happy to stay there.”

The older persons described home as a place where memories of their childhood, adulthood and parenthood are held and embodied, that is, have become part of their psyches. Irene stated, “I have a lot of memories … when no one’s here … I have a lot of thinking to do …. I can remember all the things.” Sarah described feeling comfort through reliving fond childhood memories of home where she still resides, when she stated, “It was a happy home.” When describing adulthood experiences of caring for her parents at home, she commented home to her was “the good memories you have back then …. I looked after our mum and dad [at home].” When still living at home before moving into the retirement village, Maree spoke of the emotional comfort she gained from the happy memories of parenthood and family life in her home as: “They [family] were my life and I have thoroughly enjoyed it all.”

A few older persons revealed that living at home gave comfort to their adult children who now resided in their own homes. Rose illustrated this characteristic when she talked about the happy memories her home continues to give them. She stated home
was “your comfort and your memories … memories of the children when they were small …. When they [children] all married and had their own homes, they call my place home.”

Living at home also provided physical comfort for all older persons as home was a place where they could relax. Sally said, “It’s a sort of relaxation to go down there [garden].” For some, their garden had become a haven to unwind and a place to take things easy. Irene described her experience as: “You forget your worries I reckon when you go outside,” and

_ I love to get outside in the garden …. I love to get outside more so than inside. I’ll shut the door and go outside …. I’ve got a big backyard, I can go up the back and you can hear nothing …. I forget everything …. I wouldn’t like to live in high-rise places or units or anything. I don’t like it …. I like to get outside._

Home also provided comfort as it was a place for revival and restoration when returning home after engaging with others in the community. Ellen described being at home between activities and social outings as: “You stay at home to catch your breath.” The types of activities used for revival and restoration, were as Laura commented, “Being at home is also nice for us to read.” Kathy said, “I come home and then watch my television or read a book.”

The idea of familiarity seemed to underpin the concept of comfort. Having comfort at home was also expressed as having peace of mind through living in a familiar environment. Ellen illustrated this when she said, “I know where things are so that’s a big plus …. It’s familiar.” In this way, the older persons described how they were accustomed to living in their home as it was uncomplicated to live there. Rose said, “I’m comfortable …. I know where everything is that I need …. I know the yard …
even if I didn’t have my fairly good eyesight I would still be able to get around.”

Mark claimed he was “used to the house and I could walk around without the light on and know where everything is.”

For others, the familiarity of their home ensured privacy and a place to entertain.

This was something that was considered to be missing in alternative accommodation.

Ellen said, “We know what we’re living in. It’s very comfortable, we know the area … and we’ve got plenty of privacy here, and it’s big enough. We can have the family; they still come home for Christmas and Father’s Day.”

Familiarity also gave a sense of competence. Marjorie described being accustomed to the environment of her home facilitated her living there and prevented her moving out into alternative accommodation. She explained this as: “Well, it’s just home, you know everything, where it is, instead of going into a different environment. I’m just prepared to stop at home. It makes it so that I can stay home.”

Interestingly, the characteristic of comfort was the one meaning of home that the older persons were able to renegotiate after relocation. Although only a few older persons had moved out of their homes by the conclusion of the study, all had managed to find comfort through accepting their new residence as their new home.

After relocating to a hostel Tim said, “This is my home …. I’m not going anywhere else …. I’m comfortable here.” When referring to her new residence in the retirement village, Maree’s experiences supported Tim’s comments when she said, “It’s very comfortable … happy to be here and it is, with all my things around me, it’s just like my own home.”

In summary, being comfortable was another commonly reported aspect of home emerging from the responses of older persons in this study. Living at home provided
emotional and physical comfort as home afforded the benefits of happiness and contentment, good memories, a peaceful space for relaxation and restoration, and peace of mind and stability through familiarity.

5.1.4 Staying in touch

*Staying in touch* was the final subcategory which emerged from the data relating to the meaning of home. The older persons all described being able to make contact with others was one of the major reasons for wanting to remain living at home. As home was known territory it provided a base, a way to get out into a wider community and return. When using home as a base to go out and participate in activities in the community, home also became a link to making friends. The importance of this characteristic was reinforced by Maree when she said, “As you get older it is harder to make new friends.”

Consensus among the older persons was that living at home positioned them close to their family, friends and neighbours. In this way, home provided a support network and prevented isolation. Many older persons lived at home close to their family which facilitated access to informal family support. When describing her available support network Sarah stated, “*My sister lives next door,*” and Ellen referred to her support as: “*We have got our family around there. We got our interests all round this area …. It’s just in a good position …. We’ve got a daughter down at (-).*” Anne described *staying in touch* with her friends and neighbours prevented loneliness, when she said, “*We keep in touch with everybody … they can always talk to somebody.*”

The older persons all identified that living at home enabled them to maintain ties with longstanding relationships. They described how they attach meaning to these
interactions with others over time. Marjorie explained the closeness of these relationships provided her with a high level of support when she said:

_The people around here, the neighbours around me, we’ve all been together there … since 1950 …. The majority of them are the same but we’ve got some new neighbours and they’re up the top end of the street and you wouldn’t even know their name … but the ones down where we are, there’s only about six or eight houses, they all pitch in and help one another._

However, not all were fortunate enough to continue living within the same community. For many, their community had changed as people around them moved away. Despite this change, generally the older persons believed they could retain a stable community if there were substitutes and those new to the community engaged similarly to the others they replaced. Jane commented, “_Our little community has changed completely and I was lucky enough to have replacements._”

Living at home was seen to facilitate _staying in touch_ with others, as home and its community is known territory. Similarly, as home facilitated feelings of comfort through familiarity, the concept of familiarity underpinned _staying in touch._

Knowing what was available in the local community provided the means to get out into the community and return home. Consequently, home was a place where people originate, go out and return. Mary and Kathy described how they were able to stay in touch with their communities as their homes enabled access to familiar services which provided them with daily options. Mary said, “_There is so much offering that you can do … provided you are able to get to the venue … I live at (-) … it’s handy for everything._” Kathy added: “_I like this area because I can go on my $1 ticket everywhere and there is so much to do._” Sally described her home as enabling her to stay in touch with others because, “_it is convenient to everything._”
For some older persons, living at home enabled them to use convenient facilities to access services close to their home or located within the local community, including interests, activities, shops and their GP. Alice described having the accessibility of these services from her home enabled her to stay in touch when she said, “It is very convenient where I live to the shops, the buses and the trains.” Sarah commented, “It is very convenient where I live, the shops, a doctor and a chemist and other supermarkets.”

Although Rose and Mark described their homes were not easily accessible to shops or other services, they described convenient public transport provided access to stay in touch with their broader community. Rose expressed this as: “Well the bus is just across the road. You only have to cross over the road to catch the bus … convenient.” Mark said, “It’s all uphill [to the shops] …. I get a bus … convenient.”

Interestingly, as the majority of older persons identified social relationships as motivators to stay living at home, it appears for those who had relocated, social contacts continued to be motivators to stay living in their new home. This was exemplified in the following comment by Maree after she moved into a retirement village, when she stated:

*I can look out. I’m on the ground floor which I look out and see quite a few people passing by, and sometimes if I sit out the front and they’ll wave or talk or say, “How are you?” and actually even strangers will say, “Hello, how are you?” You don’t always have a conversation with them. Just like living in your own home.*

In summary, one of the four emergent meanings of home formed from the responses of the older persons in this study was that living at home enabled the older persons to stay in touch with their community. The older persons identified that through living
at home they could form stable relationships and remain socially connected to have support from family, friends, neighbours or others. Living in a familiar environment promoted an awareness of access to transport and other facilities and this provided a means to get out into the community to engage in activities or utilise services and return home.

For those who were still at home, they saw their established social relationships as important to their wellbeing, and were reluctant to move away for fear of losing them. However, those who had moved out of their own homes had made efforts to stay in touch by establishing new social contacts.

Therefore, the meaning of home as experienced by the older persons in this study provided the context where they made decisions and performed actions and interactions to remain living in their homes. The major category ‘it’s home’ presented in this chapter demonstrates that for this group of participants, living at home is a vital element in the transition through the ageing process. Living at home facilitates self-identity through anchoring self; self-determination through enabling freedom; emotional and physical satisfaction by being comfortable and social contact by way of staying in touch.

The meaning of home explains why the older persons want to stay living at home. Ageing and community change make the older persons think about implementing strategies to stay living there. It is these changes that are the triggers for the entry point into the process to stay living at home. The following section presents the entry point as described by the older persons. The entry point was described as when something happened and the changes that ensued were the trigger that made the older person realise they had to be active in their desire to stay at home.
5.2 Entry point into the process to stay living at home

Knowing the characteristics and benefits of living at home, the older persons entered into a process to stay living at home when they realised something was threatening their ability to remain living there. For some, it was a major incident or sudden health crisis that was described as the trigger for their entry point into the process. Others described realising a gradual deterioration in their health was affecting their everyday living.

5.2.1 Sudden change in health

A sudden change in health such as a collapse or major health issue requiring surgical intervention was one factor described by some older persons necessitating their entry into the process. When talking about the time in her life that she realised her health had changed and greatly influenced her lifestyle, Irene said:

*My age, I think, crept up …. I was 84 or 5. I used to do long hikes …. I collapsed on the walk and I gave them away … that’s when I had to go to the heart specialist …. I didn’t want to collapse on another lot …. I’ve known for years but … I don’t accept it and perhaps I fight against it … age has crept up …. I’m not old. I’m just past everything else.*

Rose collapsed when travelling a long distance to visit her brother by herself and she described the impact of this sudden major change in her health as her entry point when she said:

*They live out of (-) …. I go up once a year and stay for a few weeks …. But I haven’t been up this year so far …. Well, I go by train and the last time I was up there and I came back, I collapsed on (-) Station …. So the family has now said I’m not going on my own.*
For others, the need for surgery necessitated major lifestyle changes. Mark was able to clearly identify the point at which things changed for him when he described a sudden change in his health required immediate surgical intervention. The entry point into the process to stay living at home for Mark was after an operation when he realised he needed to make changes to his everyday living and do things differently. When discussing his entry point, Mark said it was “after I got out of the hospital … slowing down.”

5.2.2 Gradual change in health
Alternatively, for other participants it was a gradual change or deterioration in their health that necessitated entry into the process to stay living at home. Many older persons described subtleties associated with the physical changes of ageing affecting their capacity to stay living at home as the trigger for their entry point. Interestingly, they usually related the entry point to their age.

Anne described experiencing physical age-related changes triggered something so that she became more determined to stay living at home. She said she noticed these changes, “I think when I reached the age of 80,” and that it was “a bit of a shock that you’d really got to 80.”

A gradual deterioration in her health was described by Sarah as the trigger for her entry point into the process, commencing when she began losing weight. She spoke about how she felt that she had slowed down and said, “I was pretty good up till …. I would have been about 84, I started to find myself getting slower.”

Tim described his entry point as the awareness of having to increase the effort required to get his everyday tasks done as:
A bit harder to walk around. Up hill, more of an effort to walk up the street and then trying to get three meals a day, and the shopping ... all this sort of shopping to do and that was a problem and then the laundry. I’ve had to do the laundry at least once a week, apart from a bit of hand washing on odd days and keeping the place clean. I’d run a vacuum cleaner around once a week and I was really very tired, especially if I went out. I’d leave the house and I came home late afternoon I just felt like flopping ... and then I had to sort of make an effort and cook some dinner.

Deteriorating eye sight, commencing around age 76 was described by Ellen as the time when things changed for her. She spoke of some of the consequences of the gradual change in her health and the need to enter into the process to respond to them when she said, “I think the biggest bugbear for me was when my eyesight started to go ... because I couldn’t drive a car, I had to give my license in. I can’t sew, I can’t read letters, I can’t read the bills.”

Marjorie described how she became unsteady on her feet and how this necessitated her making changes to her lifestyle. She realised the consequence of living at home alone was that it became unsafe and she began staying the night at her daughter’s house nearby. She described her entry point as: “Ten years now .... I had a slow combustion stove in the lounge room and then the girls say ‘Mum, you can’t light that now we’re not with you, you’ll fall on the stove, get burnt, drop wood on the floor.’ It wasn’t safe.”

In summary, as the older persons’ age and recognise change, they make a conscious decision to stay living at home. To respond to change and remain at home they enter into a process and implement actions and interactions to make lifestyle changes. The entry point into the process to stay living at home described in this chapter was
identified as a time when the older persons identified either a sudden or a gradual change in their health.

5.3 Chapter 5 summary

The major category ‘it’s home’ presented in this chapter described the reasons why the older persons in this study are determined to stay living in their homes as they age. Analysis of data revealed that living at home provided purpose and many other benefits, as home enabled the older persons to maintain the identity they had established, have freedom to do as they please, receive physical and emotional comfort through having a peaceful space, and stay in contact with others.

As home is a complex concept with many meanings, moving out of a home into other accommodation may be reliant on how the older person saw home, that is, the meaning home had for them. These different meanings therefore, may explain why some older persons work so hard implementing actions to remain living in their homes and why others accept they need to move out and relocate into alternative accommodation.

The chapter concluded with a description of the entry point into the process to stay living at home. The entry point related to a change in personal health, either sudden or gradual, and involved the conscious decision to enter a process and implement actions to stay living at home.

The following three chapters describe the three other major categories ‘maintaining autonomy,’ ‘protecting self’ and ‘connecting with others’ exploring the actions and interactions the older persons use once they enter the process to stay living at home.
Chapter 6 – Maintaining autonomy

The previous chapter presented the major category ‘it’s home’ describing the meaning and context to remain living at home. The characteristics and benefits of living at home influencing the decision to remain there, and the entry point into the process were also described. This chapter describes the actions and interactions the older persons employed once they had entered the process to maintain their autonomy and fulfil their goal of remaining in their home. When data were analysed, the major category ‘maintaining autonomy’ emerged from a range of comments about learning and compromising. This category demonstrates how the older persons utilised their inner strengths and life experiences, and shaped and modified their lifestyles to stay living at home. Drawing on inner self by using resolve and learning from past experiences, and shaping own approach through creating own rules and making compromises presented in this chapter and outlined in Table 4, are the two subcategories combining to explain the complex action ‘maintaining autonomy.’

Table 4 Major category ‘maintaining autonomy’ and subcategories

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<thead>
<tr>
<th>Subcategory</th>
<th>drawing on inner self</th>
<th>shaping own approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions</td>
<td>utilising resolve</td>
<td>creating own rules</td>
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<td></td>
<td>depending on experiences</td>
<td>making compromises</td>
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6.1 Maintaining autonomy

Maintaining autonomy was a major action identified in this study. The older persons remained autonomous by being in control and staying independent. Through avoiding dependence on others, they were able to remain self-determining, preserve their self-esteem and confidence, and have the ability to endure future challenges.

Being autonomous meant the older persons made their own decisions and took responsibility for their everyday living, which was a precursor for remaining at home. In return, living at home facilitated their independence and autonomy. Anne expressed the positive benefit of being in control when living in her home as: “I feel it’s independence.”

The older persons were aware that to remain autonomous they needed to stay in control of their decisions and not allow others to make decisions for them. The following examples highlight how they used their strength and confidence to reject restrictions imposed upon them by others. When describing how others try to encourage her to give up things, Irene stated, “I won’t give anything else up that I can do …. I accept what I can’t do …. I don’t just sit down and cry about it.” Rose described how she refused family assistance when her daughter suggested she build and move into accommodation at the back of her house. Rose believed if she moved out of her own home she would lose her autonomy and become more dependent on her family. She said, “My daughter suggested that I sell up and build a granny flat in their back …. I said no I am quite happy in my own home.”

Through ‘maintaining autonomy’ the older persons were able to shape their approach and live life the way they desired. Ellen described living life the way she desired at home as: “I have got to this stage that I now think our life is too short, I
am on the downhill run, if we want to sit down and read a book, we sit down and read a book.” Through undertaking the planning and organising themselves, the older persons maintained their freedom and autonomy, and prevented others from determining daily activities. For example, as Laura said, “You create your work and the other people can’t interfere … so we feel happy doing our things.”

The older persons described their strong desire to remain autonomous and independent was driven by their intention to avoid being a burden on their families. Irene said, “I hope I die here [at home], not be a bother to anybody.” This was supported by the comment made by Anne when she stated, “I think the least strain you put on your family, that’s what makes you independent.”

Other less important benefits of ‘maintaining autonomy’ related to feelings of good self-esteem and feeling positive about themselves. Ellen described having this as: “You feel better in yourself.” Jane commented, “It is definitely good for your self-esteem to be able to do things.” Sarah said, “I’ve been contented living at home …. I’m able to do things.”

The desire to maintain autonomy appeared to drive the older persons to keep going and endure future challenges. Sally stated, “Well, as long as you’re doing everything for yourself. While you’re doing that you’ve got your independence. Keeps you going I think is having your own independence.” Maree said, “I’m 89 this year …. I’ve done very well, I feel I’ve been blessed really. Well, it’s the attitude see.”

However, ‘maintaining autonomy’ required the older person to have an awareness of when to make compromises and a willingness to do so. It was essential to be able to determine when it was appropriate to relinquish portions of their work so that they were not required to give up everything. Agreeing to attend the day care centre twice
a week and participate in activities on another three days was determined by Marjorie to be a better option than moving out of her home into alternative care. She described her experiences of making compromises so that she could stay living at home as:

“We play dominoes … at the day centre …. I could think of a lot of other things I could be doing … but you’ve just got to do what you can.”

6.1.1 Drawing on inner self

The ageing process and the changing environment required the older persons to draw upon and utilise their inner strengths to make their own decisions about their everyday living. The participants all described using their resolve and learning from past experiences as actions enabling them to remain self-reliant, independent and autonomous to stay living in their own homes.

Utilising resolve

One of the ways the older persons spoke about **drawing on inner self** was by relying on their strength and determination. All older persons who remained in their homes described using their inner strength to stay motivated and determined. Sally described using her resolve as: “You’ve just got to be strong and do it, that’s what I think.”

Drawing on resolve appeared to become more important as the older persons aged, as Anne said:

*I think I’m more determined now than I was many years ago … because you’ll find that, if there’s nobody to do it, it’s got to be done … you just get and do it, do the things that you think you can’t do, you just go get to and do them.*
In particular, using resolve became even more critical with corresponding deterioration in physical health. Anne stated, “I do have a problem … high blood pressure … I’m still determined that I’m going to get there.”

Maintaining motivation also included having the right attitude to endure challenges. Determination to keep going for Anne provided motivation later in life to spend time with others. She described how she perseveres daily when she said:

*I wake up in the morning and I say I don’t think I can go out today. I’m sure I can’t. But I get up and I say well, what else can you do? You’re either sitting here all day or you go out and have company.*

For many, drawing on resolve in later life included possessing an attitude of fulfilling one’s destiny, as Maree stated, “You have to get on with your life.” Maintaining an attitude to get on with life entailed having motivation and determination to undertake tasks. Laura described this as: “Unless you try you don’t know.” Drawing on their strength, determination and motivation to keep going, was the approach taken by all older persons, as Irene said, “I don’t want to lay down and rest …. I want to keep going …. Whatever it takes.”

*Depending on experiences*

In addition to utilising their resolve, the older persons relied on learning from their previous experiences to remain autonomous. Learning from experiences enabled them to have the required knowledge and skills to be self-reliant and stay living in their own homes. Anne said, “I think we have to learn to look after ourselves.”

The older persons currently draw on and use what they have learned when presented with the challenges of ageing. Peggy said what she “learned to manage in earlier
years of life is valuable for the later years.” Rose stated, “You have to learn all those sort of things as you are growing older and they all come back to you in the end.”

The experiences older persons drew on arose from having been in child-parent, adult-partner and older adult-others relationships. Through these past experiences, they had gained knowledge and skills from their parents, partner and others. Sarah, for example, referred to things she learned from her parents and how she continued to use them as: “I wouldn’t run across the road thinking I was going to beat the car … all that sort of thing our parents did. They taught us that and I think I sort of carried that on.”

Experiences from earlier adult-partner relationships also provided valuable learning to draw on and utilise. Sharing daily domestic work with his wife throughout the years gave Tom knowledge and skills he could draw upon in later life. He said, “Our household when we got married, nothing was like a woman’s job or a man’s job. The wife would come out and mow the lawn when I was doing something else. I would wash up.” Jane spoke of drawing on her past experiences when she said, “The fact that I had a husband who refused to do absolutely anything … turned out to be helpful because when I was then alone I had to do everything for myself.”

Many older persons made reference to learning from experiences earlier in life as a consequence of a life changing event, such as the death of a partner. These experiences were particularly useful at a time later in their life. Kathy described this as: “When my husband died I still had three children at school, so I have learnt to be independent.”

As well as depending on knowledge and skills learned from their past experiences, the older persons described utilising learning from the more recent successful
experiences of older adult-others as another strategy. For example, Tom described attending the centre provided him with opportunities to learn as: “You learn off each other.” Ellen spoke of her recent learning from the experiences of other older adults when she said:

When you have something go wrong with you, you think it is the end of the world … but if you’ve got somebody to come in and just talk and they’ve been through it …. The attitude they actually gave you shared their experience.

In contrast, the older persons applied learning from the recent though less successful experiences of others. Seeing other people’s misfortunes provided insight for Frank’s own approach a few years ago. These experiences were the catalyst for his decision to move into a more suitable home in the retirement village as he became aware of his own ageing. He stated, “I have seen so much hardship amongst older people living on their own. I have seen a lot of homes actually neglected because they had no other help.” In this instance, ‘maintaining autonomy’ to him was not staying at home.

6.1.2 Shaping own approach

Shaping own approach was the other action essential for ‘maintaining autonomy.’ This action was described by the older persons as living life their way and not allowing others to interfere with everyday living. It involved adopting a lifestyle that was determined by the older persons themselves, doing what they wanted to do, when they wanted to do it, and making compromises and giving up some things to be able to continue to do others. By making these adjustments to the way they carried out their daily living, the older persons were able to continue to live autonomously in their own homes.
Creating own rules

To shape their approach, the older persons created their own rules. They described these strategies as Anne said, “I just want to do what I want to do.” This enabled them to develop the lifestyle they desired as they aged, for example as Rose stated, “I go away when I feel like it,” and

Sometimes the ironing will go two weeks because I don’t feel like doing the ironing ... and then I’ll get in and do it .... I do things when I feel like it as far as the housework goes .... I only have a routine with things when I get up in the morning. I’ve got a routine the way I do things ... but through the day as far as the housework goes I do it when I feel like it.

A common strategy was, as Tom said, “You set your own pace.” Determining the pace enabled the older persons to manage their own time and undertake daily activities within a desired timeframe. Alice described this as: “You manage to do what you’ve got to do inside when you can.”

Taking a longer time to perform tasks and having short rests in between tasks or activities was essential to ensure daily chores were completed in their own time. For example, Anne described taking her time to climb the stairs at a comfortable pace as: “I’ve got about 32 stairs .... I’m so used to them that it doesn’t worry me. I just take my time.” Sarah described setting her pace to go slower as: “I take my time, I don’t hurry like I used to be able to hurry,” and taking longer in undertaking her domestic work, she said:

I used to do in that time all the things that I could do then. I take longer to do now as I say .... I could go off and I could do the washing and ironing and all that in one day. Now it takes me a couple of days to do ... and the housework and I do gardening .... Just takes longer to do them.
The older persons described taking short breaks in between doing domestic work at home. Sarah described this as: “I take in between little rests.” Many described implementing this change of pace to ensure their domestic work is undertaken in a manner to facilitate their ability to complete tasks. Sarah commented she will “sit down, rest, get up and do a bit more, sit.” Irene described breaking down her work into smaller tasks as: “But I can only do a certain amount and I’ve got to stop …. I rest more today than I used to.”

Taking their time and having short breaks when getting around in the community was another strategy described by the older persons to shape their approach. Rose described allocating sufficient time to undertake tasks, such as grocery shopping as:

I can still go down to Woolworths and get my order up and I can take my time .... I have a sit on a fence here and there ... and have a little rest and then it takes me a couple of hours to get my order up but I only do that about once a month .... You take your time.

Underlying these strategies to create their own rules was the ability to avoid getting concerned about completing work by pushing oneself to an unsafe pace. Many older persons described living at home facilitated their ability to shape their own approach by enabling them to adjust their routines. Irene talked about breaking existing routines as: “I break them [routines] a lot of times .... When you are on your own it doesn’t matter .... If I don’t feel like washing today I’ll put it off until tomorrow.” Ellen described using this strategy when she said, “We’ve got to the stage where we think, well it is ok if something doesn’t get done today, it will still be there waiting for us tomorrow.”
Making compromises

In addition to creating their own rules, the other common strategy used by the older persons to shape their own approach was making compromises. Creating own rules described how the older persons chose to do things differently, in the way they wanted to do them, when they wanted to do them. Whereas, making compromises was described by the older persons as giving up some things so that they did not have to give up everything. This action involves determining ways of negotiating the completion of essential and non-essential tasks at home and in the community. It entailed having an awareness of individual ability and limitations, and maintaining the desire to be autonomous. Anne’s comment demonstrates her rationalisation of the necessity to make compromises when she said, “Can be without it if you can’t do it.”

The older persons described strategies were to make adjustments, being adaptable and flexible, and plan and organise living at home by prioritising daily activities and adjusting them as required. Ellen stated, “When you get to our age you’ve got to work your social things around going to doctors, and if you’re not going to doctors they [friends] might be going to doctors so you just work around it.” Changing the mode of transport was one adjustment made to compromise. Tom said, “We used to drive everywhere but we are using more public transport now than before.”

Adjusting the frequency of activities was another common strategy. John who now travels by public transport, described he was able to continue to visit his son by changing the frequency of his visits. He stated, “When I was driving I used to go nearly every week but now days I go over about every fortnight.” He also adjusted his routine to shop more frequently so that he could continue to do the shopping himself. He expressed this as: “I do a bit every week because you get a couple of big bags that are heavy to carry home.”
Irene spoke about how she now does domestic tasks differently in the kitchen. When using the stove she stated, “I've scalded my fingers a few times trying to get a cup of tea .... I soon learned how to get around it.” Marjorie described her experience of getting around environmental barriers in her home by showering at her daughter’s house. She said, “The others I do at (-) [her daughter’s house] because she’s got a walk-in shower ... at my place you’ve got to get into the bath .... It’s a big bath .... Deep .... I can’t always get my leg over the edge of the bath.”

The older persons discussed being aware of the necessity to make compromises as they were no longer able to undertake some tasks, as Anne said, “I don’t do all I used to.” They all described these strategies as accepting their limitations, recognising that some activities created physical barriers they were unable to negotiate at home. When talking about her declining physical ability and the need to give up some things, Irene said:

\[ I \text{ used to grow all my own vegetables, but I can’t now, I have to give it up ....} \]
\[ \text{No digging today and no vegetables because I can’t do it .... I can’t look after them properly ... I can’t reach up and do a lot of things I’d like to do .... I just leave it.} \]

Many older persons accepted they could no longer do some tasks and made compromises to prevent a health crisis. Irene continued to maintain membership in different associations despite giving up participation in many of the activities to prevent another collapse. She said:

\[ I \text{ joined two or three places when I left work but recently I had to give them up. I found it was too far to go to town all the time .... I am still a member though .... We do three, four or five miles on the hikes, we used to, but I don’t} \]
do it now. I gave up town as well because of the steps and everything and I didn’t want to collapse on another lot.

David described his experience of giving up volunteer work so that he would not compromise his own health as: “I offered my time once a week. I used to pick people up, take them to hospital …. I did this for nearly five years. Till I couldn’t do it anymore.”

Others spoke about accepting their limitations but preferring not to ask for more help. As a consequence of not wanting to accept further assistance, they were no longer able to participate in the activity. Tim described how he doesn’t participate in the weekly bus trips run by the hostel now that he has difficulty getting on and off the bus. When speaking about his decision to avoid going on the bus trips rather than ask for help, he said:

Well, they have bus trips here sometimes but I don’t go on them. I find it very hard getting on and off buses, you know, the narrow stairs … the seats are low and they’re usually all old ladies. I can’t ask them to help me out, you know. I can’t ask them to give me a lift …. I can’t ask old ladies to stand up and lift me, no.

Irene talked about how she had recently ceased her membership at the centre due to her deteriorating eyesight and reluctance to ask for more help. She stated, “I went [stopped going] because I couldn’t see too good and I can’t keep asking other people to do things.”

In summary, making compromises and adjustments were actions of the subcategory shaping own approach. The consequences of not undertaking these and other actions of ‘maintaining autonomy’ are discussed below.
6.2 Consequences of not maintaining autonomy

If the older persons were unable to successfully implement the strategies necessary for ‘maintaining autonomy’ there would be negative consequences and they would be unable to remain living at home. The consequences identified in the data were feelings of frustration, dependence on others, low self-esteem, no future direction, and relocation. These consequences are illustrated in the following comments.

Generally, all older persons described the limitations resulting from ageing leave them with feelings of dissatisfaction. Tim spoke of his frustration through not being able to achieve what he wants as: “It is frustrating when you think of the things that you used to be able to do and you can’t do.” Irene said, “It annoys me, I don’t get this done, I don’t get that done.”

Marjorie talked about relying on her daughter for assistance with daily activities created dependence, and as a result her family has taken away her autonomy. She said, “It has its moments …. I’ll want to do something or go somewhere, I’ve got to depend on (-) [her daughter] … Well I can’t go in shops, I don’t go on escalators because I fall on them.”

Many made the assumption that they would be dependent on others if they moved out of their home. Rose spoke of the likelihood of not being in control of her own decisions if she went to live at her daughters’ home. She said, “You’d lose some of your independence … because you’re sort of depending on them more.”

After relocating to the hostel, Tim described dependence on others as a consequence of the move. He stated, “Well, you can’t just go out, I mean, if I want to go out I’ve got to get a taxi or my sister will pick me up.”
The older persons talked about moving out of their home as a last alternative but had
accepted it as a possibility in the future. They discussed the impending notion of
deteriorating health and the possibility of losing the capacity to look after themselves
in the future. Irene said, “Well, if I can’t [look after myself], I’ll have to go into a
home I suppose.” When discussing her future Anne said:

If I can’t look after myself and do for myself probably then I’d have to change
…. Not a long future. I don’t want to be a burden on anybody …. That’s
because I’ve always been independent so I couldn’t be a burden on anybody, I
can’t be, I’d have to go into a nursing home.

Sarah is prepared to move out of her home into assisted living in the future rather
than burden her family with providing care for her. She said:

The only thing that I have thought of, if ever I got to the stage when I couldn’t
look after myself I wouldn’t put the responsibilities on my family. I would go
into a home or something like that because I wouldn’t like to make them
responsible for me …. Because they’re only young … and they’ve got their
own children and family to look after …. That’s the way I look at it.

Almost all older persons described they would feel worthless if they were unable to
stay living at home. Sarah said, “I think you leave, you feel … useless.” The reasons
for feeling this way was because they would be confined to rules and regulations in
alternative accommodation, and have less autonomy and control over their lives, as
Sarah said, “If you wanted to go out … you’d have to have permission … be in by a
certain time.”

For those who had relocated or become dependent on others, the future was not seen
in a positive light. After relocating to a hostel, Tim said:
I try not to [think about the future]. I realise that of course here every now and then you hear when somebody died here or they went to hospital and died. Well I mean, we all got to die …. I just hope, everybody hopes when they’re older they’ll go quickly when the time comes.

Maree commented, “I don’t think of the future …. I want to get well … and be able to help myself. I don’t even think about it …. I would rather die in bed.”

Although Marjorie still lived at home, she described a consequence of having lost her autonomy meant that she could see no future. She stated, “Well, I reckon I would be alright on my own but they said ‘you’ll fall over, mum’ …. They don’t know …. Well I think about the future but I’m not having anything …. It just comes to a blank wall now.”

6.3 Chapter 6 summary

This chapter was the second of four chapters presenting a description of the major categories. The chapter included a description of the major category ‘maintaining autonomy’ and the two subcategories drawing on inner self and shaping own approach, describing some of the actions and interactions the older persons used to remain living at home. All older persons in this study wanted to continue to make their own decisions and do things themselves whilst they had the capacity. They described these actions as trusting their own instincts and judgements, and believing in their ability to undertake everyday living.

Where the older persons had undertaken strategies to manage the changing conditions imposed upon them and maintain autonomy, the consequences were positive and they were able to remain self-determining, make decisions about their everyday living, and stay living in their home. However, if they were unable to
successfully engage in the actions and interactions for ‘maintaining autonomy,’ the consequences were negative. Negative consequences that inhibited the older persons’ ability to stay living at home were found to occur as a result of an increasing level of dependence on others and frustration from an inability to undertake tasks.

The following chapter presents the third equally important major category, ‘protecting self’ describing the complex actions used by the older persons to keep well and stay safe living at home.
Chapter 7 – Protecting self

The previous two chapters presented two of the four major categories; ‘it’s home’ and ‘maintaining autonomy.’ The third major category ‘protecting self’ is presented in this chapter and describes the actions the older persons used to maintain wellness to stay living in their homes. The two subcategories keeping well and staying safe presented in Table 5 combined to explain the complex action ‘protecting self.’ The consequences of not implementing the actions for ‘protecting self’ described by the older persons as essential to remain living at home are presented in the final section of this chapter.

Table 5  Major category ‘protecting self’ and subcategories

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<td>Subcategory</td>
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7.1  Protecting self

The realisation of their ageing and the associated increase in health breakdown was an incentive for the older persons to protect themselves by maintaining their wellbeing. Having good health for their age and the ability to keep active were essential features facilitating living at home. In addition, living in a home that was
safe, protected the older persons from risks in the home and harm from the community. The participants all identified these strategies as enabling them to maintain a level of wellness to stay living in their homes, as Maree said, “The biggest thing too is our health. Our health is the main thing and if we have got that we can do things. Without that, if you haven’t got that you have got nothing.”

Most of the older persons expressed that their health was good and compared themselves to others their age. Rose said, “It’s good for my age.” Irene talked about her health as: “I went to the Chest Specialist … and he said I was his fittest patient he had.”

Some older persons referred to the amount of medication they took when describing their health. Sarah talked about her good health as: “I’m not on any medication … no medication at all.” Others spoke of their health in terms of how it facilitated their everyday living. Rose said, “I don’t think that [health] stops me from doing … well my health’s pretty good and I can get on a bus, I can go out.”

Good health was important so that the older persons could undertake activities whilst they were still able to do so. It was identified that there may come a time when they will be unable to get out of the home. Tim stated, “I feel you should get out while you can. While I’m still capable of getting out, I’ll go out and if the time comes when I can’t get out and about, at least I’ve done it.”

To maintain their wellbeing the older persons also took precautions to remain safe. Making the home safe transformed their home into a secure familiar environment where they could live carefully and comfortably, as Tim said, “It’s always a risk stepping into a bath no matter how careful you are, mats or anything at all, you can go for a very bad fall.”
‘Protecting self’ by keeping well and staying safe enabled the older persons to get out into the community and participate in activities with others. Many talked about keeping active as keeping them healthy. Tom described his experiences of going out and engaging in activities at the centre as: “The activities help you with your health.” As a consequence, the older persons remained content and protected. Maree said, “as long as I’m not stuck at home I’m quite happy with my life.” Irene stated, “Well I can’t see it’s [living at home] doing me any harm … and I don’t think I’d do any better in hospital.”

7.1.1 Keeping well

keeping well was one of two actions describing how the older persons were able to protect themselves against changes brought about by the ageing process and their changing environment. All older persons described maintaining healthy lifestyles and trusting health professionals as strategies they used to assist them to stay well at home. When discussing the importance of keeping well David said, “Health is number 1.”

Living healthily

One of the most common actions relied on by the older persons for keeping well was living healthily. Living healthily was described as adhering to good health practices. These practices include having good nutrition, avoiding unhealthy habits, keeping busy and occupied in the home, and keeping mentally and physically active by engaging in activities with others in the community. For example, Irene described the ways she lived healthily by maintaining good nutrition as:

I’ve never had these quick meals much and I mostly cook my own fresh vegetables I get, take them home from the shop …. I don’t get frozen ones,
and fresh meat, the butchers, you cook it yourself I do … very plain food … fresh fruit.

Ellen said, “We have fruit, vegetables, meat and cheese and we enjoy a glass of wine and they tell us that the glasses of wine should be red wine …. It’s very good for you and I’ll believe them on that.”

There were only two male participants living alone who described living healthily by going out into the community to obtain a well-balanced meal every day. Eating out was necessary as they did not have the skills to make themselves a nutritious daily meal. When talking about the additional benefits of attending organised activities Tim said, “you can go out and get a good lunch.” John described his experiences as: “I have somewhere to go everyday and I don’t cook, but I go out and have meals wherever I may be.”

Only some older persons described keeping well and looking after their health by avoiding unhealthy habits such as alcohol, cigarette smoking and gambling. Rose described her experiences as: “I don’t smoke, drink or gamble,” and Irene stated, “I don’t drink.”

As the older persons were no longer engaged in full-time employment, they adopted other strategies of healthy living by keeping busy or occupied to utilise their extra time constructively. This strategy appeared to be an extremely important one for keeping well. For Marjorie keeping occupied at home was described simply as: “You just potter around.” Laura described her experience as:

We are retired now we don’t work any more. We try to be occupied …. Because I am not busy anymore I got all the time of the world in my hands, so I have to be busy. I am busy out of my house and do the things in the house.
Not using their time effectively and efficiently was considered lazy and unhealthy. Rose described her experiences of keeping busy at home to avoid such unhealthy behaviour as: “If you get bored inside, you go out and do something instead of lying in bed.” Irene said, “I like to do it [fill the bins with grass cuttings]. I’d hate to sit around all day, it’s not my idea. I’ve either got to be up doing things or I’ll lay down and rest when I’m tired.”

In particular, going out of the home to keep active was considered essential to remain healthy, as it was unhealthy to stay at home and do nothing. John commented, “I go out quite a lot because I do not like sitting around looking at myself and doing nothing because that does not do anybody, young or old, doesn’t do them any good.” Frank described his experiences as: “It so happens that I go out daily. I also do not wish to be at home during the daytime unless I am doing something. God gave tendency for you to sort of nod and fall asleep.”

Many older persons talked about having time on their hands and how they occupied this time outside the home, engaging in activity with others in the community on a regular basis to keep mentally and physically healthy, as Frank stated, “I spend a lot of time out of my home. I go to other things.” This attitude underpinned the desire to engage with others undertaking the activity to establish social relationships and avoid spending too much time at home isolated. Ellen described her experiences of keeping active by going out of the home as: “We are so busy going out anyway. You can read a book when you stay at home to catch your breath because you have been out so much.”

The older persons described going out and engaging in some form of exercise regularly assisted them to keep physically well. Examples included gentle exercise,
weight bearing activities and recreational activities, such as walking and playing bowls. For example as Kathy said, “I get out because I have got to keep my bones strong. I go walking …. I am always on the go.” Irene described keeping active as: “I still play bowls.”

Getting out of the home and attending the seniors’ centre on a regular basis was a strategy used by all older persons. They all described engaging in the activities at the centre on a weekly basis as assisting them to look after their health holistically. Mary’s comment reflects this strategy when she said, “The major interest of all this particular group is looking after our health by doing activities.”

Many older persons described it was important to keep active by replacing activities with more appropriate ones when they are no longer able to do them. Ellen described how she gave up participation in the exercise classes because “they got a little bit too strenuous,” and said:

We probably don’t go out as much now as we did, but we still keep up interests, outside interests. We used to pick up (-) but we’ve given that away but we’ve taken up with a (-) day group which meets every Monday and we play cards and have to do a few exercises, a normal day club meeting …. Then we have a few lots of friends that we meet up with once a month for lunch or cards or just talking or something like that. So we keep ourselves occupied, but then, as I’ve said then, it applies more so now I think. We have a run of it and then we take a day or so to catch our breath, get ourselves steamed up to go out again.

Living healthily also involved looking after one’s mental health. The older persons described maintaining mental stimulation was an important factor in assisting in the prevention of health breakdown. For example, Anne said, “If you go out you meet people and you can talk to people and that keeps your brain active” and
“Alzheimer’s … if you don’t keep your brain active, once your brain goes … you think to yourself it might happen to me any day.” Sally described her rationale for undertaking mentally stimulating activities as: “I would say it [bingo] makes you keep your mind.” Ellen described her experiences as: “When we retired we decided we had to find something to really keep our brain active and something we could do together …. We go out at least once a week playing bridge and it is beaut.”

Relying on health professionals

The other main action used for keeping well was to rely on health professionals. This involved maintaining a relationship with the GP to assist the older persons to look after their health. As Anne said, “I have blood pressure tablets and the doctor keeps a check on it …. I think if you keep on, you must have a doctor that you can sort of … have faith in your doctor.”

The older persons described relying on their GP to facilitate their wellbeing and monitor their health closely on a regular basis. They trusted their GP to provide advice, prescribe medications when necessary, offer appropriate testing and referral for testing, and make home visits when required. For example, Maree described relying on her GP to give advice when she said, “The doctor said I must walk.” Irene stated, “The doctors told me some years ago I should rest a lot more than I do …. He said work a bit if you’ve got to but rest a bit too.”

Others described relying on their GP to prescribe medication to prevent a health crisis, for example as Rose said, “I’m on quite a few tablets …. I suppose they keep you going … heart tablets and things like that.” Irene said, “I did collapse once about three years ago or more and the doctor, the heart specialist put me on tablets,” and “I only take medicine the specialist gives me.”
Some older persons described their experiences of relying on their GP to monitor their health closely, as Ellen said, “I've got to go to the doctor, my blood pressure and things like that. I only go in once every six months or something like that … just to check up.” When talking about relying on her GP for continued monitoring and conducting necessary tests Sarah said:

*I lost nearly a stone and my doctor was very anxious over that. For all the tests I have done there’s nothing wrong with me …. But he wants to keep an eye on me for the next few months to see how things go.*

Securing a relationship with a GP who makes home visits was another strategy considered essential to prevent a health crisis. Relying on home visits when they were unable to get to the GP surgery due to illness or a lack of transport assisted the older persons to look after their health. Anne said, “it’s a big thing … they’ll come to you at home … they’ll always come if you want them to come to your home.” Mark described having confidence in his GP to make a home visit when he is unwell as: “If I can’t, the doctor comes down to me.” Marjorie said, “I just ring up and he comes. When I need him he’s there.”

At times, some older persons relied on the Occupational Therapist (OT) to assist them to maintain functional living by assessing their needs for mobility and independence, and facilitating changes in their home. Organising the installation of support structures enabled the older persons to mobilise safely and protect them from injury, for example as Sarah said:

*I have a low railing at the back and front that has been put up since I came out of hospital. Then I have a railing alongside the toilet so that if I need to use it I can get myself up.*
Jane also described her experiences of utilising the OT to assess her home and modify the home environment by organising railings and lights to be installed in key areas of her home to maximise her independent living. She stated:

_When my sight went, I had great difficulties. They came out and assessed me and for a reasonable price … the fellow put railing by the steps, back steps a sensor light so that I had light when I came home at night._

Tim described his experience as:

_One of the occupational therapists at the hospital showed me some things, one time you sort of wouldn’t think about getting dressed and undressed but, you’ve got to sort of do it sitting down, like putting on a shirt, you hold it towards you like opened, you get yourself up, and you sit down on the bed and you work yourself into it … and gradually work it up like that. You’ve got to do all these things differently but you want to be independent for as long as you can._

Only a few older persons talked about using a physiotherapist regularly. Maree described utilising the physiotherapist to assist her mobility and maintain her independence. She said:

_I’m doing exercises, I walk every day and I have a physio that comes and gives me exercises so I’m doing all the right things to try and get myself, in the hope one day I’ll be able to do what I used to be able to do._

7.1.2 _Staying safe_

In addition to **keeping well**, the other action used by the older persons for ‘**protecting self**’ was **staying safe**. This subcategory was achieved through attending to risk by preventing injury in the home or harm from others in the community, and making their homes safe by removing existing structures or installing new supports.
Attending to risk

All older persons described attending to risk as having an awareness of the risks in the home and taking care to do things safely so they could stay living in their own homes. Anne said, “When I go up and down the stairs I’m always careful …. I just go very slow, one step at a time …. Hang on the rail.” Tim’s approach is a typical example of attending to risk as he described how he rationalises each action to avoid taking risks and jeopardise his wellbeing as: “It’s not worth the risk. It is easier to pay an electrician than crash to the floor and get a broken limb …. When you are older it’s a bit foolish to take a bath … you can slip on anything.”

The ways to minimise risk employed by the older persons were those used to prevent physical injury in and around the home. For example, Ellen prevented the risk of injury by living in a single storey dwelling, where there are no stairs as they are a potential risk for falls. She said, “We are on a single level home, there’s no steps that makes a big difference … on a single level that makes it easier.” Maree described her experience of purchasing a ground floor unit in the retirement village for safety when she said, “I wanted a ground-floor. Well, as you get older you don’t want to be going up steps.”

Other strategies of devising physical aids to reduce the risk of a fall in the home were used by some older persons. For example, Tim described using simple household items as a substitute for a ladder or chair to reach high places and minimise the risk of falling as: “I have a box, I take it in two stages. I have got a solid little box like a step. I put the box in place and I use the broom to steady myself.”

For many older persons, using a walking stick or frame as a physical aid to minimise the risk of a fall was another strategy utilised. Maree said, “I have got a wheeler that
I go for a walk right around my units every day.” Other examples included using a walking stick for confidence as Sarah said, “I have a walking stick. I got that brought from the hospital … serves me the walking stick I have.” Mark described using a walking stick since being discharged from hospital for stability. He said, “I was walking with a stick when I got home …. Slowly, but I was getting around …. Even down home nowadays I use the stick half the time …. I get it out and just use that for balance.”

For others, technology was a strategy used to attend to risk when living alone. Frank explained the use of Telecross service assistance is “so a person is not without help for more than 24 hours.” Maree was the only older person who used VitalCall as an aid to attend to risk of harm or injury in the home at all times. She said:

> I can get the ambulance or the police or my daughter. There is always someone there and that is a must on your own. It’s around my neck all the time … and I know if I get sick I can press that and they are always there …. There is always someone there and that is a must when you are on your own …. I know that if I take sick that I’ve got help.

Marjorie discussed her experience of attending to risk by utilising the simple technology of the telephone’s speed dial function. She spoke about access to emergency help from her neighbour as: “With (-) [her neighbour] across the road, I’ve got her ’phone number, I’ve got a lot of ’phone numbers … that are dialled in on

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3 Telecross is a free service by the Red Cross for older persons who live alone. Trained volunteers make a daily telephone call to see that the older person is well. If there is no response after two calls, an emergency procedure is implemented to follow up (Australian Red Cross, 2008).

4 VitalCall is a 24 hour emergency response service in the home. The older person wears a water resistant pendant and when pressed in an emergency the call is directed from a base unit in the home to a national response centre where an operator acts on the emergency call (VitalCall, n.d.).
the 'phone … and I just press the button if I want (-) [the neighbour].” She also described having her daughter’s work number available on the speed dial for use during the daytime as: “It’s close. Well, if anything happens and I want her I just press the (-) [daughter] button …. She comes.”

Another major strategy the older persons all described to keep safe was attending to the perceived risk of danger from the community. Anne preferred living in an upstairs unit as it provided a safer home, reducing the risk of harm from outside intruders. She said, “I like living upstairs because I think you are safer upstairs.”

This strategy included not going out into the community alone at night and keeping the house locked at all times during the day and night. The older persons identified their fear of a changing community and the accompanying violence and crime as the rationale for using this strategy. For example, Anne said, “I think we are afraid to go out at night. The fear of going outside … The way the living is now and the problems on the streets, you’re just not safe to go out.” Irene described her awareness of risk and strategies to prevent harm from others in the community, particularly at night as:

I always like to be home before dark …. I just don’t go out at night …. I make sure I get the bin out of a night before dark …. Well I wouldn’t [go out at night] because of the way the world is today. I used to go around everywhere …. When I was young, I wouldn’t today because I’ve been robbed and I’ve been broken into.

Similarly for some, attending to risk was achieved by being accompanied by a family member when going out at night. For example, Sarah said, “The only time I go out to anything is when the family picks me up and brings me home.”
Many older persons described attending to risk by keeping their doors and windows locked at all times to keep intruders out. Rose said, “I always keep the security door locked in the daytime.” Irene described her experiences as: “I certainly lock the doors after dark.” Tim talked about securing his windows to keep intruders out when he said:

(The) window down in the second bedroom, I thought well, if somebody’s going to break in that’s where they’ll go so I got one of those security screens put up over that …. I put some sort of black bars across the back windows, which were not all that strong but I could do that myself … any ratbag looking at the outside would think that they’re bars … so that worked out well.

In addition to these strategies, having observant and caring neighbours keeping watch assisted the older persons to minimise the risk of harm from others and feel safe living at home. When talking about her neighbours Jane said, “There is also a safety factor involved in that because I knew that they watched out for me …. I felt more comfortable knowing that there was somebody keeping an eye out for me.”

Making the home safe
Another action used by the older persons for staying safe was making the home safe. Many of the safety measures taken were previously done through consultation with the OT. This strategy involved modifying their home environment by removing existing structures, such as a bath or steps which were considered unsafe and had the potential to cause injury. For example, Tim said:

I make this point that you should go and make your houses as safe as possible, I have a bath taken out before I moved in … so it is safe. It is always a risk stepping into a bath no matter how careful you are … you can go for a very bad fall.
Others discussed adding new structures, such as ramps or railings inside and outside the home to prevent injury and promote a safer environment. Mark described adding “rails around the toilet and the shower.” Sarah commented, “I have a low railing at the back and front … and a railing alongside of the toilet.” Rose said:

I don’t have many steps, I have two steps at the front and one at the back. My son put things on so that I can hold on to … he put one at the front and one at the back …. I’ve had a step down to the cement at the front … and my younger son put a ramp there for me.

There was only one person who described using existing structures in the home that had been previously modified for another person to maintain his home as a safe environment. When discussing his experience, Mark stated:

I’ve got a wheelchair ramp on the front of the house …. I put it in for my wife when she was in the wheelchair …. Rails around the toilet … and the shower …. I put myself in a wheelchair after hospital, come in handy at the present time.

In summary, preventing risk and promoting safety at home and in the community were strategies identified in the subcategory staying safe. The following section of this chapter presents the perceived consequences of not employing the complex action *‘protecting self’* as described by the older persons in this study.

### 7.2 Consequences of not protecting self

If the older persons were unable to successfully implement actions and interactions to protect themselves, there were negative consequences for them. The consequences of not *keeping well* and *staying safe* were a loss of independence and an inability to
undertake tasks. As a result of these consequences, the older persons perceived they would be forced to move out of their homes.

For some, the need to remain safe comes at a cost to their independence. Marjorie stated that her family have made her safety a priority and now she has less capacity to do things herself. She said:

_They’d taken my independence off me because they won’t let me go shopping because I’ll fall over … which I have done, on the escalators …. I fell over the other week. The escalators were going up and (–) [her daughter] was down the bottom screaming out … and all of a sudden, don’t know who it was, they put their arm around me and pulled me up …. They [her family] won’t let me go shopping, they won’t let me cook … they’d say ‘You can’t go up the street mum because you can’t walk that far’ … it’s only because they’ve taken my independence that I can’t walk far._

The older persons recognised that having a reduced capacity due to poor health or unsafe conditions, leads to a low level of wellness. An inability to do things has resulted in Marjorie not doing anything during the day except watching television. She said, “I go to sleep all the time.” Irene emphasised, “If you don’t do anything, you’ll sit down and die.”

Many older persons spoke of the experiences of others who were unable to protect themselves to illustrate how deteriorating health and the inability to remain safe necessitated relocation to a nursing home. Anne spoke of her neighbour’s experience of failing health when she said, “My neighbour went [into a nursing home] … she was having falls and it wasn’t safe for her … she had a fire, she left something on the stove.” Rose talked about her brother’s situation and said:
One brother younger than me … he’s in a nursing home now … he’s had Parkinson’s for years … he got that way he would fall over easily and (-) [his wife] couldn’t pick him up…. I was just upset that he had to go into a nursing home but I know that he had to because they couldn’t manage at home.

Frank said:

I was visiting a person who was terminally ill, his son and daughter-in-law were living with him … he had a fall and he broke his hip or something. They could not keep him in the house because they couldn’t carry him. So this was why reluctantly he went into the nursing home but his son and daughter in law were unable to help him.

7.3 Chapter 7 summary

This chapter presented the third major category ‘protecting self’ describing the complex actions used by the older persons to remain living at home. These actions and interactions were described as keeping well by living healthily and relying on health professionals, and staying safe by attending to risk and making the home safe.

The chapter concluded with a section describing the consequences of not ‘protecting self.’ The older persons described if they were unable to successfully engage in the actions and interactions for ‘protecting self’ by keeping well and staying safe, they would be no longer able to protect themselves, resulting in a loss of independence, obstructing their ability to remain living at home.

The following chapter presents the forth major category ‘connecting with others’ describing other equally important actions the older persons engage in to stay living at home.
Chapter 8 – Connecting with others

Three major categories; ‘it’s home,’ ‘maintaining autonomy’ and ‘protecting self’ describing the context and actions undertaken by older persons to remain living at home were presented in the previous chapters. This chapter presents the forth major category ‘connecting with others’ and describes the actions employed by older persons to form relationships with others to stay living in their home. The older persons described two subcategories, outlined in Table 6, combined to explain the complex action ‘connecting with others.’ Firstly, being there for each other by ensuring others are available if needed, and giving and receiving support. Secondly, positioning self, to secure friendships and companionship, and ensure formal and informal assistance is available when required. The chapter concludes with a description of the consequences of not implementing these actions to stay living at home.

Table 6 Major category ‘connecting with others’ and subcategories

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<thead>
<tr>
<th>Major category: ‘connecting with others’</th>
<th>being there for each other</th>
<th>positioning self</th>
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</thead>
<tbody>
<tr>
<td>Subcategory</td>
<td>having others there</td>
<td>sharing with others</td>
</tr>
<tr>
<td>Actions</td>
<td>helping each other out</td>
<td>outsourcing work</td>
</tr>
</tbody>
</table>

202
8.1 Connecting with others

The older persons connected with others through a combination of two actions; being 
there for each other and positioning self. Being there for each other included 
having others there to feel secure and avoid loneliness. In addition, having mutual 
support by helping each other out produced feelings of self-esteem and self-worth. 

Positioning self to share with others provided the older persons with friendships and 
companionship, and together with outsourcing work when needed these actions 
helped avoid isolation. Consequently, ‘connecting with others’ facilitated living at home.

Ensuring there were others around and present in your life means having continued 
support that was readily available. Ellen described having her husband provide 
support and assistance meant she could stay living at home. She said:

Without him I would, well, we’ve been talking lately … if anything happened 
to him I couldn’t cope here by myself …. Because of my eyesight and he does 
the shopping and he reads the mail to me and there’s all those sorts of things. 
He pays the bills so … I wouldn’t be able to stay here … if there was only me.

Having others there also provided a sense of safety and security, particularly when 
living alone. Rose described having family to call on as: “You feel safe that 
somebody is there.” Anne spoke of having her neighbour available and said: “You 
feel more secure.”

Consequently, having the frequent presence of family, neighbours or friends to call 
on when needed resulted in the older persons having support that was always 
available. Although many older persons lived alone, having this support helped
prevent loneliness. Ellen described this benefit when she stated, “You haven’t got to be lonely … you’ve got people all round you.” Sarah described her experiences as:

That’s one thing I’ve never ever felt lonely …. Even though I’m on my own, I know that I have friends that I could call on … even neighbours, we’re not in and out of one another’s houses …. They just know that if I need something done they’d be there, and my sister and my family … so you’ve got all those people around you. So if you’ve got people around you, you’re not lonely.

The older persons worked hard to help each other out and maintain a level of reciprocal support which was mutually beneficial. Tom described this as: “Helping others helps me.” Sally stated, “You help people and you get it back too. I have done a lot of that in my life.” Jane described how this mutual benefit was a positive experience and provided self-esteem. She said, “I feel a sense of worth through giving to other people.” Laura said, “It is very rewarding.”

Sharing with others resulted in the older persons communicating and socialising with other people. The older persons positioned themselves to form friendships and companionship and therefore they were unconcerned about not having support available. Anne described this as being “determined that you’re not going to sit and worry all day but to just go out and meet other people … if you’re with company you don’t worry.” John stated, “With my company of the Senior Citizens I am doing quite well.”

Positioning themselves within the community meant that the older persons could get out of the home and be with others. Being in the company of friends or socialising with others prevented the older persons from being bored or isolated. Mark said, “I’d be bored if I had to stay at home all the time …. I like meeting people … it keeps me
going now.” Anne described ‘connecting with others’ as avoiding isolation. She said:

> It’s convenient for me to come to the centre, community bus picks me up and brings me and takes me home. It’s a day out and you’re with people … you don’t become just by yourself and with yourself all the time.

Positioning themselves to connect with others to outsource work resulted in the older persons getting their daily work done. Anne described her experience as: “I don’t have to go shopping. I’ve this shop, it’s not far, it’s a small shop, an IGA shop. I just ring up and the girl gets the things ready and he brings them when he closes the shop.”

8.1.1 Being there for each other

**Being there for each other** was an action whereby the older persons established an informal system of support that was readily available through their family, friends, neighbours or others in their local community. Participants described forming relationships with others in their community to ensure mutual support for times when needed. **Being there for each other** was a community resource that they had put into place and could draw upon to address the changing conditions of ageing and their environment to remain living in their own homes. Anne’s situation exemplified the action of reciprocal support when she said, “if you have a good neighbour, it makes a big difference. You could depend on your neighbour and she can depend on you.”

**Having others there**

One of the actions relied on by the older persons for **being there for each other** was having others there. Sally described using this frequent presence of support as having “somebody there you can call on.”
All older persons described having others such as their family, neighbours and persons at the centre, available to depend on when needed. Rose said, “My family are very good … they look after me well.” Ellen talked about having her adult children readily available when she said, “They’re always at the end of the ’phone if you need them …. We try not to impose too much of course. They’ve got their own lives … but we know that they’re there if we need them.”

Although Anne’s daughters were not close by, she described having the presence of another family member willingly provide regular observation when she said, “I had two daughters but I never see them …. They’re on the coast somewhere and one’s in Queensland. They have their own homes … the grandson looks after me, he checks on me … takes me to dinner … comes every week.” Rose described depending on her elderly brother to be available and willing to travel to Sydney to care for her when she needs him, particularly at times of illness. She said:

So he only gets down a couple of times a year …. But if I’m sick he’ll come down and look after me …. Last year I had a couple of goes in hospital, I had a slight heart turn …. He stayed seven weeks that time to look after me.

Irene also spoke of support provided by other ageing family members. She described how her ageing brothers and sisters provided support for each other in their later years as: “There was 12 of us in the family … and we stuck together … we were so close together even though we were that old.”

Other older persons spoke of having others there to provide support by worrying and showing concern for their wellbeing. Sarah said:

I was back in the hospital again. I was only there for a few days and then his [her nephew] wife, who is a doctor took me to her place but I felt as if I stayed
there too long because she had me stay there with her … to see how I would go but I was all right. I think I could have gone back to my home but she was anxious.

For some, their reliance on family members to provide support, secured support for the future. Mark said:

Well, normally I’m pretty good up till this time when I had the operation …. My grandson looks after me, he’s a fusspot … he worries about me all the time …. Makes sure I’m not doing something I shouldn’t be doing … he’ll always look after me, always be there with me.

In addition to having someone available and concerned about them, some older persons identified a strategy as having family available to use as a sounding board, someone who would listen to them when they needed to talk about their problems. They described how they trusted and felt safe discussing their personal feelings and issues with some members of their family. Rose described her experiences as:

I don’t go out, like some people get the bus and they’ll talk to a complete stranger and tell them all their troubles and their pleasures and that sort of thing. I don’t do that. I’ll listen to anyone else’s …. Telling me what they want, what they’ve done, and what all their pains and aches and things are … but I don’t up and tell strangers all my troubles …. My daughters listen to me. My sons would listen to me too.

For many, an alternative to ensuring family was readily available to provide support, was having neighbours available. The close proximity of neighbours and their frequent presence enabled them to be readily available. Ellen put this succinctly as: “They [neighbours] are there.” When describing the willingness of her neighbours to provide support when needed, she stated, “I have got neighbours there and I jolly well know that if I was in trouble I would only have to go and knock on their door.”
Tim who lived alone when living at home, described his experience of having a neighbour available for support as: “Fortunately I was on good terms with the chap next door and we used to sort of check up on each other.”

Despite moving out of her home, Maree referred to securing support from others living in the retirement village and said, “Well, I’m very lucky to, I’m able to go to restaurants and cards and things like that because I have friends living in here that will take me and help me.”

There was a high value placed on having others there and as such, the older persons all agreed it was essential to observe the unspoken rules of neighbour support. In this way, they would not jeopardise losing it. These rules included supporting each other in the community whilst respecting and maintaining privacy, being careful not to interfere in each others lives, and not imposing too much on the time and energy of each other. Mary said, “It’s the old community spirit without imposing on them.” Irene spoke of not commanding too much of neighbour time when she said, “Good neighbours do anything for you and you pop in and out.” Maree described ensuring neighbour privacy when she stated, “I have got them there as I need them … all did their own thing and we used to meet up for a BBQ or something like that. But not in one another’s places.”

As well as having family and neighbours there to provide support, the older persons all described attending the centre regularly to ensure they have people around them for support. When speaking about other older people attending the centre, Anne said, “You can always depend on somebody. If you really want anything, there’s always somebody you can depend on.” Others discussed the caring nature of the staff at the
centre and how they demonstrated concern for their wellbeing. Mark described it was like having a substitute family. He said:

\[I've \text{ always got the council's [centre] support too \ldots whenever I was sick I've always got plenty of support. Well it's just like having another family being here \ldots up in the office here every time you get sick you always know they worry about you all the time.}\]

Helping each other out

In addition to having others there, the older persons described helping each other out as the other action relied on for being there for each other, as Anne stated, “We always help one another. We never have any problems.” Helping each other out involved forming relationships or friendships with others as a safeguard to look after each other either everyday or only when required. This ensured an arrangement was in place and available if required in the future. When describing the relationship with her neighbours Ellen said, “They’re there if we need them. Same as we’re here if they need any help.”

The older persons described having good neighbours as being essential to provide mutual support as they always look after each other to ensure they are alright. Neighbours provide friendly observation, they watch over each other and care for each other when needed, as Peggy said, “You’re looking out for your neighbours. If they are a bit sick you can go and get the messages for them. That is voluntary.”

Looking after each other was mutually beneficial and occurred on a regular basis. The following examples by Irene and Anne illustrate this strategy. Irene spoke about a regular telephone arrangement she has with her sister. She stated:
With my sister, once a week we make it a habit, we communicate … we have a chat and see if we are both alright and what we are doing … we have a certain time on a certain day we call one another.

Anne described the long standing arrangement with her neighbour. She said, “My neighbour is next door to me … we have been together as friends for 40 years and we look after one another … make sure we are alright each day.”

As opposed to providing support on a regular basis, the older persons also talked about helping each other out only when required. Frank described doing tasks for each other when needed as: “Personally, we may help one another. A neighbour of mine has arthritis problems so I used to put her bins out and take them in. That is just a personal matter.” Rose said, “Another one two doors up, if she wants anything she’ll just ring me or I’ll ring her if I want something. So it’s good.” Sarah discussed the arrangement she has with her neighbours as: “I’ve got good neighbours next door … if I wanted anything done, [and] they would be ones that I’d help.”

Helping each other out also included using each others resources. In this way, the older persons always had access to a familiar person they trusted to provide support, rather than relying on someone unknown. Rose described how she helps her neighbour and as her neighbour is unable to reciprocate, the neighbours’ daughter helps her when needed. She stated:

I still have a couple of neighbours that have been here as long as I have or nearly as long as I have, that I’ve known for so long. I’m not one for making new friends …. I can’t imagine going amongst a lot of strangers …. Most of them are gone but I have a few that are still there. I have a neighbour across the road, she built there just before we shifted there and she’s almost blind now …. I do things for her and take her, she can’t go out on her own or anything. I’d hate to move because of her in one way …. I feel I can help her
a bit and she helps me a bit because sometimes her daughter will take me to the doctor’s when she takes her and that sort of thing.

In terms of securing support, many older persons described providing reciprocal support was insurance for the provision of future support. Anne described having this future safeguard from others attending the centre as:

Because of my own situation, being left early with my husband passed away and then my family moved away, I just want to be independent and go and try and do something that’ll help some other people …. Do things for them that I may want myself one day, want somebody to help me …. It’s the most important thing, I think, is to have friends and have people that will help you.

8.1.2 Positioning self

Positioning self was the other term given to the major action described by all older persons for ‘connecting with others.’ The older persons described this action as placing themselves where they were able to socialise, have friendships, companionship and access to assistance from the community to stay living at home, as Jane said, “You have to be part of the community.” For all older persons, engaging in activities at the centre appeared to have facilitated many social connections.

Sharing with others

One of the strategies relied on by all older persons for positioning self was sharing with others. They all described this strategy as locating themselves amongst others to facilitate communication and socialisation. For example, as Sarah said, “You do need to meet people.” Anne described the need to socialise with others as: “You have got to mix with people.” Rose commented, “You might have a yarn to somebody, your next door neighbour or someone going past … somebody sees you and sings out.”
David described communicating and socialising with others was particularly important when older. He said, “Even a phone call is really socialization… communication is very important in old age.” Dan supported the need to position oneself to be socially connected, highlighting the experiences of other older persons who had not done so. He stated, “You get devastated some times … he’s got no friends … communication is very important in old age.”

Sharing with others to have friendships and companionship was a very important strategy particularly when living alone, as Jane said:

> For years and years people remained stable in my community where I was living … knew one another very well … and they were all very friendly. I had support, not physical support but a companionship was there … they were absolutely marvellous to me in that they would call me for a cup of tea or for a drink and now they have moved. I am finding that very lonely and I miss them terribly. I think that companionship when you’re living alone is tremendously important.

For many older persons, the centre provided a place to socialise with others and sustain friendships. Irene talked about her experience as: “Coming to the centre is … the only social one outside of my sons that I see now.” Mark described having friendships at the centre provided a local connection and recognition. He said, “Mainly meeting people and talking to people …. I know people who come here … or they all know me.” Regularly attending the centre enabled the older persons to establish friendships and become part of a group. Marjorie described her rationale for attending the centre regularly as: “It’s friendship.” Anne said, “I spend my time with Senior Citizens two days a week and that keeps me occupied. You meet friends and you have friends when you go to these places.”
Others described attending the centre provided them with something more than
friendship, it provided a connectedness through companionship. Anne stated, “It’s
the people and the interest. It’s company and you make good friends, you have lots of
friends.” Sarah spoke of the companionship she shares with others at the centre when
she stated:

*I look forward to coming here. I come on a Wednesday and Friday …. 
Wednesday I play bowls, Friday morning I usually play bowls and bingo in
the afternoon …. I came in 1990 …. I think it’s the company …. They’re all
really nice here … and they all get on well together.*

Those who had moved out of their home talked about positioning themselves to
connect with their new community. Maree who had relocated into a retirement
village described sharing activities with others and said:

*I came into this place and knew nobody and, as I’ve said, they’ve got lots of
things you can do, water aerobics and exercise and bowls and so forth, so, if
you want to meet people you join in what you want to do, and that’s how you
meet people.*

When describing his experience after moving into the hostel Tim said:

*I try and be sociable here because they have a lot of turn-outs here, different
things, exercise is 9.30 which I went to this morning, very simple exercise …. 
Then they have things in the afternoons, sometimes they play Bingo or play
Dominoes. I try to take part in all those things when I can …. I always try and
do anything that I can …. I try and be sociable. It’s important for me to talk
to the other people, otherwise you don’t talk to anyone except at meal times.*

Interestingly, for some older persons, sharing with others occurred at a different
level, one where they were not actively involved with the people around them but
they had made a passive connection. Ellen talked about a recent experience when she said:

Yesterday, there was a man sitting in the lounge at the club and he was reading a book. Now, undoubtedly, he was going for lunch later on … and there’s somebody who comes there every day and has a beer … but I’m sure that those people go there purely to meet somebody …. Just to have movement going on …. There’s something going on and I think that that’s necessary.

Once positioned close to others, it was important to stay close and connected and not move away. Tom spoke of this strategy when he said, “I think a lot has to do with the friends you meet when you settle down. You just think I have got them all here, why move away from them.”

**Outsourcing work**

In addition to sharing with others, the older persons relied on outsourcing work as an action for ‘**connecting with others**.’ They all described positioning themselves to organise and contract assistance for work they were unable to do themselves. Peggy said, “I get assistance when I want to have it.” To outsource work it was essential to connect with others to know what services were available and how they could be obtained. As David said, “What a lot of people don’t know, who are at home on their own is that they should ring the council to see what is available …. There are a lot of voluntary societies who can help you.”

Informal unpaid assistance engaged from the family was one avenue for the older persons to outsource their work. This included organising assistance from sons, daughters, grandsons and granddaughters. The types of assistance included small jobs around the home, home maintenance, additions or modifications to the home
and assistance to get out into the community for shopping or to get to GP appointments. Rose described how she organises her family to undertake small tasks for her. She said, “They do them [little jobs] for me. I am very lucky …. The boys are not as attentive but I just say I want this done.”

Outsourcing work in the home on a regular basis to the family was one strategy used by the older persons. Although the older persons would be eligible for services, at times they preferred to maintain some control at home by outsourcing to family. Rose described how her daughter does any chores she is physically unable to do on a regular basis. She said, “My eldest daughter … she comes every alternate Saturday. The other Saturday she came down and did any high work, dusting and all those things like that that I can’t get to now … because I can’t stand on the ladder.” In a subsequent interview, Rose described determining the assistance required gives her choice to complete the work herself sometimes rather than outsourcing it to family. She said:

My granddaughter will come and say to me is there anything you want done, that you want cleaned … vacuum cleaning or something. My daughter said to one of my granddaughters a couple of weeks ago … “I was coming down to do the floors but when I got down here mum had already done the floors.” I just felt I wanted to do them and so I did them before she got there …. But they will do things. If I need something done I can just say well I want something done.

Many older persons discussed organising informal assistance from their family with small tasks and general home maintenance when required. Peggy spoke of her experiences of outsourcing work to the family when she said, “I do when I want them to do. Changing globes and things I won’t do that.” Irene commented, “My son
comes and does the lawn for me.” Marjorie stated, “My son-in-law does the grass, cuts the lawns, cuts the wood for my fire.”

Other older persons engaged assistance from their family to get out of their home to connect with others. Irene described how she had positioned herself and organised her family to take her shopping and said, “Sometimes when my son comes I get him to help …. He takes me shopping now and again … he’s good that way, he wheels the barrow around, he’ll get them off the shelf … and bring them home.”

Marjorie talked about outsourcing work she was unable to do to her neighbour both regularly and at times when needed. She said:

I have a neighbour, she lives across the road from me, and [she] does all sorts of things for me. I’ve got birds, rosellas and she comes over every day to feed them because I’ve got three steps and they reckon I will fall down the steps …. I’ve been there two years longer than what [she] has …. Now I’m going into respite in a fortnight and she’ll come over and feed the animals for me … and lock the house up and … if I want anything doing she’ll do it …. I think she’s about 72 …. She comes over and does whatever’s got to be done.

Alternatively, the older persons in the study knew where to outsource work at a formal level for an affordable price. Types of contracted assistance included home maintenance, housework, shopping and community transport for appointments. Many participants discussed engaging paid assistance for home maintenance, particularly mowing the lawn. Alice said, “I don’t mow the lawn, somebody else comes in and does that.” Tim stated, “I have a chap mow the lawn.”

Outsourcing housework such as cleaning and vacuuming regularly or at times when unwell was another strategy. Ellen described contracting work regularly for home duties as: “I have a lass come in about once every three weeks to vacuum the floors
and do anything that needs to be done … and that does me.” When talking about the past after she suffered a major health crisis, she said, “I have had help from homecare to come out.”

For some older persons a strategy used was to outsource shopping. Contracting formal assistance with shopping on a regular basis entailed making a trade-off by paying a little extra money for the service to get all or some of the shopping done on a regular basis. Sarah said:

I do my own shopping. I shop in the shopping centre … and there’s a young couple there … they’re very nice. I go down and I place an order with them and they pack it and deliver it …. I always look at it this way they may be a little bit dearer in their things … but it’s the convenience and I don’t have to pay my bus fare going in and bus fare coming home …. But if you go to the other stores you’ve got to pay for delivery … so it works out even … and they’re very nice. I’ll be going down there today and they’ll deliver my order tomorrow. I get a fortnightly order.

The older persons also described engaging formal assistance through organised community transport by the local government. Rose pays for transport to get to appointments and said:

If I can’t get the bus to where I’m going I just have to get a taxi …. But I haven’t had to do that very often. I get the service car. I just pay $10 or $12 and they take you to wherever you want to go and then you ring them and they come back for you.

Anne described her experiences as: “they pick me up and take me home …. The Local Council has community transport and they will take you to the doctor’s or any appointments.”
Many others discussed engaging community transport for shopping. Rose said, “Where I get the car, you can get a bus, it comes pension day and takes you shopping…. Costs you a few dollars…. They take you shopping and wait and then bring you back home with your shopping.” David stated, “Local council … they take people with need to the hospital … also shopping.”

Recognising the need to outsource work was essential to remain living at home. The ability to realise when to connect with others to obtain assistance enabled the older persons to be prepared for the future. *Positioning self* to outsource work when needed was a better alternative than moving out of the home and into alternative accommodation. When thinking about considering outsourcing work at home in the future, Sarah commented, “I probably would [get services].”

In summary, the above strategies were described by the older persons in this study as being essential to stay living at home. The following section of this chapter presents the consequences of not implementing the complex action of ‘*connecting with others*.’

### 8.2 Consequences of not connecting with others

The older persons described if they could not successfully implement the actions and interactions necessary for ‘*connecting with others*’ they would be unable to remain living at home. They felt the consequences of not *being there for each other* were that there would be no one to watch out for them, and they believed this would lead to depression, loneliness, isolation and dependence on others. When Anne lost the support of her neighbour, she had no one available to provide the friendly observation and care when she needed it. She said:
“He [GP] thought that I wasn’t really to be on my own. My neighbour always had a key and I had a key to her place and we looked after one another for many years and then when you’re left and you’ve got nobody.”

Many talked about the consequences others faced when there was no one available to call on when needed. Jane commented, “When you can’t drive and you haven’t got anybody to take you anywhere that gets very difficult. People often leave their homes because they become isolated.” Frank stated: “I feel that older people can live in their homes … but if they are moving to nursing homes … it is because they have nobody to look after them.”

Other consequences related to not positioning self to have friendships, companionship or assistance. Dan described not socialising or sharing with others led to boredom or depression. Seeing the experiences of others in the past he said:

One of the main things is that they [older persons] want socialisation. One of the major problems in nurseries [nursing homes] is complete depression … if you leave me six, seven, 10 hours without a word, five, six days per week … will put you in a depression state.

Ellen commented:

If you’re unable to mix socially with people and talk and have a laugh, I think you could become very withdrawn, and I don’t think that’s good for anybody let alone as you get older. I don’t think that that does you any good or your family any good …. I think it’s very necessary to just keep on, well I’ve always been a people person anyway and I think that it’s very necessary. Well, life can become very depressing, I think it would … become boring, I know I’d hate it.

Furthermore, communicating and socialising with others was necessary to avoid loneliness. Anne said, “Being lonely and nobody to talk to …. You just couldn’t be
on your own all the time. You’ve got to have some outlet, somewhere.” Laura spoke of the negative consequences of not socialising with others and said, “We come here … meet with friends or have another life, don’t be at home all day because it is very bad.” Maree said, “But if you don’t do anything, well, you’re stuck in the house by yourself.”

When referring to outsourcing work, there appeared to be a limit imposed on the amount of assistance the older persons could access. When talking about her dependence on others for transport, Sarah said, “I’m dependent on the Baptists … they allocate me so many hours …. I decide what I want but I don’t always get it … I’ve got to accept what they can do.”

As well as creating a dependence on others, at times outsourcing work prevented some from doing tasks or activities they enjoyed doing. Marjorie illustrated this consequence when she said:

I go on a Thursday, we do the shopping but she [her daughter] leaves me at the checkout and goes and does the shopping. I don’t know how long it is since I’ve been in the shops …. I can’t go in the shop and press the buttons …. I sit on the seat at the checkout, she does all the shopping …. I tell her what I want … and she gets it, but it’s not the same as going along and seeing things.

Overall, the older persons discussed that the greatest consequence of not ‘connecting with others’ was that they would be required to move out of their home into a nursing home. Through the experiences of others they knew, they described if they were to live in a nursing home, they would feel useless, be unable to do things themselves, lose their independence and have to ask others for permission to do things.
8.3 Chapter 8 summary

This chapter presented the forth major category ‘connecting with others’ describing the strategies the older persons used to stay living at home. The two subcategories of this major category were being there for each other by having others there and helping each other out and positioning self through sharing with others and outsourcing work. This was followed by a description of the consequences of not employing these strategies to stay living at home. The older persons described if they were unable to successfully implement actions for being there for each other and positioning self, they would be depressed, lonely, isolated, dependent on others and unable to do activities they enjoy doing.

The following chapter draws together and builds on the findings of this chapter and the previous three chapters to present the substantive grounded theory ‘holding momentum: sustaining living at home,’ describing the central process used by the older persons to stay living at home.
Chapter 9 – ‘Holding momentum’: Sustaining living at home

The four major categories describing the context and experiences influencing the older persons’ capacity to sustain their living at home were presented in the previous four chapters. This chapter brings together the categories into a substantive grounded theory explaining the central category and process ‘holding momentum: sustaining living at home,’ utilised by older persons to stay living at home. The theory is presented through an explanation of the three main characteristics of the central process, specifically realising, knowing and persisting and reviewing and making a move, and the intervening conditions which act as mediating factors influencing the process. The theory is demonstrated through a model and supported by a storyline showing the relationship of the central category to all other categories and concepts.

9.1 The central category and process

‘Holding momentum: sustaining living at home’ referred to henceforth as ‘holding momentum’ is the central process that links all categories and explains the similarities and differences between the older persons sustaining their living at home. It is a process of continual decision making, re-evaluating and making new decisions relating to ageing at home. Although there were differences in the way the older persons individually engaged in the process and the length of time they spent in the process, when ‘holding momentum’ the older persons recognise personal and
community change, and make the decision to undertake actions and interactions required to facilitate holding the momentum associated with these changes.

The process ‘holding momentum’ explains how living at home was achieved by controlling the forward progression of depleting personal resources associated with change. This process occurs within the relationship between the person, their home and their community. The relationship is explained through four major categories describing the significance of home and the capacity of the person and their interdependent networks to sustain living at home. To remain in control of aspects of their daily lives and successfully hold momentum, the older persons maintain a continuous circular movement to mark time or tread water to stay in the process. ‘Holding momentum’ commences from the time the older persons enter the process until they reach an exit point and make the decision to move to alternative accommodation.

The level of effort required throughout the process varies from a minimal to maximum amount. The older persons manage the process themselves and demonstrate to others their capacity to do this to prevent others from interfering. They realise the level of their personal resource, their strengths and limitations. They do the easy, manageable things to address familiar conditions. They have knowledge, experience, capacity and self-determination to undertake everyday activities and remain independent and autonomous.

As they age, the older persons’ capacity to maintain the required level of effort is reduced and they determine whether to undertake tasks themselves or engage the assistance of others regularly, on a daily basis or at times in response to change. During their lifetime, the older persons have sought out and acquired community
resources including family, friends, neighbours and health practitioners. They are aware of the capacities of these resources and therefore know when and where to seek assistance. They have developed the ability to draw on the expertise and support of these resources. They earn the trust of others and in turn use others they can trust. Those older persons with limited community resources draw heavily on them and rely more on the others at the community centre.

9.2 Characteristics of ‘holding momentum’

The analysis revealed three main characteristics, namely realising, knowing and persisting, and reviewing and making a move which describe the central category and process ‘holding momentum’ as shown in Figure 2 on p. 226. Each characteristic is developed from concepts describing the motivation and actions older persons engage to sustain their living at home. All three characteristics reinforce each other, require distinct decisions and strategies, and are essential for sustainability at home.

The process of ‘holding momentum’ represented in Figure 2 on p. 226 is a continuous cyclical one over time. This process is characterised by realising which occurs at the beginning of the process and incorporates the entry point. In the model, ageing is a linear process occurring over time, whereas the process itself is a circular one where the older persons move through continual cycles characterised by knowing and persisting. Each cycle represents the strategies used and the confirmation of the decision to remain at home before moving into another cycle. These strategies are implemented in response to intervening conditions which are positioned above the major actions as they continually impact upon them. The characteristic reviewing and making a move is positioned at the end of the process.
as it represents an evaluation of the situation and includes the exit point. As the process of ‘holding momentum’ is an individual one, the number of cycles of knowing and persisting will be determined by the person themselves.

9.2.1 Realising

The process ‘holding momentum’ is purposeful as it is undertaken by the older persons to address the changing needs defined by them as they age to sustain living at home. Ageing is an uncompromising, destabilising condition that results in physical and psychological limitations. Changing conditions associated with ageing range from minor subtle physical and psychological changes to major health incidents and breakdown. With the ageing trajectory, change can occur both slowly and rapidly as the older persons experience gradual deterioration in their health over time, such as a feeling of getting slower or a general feeling of being unwell, or sudden health incidents, such as a collapse or an immediate need for surgery. The older persons accept and anticipate some change as part of the ageing process. When realising change is impacting negatively on their everyday living, the older persons make a conscious decision to enter the process.
Figure 2  Model of ‘holding momentum’

**Intervening Conditions**
- Personal Style
- Personal Health
- Accessing Support

**Entry Point**
- REALISING

**Process: Holding Momentum**

**Ageing**
- Knowing and Persisting
- Knowing and Persisting
- Knowing and Persisting

**Exit Point**
- REVIEWING AND MAKING A MOVE
Entry point into the process to stay living at home

There is no single entry point for everyone as the older persons enter with different life circumstances culminating in variations in personal style, personal health and accessing support. The entry point into the process shown in Figure 2 on p. 226 is the time when the older persons realise subtle gradual changes in health or sudden changes in health have decreased their capacity to get their everyday work done.

Changes in health described as the trigger for their entry point into the process presented the older persons with functional limitations. The limitations occurred as a result of diminished physical wellbeing brought about by changes due to ageing and existing co-morbidities. These factors imposed a situation where the older persons found they were required to engage in actions and interactions to continue living at home. The differences in changes associated with ageing and related co-morbidities accounted for the variations existing within individual entry into the process. The older persons usually related the entry point (described in Chapter 5) to a specific age in their life.

9.2.2 Knowing and persisting

Knowing and persisting shown in Figure 3 on p. 228 is the next characteristic after realising and part of the cyclical process. It occurs within each cycle in Figure 2 on p. 226 and continues throughout the entire process of ‘holding momentum.’

Knowing and persisting incorporates the four major categories: ‘it’s home,’ ‘maintaining autonomy,’ ‘protecting self’ and ‘connecting with others.’

The older persons are motivated to persist because of the importance of home. The major category ‘it’s home’ is a major constituent of knowing and persisting. The intervening conditions are a major feature of knowing and persisting as they
influence the ability to persist. The facilitating conditions of personal strength, good health and access to support assist the older persons to persist in the process, whereas the constraining conditions of poor health and lack of support impose further changes. When persisting and responding to changes by employing actions and interactions from the other three major categories; ‘maintaining autonomy,’ ‘protecting self’ and ‘connecting with others,’ the older persons demonstrate their ability to manage intervening conditions.

Figure 3 Cycle of knowing and persisting

![Diagram of Cycle of Knowing and Persisting]

IT'S HOME

CYCLE OF KNOWING AND PERSISTING
Knowing - the importance of home

Knowing represents a significant acknowledgement as the older persons understand the importance of living at home and confirm they want to stay living there. They enjoy living at home as home provides them with purpose and gives a reason to work hard to remain there. When living at home, strategies are more automatic, require less thinking and less effort, as implementing strategies to address change is not as demanding at home in a familiar controlled environment.

The effects of the conditions of ageing are easily recognised and responded to whilst older persons live in the familiar context of their home. The long term exposure to subtle ageing changes affecting daily living at home makes it easier for the older persons to adapt and make small adjustments to stay safe and healthy. When change occurs suddenly, living at home makes it easier to be confident to make decisions and make compromises. The older persons know the importance of living at home as living at home provides a context that gives them stability and peace of mind through the uncomplicated space. Home facilitates capacity to remain autonomous, maintain wellbeing and retain connections with others.

The major category ‘it’s home’ describes the characteristics and benefits of living at home, as home provides motivation for all older persons to sustain living there irrespective of individual circumstances. There are four subcategories of the major category ‘it’s home’ explaining the meaning of home, including anchoring self, enabling freedom, being comfortable and staying in touch. Through anchoring self at home the older persons secure an identity and stability. Living at home assists in enabling freedom as home is known territory where the older persons create a work environment and personalise their activities. Living at home also assists with being
comfortable as home enables older persons to secure physical and emotional comfort through their familiar controlled space. As home exists within the social context, staying in touch enables the older persons to maintain social relationships with others through the use of convenient services and facilities.

Persisting - despite change
Through the experience of knowing and persisting as part of the cyclical process, the older persons have developed the capacity to adapt and adjust to changing conditions. They can predict some changes and use their personal style to respond to these changes by engaging actions and interactions of their choice.

Three major categories; ‘maintaining autonomy,’ ‘protecting self’ and ‘connecting with others’ are fundamental to ‘holding momentum’ as they describe the actions and interactions undertaken by older persons to continue persisting in response to changing conditions. ‘Maintaining autonomy’ describes the utilisation of inner strength and self-determination, ‘protecting self’ describes the optimisation of personal health and safety, and ‘connecting with others’ describes the sustainability of relationships with families, friends and the wider community. These three major categories differ according to the actions or interactions which are used separately or at times in combination to manage the intervening conditions.

Facilitative attributes of inner strength, good health and access to support assist the older persons to hold momentum. Their motivation to continue persisting and sustain living at home is brought about by the personal satisfaction gained from living there. The capacity to persist is influenced by factors of personal style, personal health and accessing support generated from the data influencing the older persons’ experiences. Individual differences in these three factors accounted for the
variation in the experiences amongst the older persons and their ability to sustain their living at home.

**Personal style**

**Persisting** requires the use of *personal style* which was the first facilitating condition described differently by the older persons. Style was shaped by individual experiences but despite this, all older persons affirmed *personal style* required the sustainability of strength, determination and motivation. The older persons are determined and tenacious and direct their energy to doing things themselves. They are able to sustain living at home with minimal effort as they use effective actions and interactions that conserve their energy. They rely on their physical and emotional energy and use it to respond to changing conditions so they can stay at home. Some possessed other personal characteristics of being positive, organised and sociable. When the older persons possessed these attributes, they could draw upon them individually or in any combination when required and remain independent and autonomous at home.

The first and possibly most important attribute of *personal style* was the possession of inner strength. For example, Irene described herself as: “I’m probably hard … tough … tough old bird.” Alice described having “a good and strong attitude to whatever you want to do.” This inner strength, as Anne said, “I think I am pretty strong and determined,” underlay the determination to undertake what the older persons needed to do to persist and remain living at home.

This situation corresponded to having the ability to do tasks and avoid being a burden on others. Closely connected with inner strength was the attribute of determination, described by the older persons, for example as Anne said, “If I know
I’ve got to do something I just do it.” Determination underpinned not just doing the immediate activities that needed to be done in everyday living but also focused on the longer term goal to stay living at home, as Kathy said, “I am determined that I am going to stay in my house as long as I can.”

Generally, the older persons had become stronger in character as they aged, and more adaptable. With advancing time and subtle changes or deterioration with ageing, the older person’s general capacity to cope changed. Accompanying maturity, their psychological health became stronger and their determination to sustain motivation to continue persisting at home increased. This ability influenced the degree to which the older persons were able to respond to change and persist in the process. When talking about ageing, Kathy said, “You become adaptable.” Maree described her experience when she said, “But when you’ve never been sick, it takes a lot of adjusting. Well, I feel that I had to do something, I couldn’t just sit there and feel sorry for myself.”

For some older persons, becoming adaptable was shaped by past experiences involving adjustment to the loss of someone very close to them, as Maree said, “You lose your husband and then you have to readjust … you miss them so much … but you have to pull yourself together.” Rose described her experiences as: “When you lose your partner you find that you just have to do things you never thought you would do before.”

Another important attribute of personal style described by almost all older persons was to have a positive attitude. For example, Rose described her attitude as she “thinks positively.” Ellen valued and acknowledged Jane’s use of positive attitude in
the focus group when she commented, “I tell you what Jane, you have got such a positive attitude.”

For many, having good organisation skills, particularly in the home, was identified as another attribute of personal style. When describing how being ordered and structured enabled him to be more competent and continue living at home alone for many years, Tim said, “You have to be organised.”

In addition to being positive and organised, many older persons talked about being friendly and sociable as another facilitating attribute they possessed. For example, when discussing her style, Rose said she has “a quiet nature, a friendly nature, I’ll speak to anyone.” Mark also described his pleasant nature as an attribute when he said, “I’m very friendly with everybody.”

Although the older persons possessed different combinations of these attributes, their personal style was one condition facilitating their ability to continue persisting and sustain their living at home. Another intervening condition was personal health.

Personal health

In addition to personal style, personal health was a second factor influencing how long the older persons were able to persist in ‘holding momentum.’ With the progression of time and accompanying changes in health status, the older persons understood they would need to work harder to stay living at home.

Individual experiences of wellbeing and health breakdown not only influenced entry into the process but they also influenced the actions and interactions the older persons employed, and the degree to which they utilised them. This intervening condition, sometimes facilitating and at other times constraining, required the older
persons to regularly renew their actions and interactions in response to further illness and health breakdown to sustain their living at home. When asked what would prevent her from having to move into alternative accommodation to receive a higher level of care, Maree said, “It would only be my health and as I say, as the doctor says to me ... you’ve been so healthy.”

Good health was a facilitating condition, described as being a critical pre-requisite for **persisting** in the process. Not surprisingly, as the majority of the older persons lived at home, they believed they were in good health, as Irene stated, “My health is good considering my age.” Many formed these views as they measured their level of health by comparing themselves to the general physical appearance and functional ability of other older persons. Irene said, “I have a lot of energy I think than most people my age .... I see other people who’ve got walking sticks and they can’t bend and they can’t do a lot of things.”

Having good health enabled the older person to respond to changing circumstances and continue **persisting**. The older persons expressed that good physical and mental health gave them the ability to perform everyday tasks and activities. Rose said, “As long as I can do things for myself I’ll do them.” Irene stated, “I’ve got that many interests .... I love reading .... I’m still interested in what goes on down at the centre ... my brain is still working ... my memory’s pretty good.” Peggy described how her good health enables her to clean the kitchen and bathroom floors when she said, “I can do it so I’ll keep going.”

Alternatively, poor health was the most influential restraining factor for all older persons. Having poor health appeared to impose permanent restrictions on daily living. In a later interview Irene expressed this as:
I don’t have the energy now to do it, what I used to do. That’s the trouble for me .... I haven’t got the things I used to have .... I find I am not up to it so much now .... I lose more mobility every year.

For some older persons, changes in personal health prevented them from undertaking some activities. Mark described how a recent health condition prevents him from doing some things when he said, “It’s [the operation] slowed me down a bit .... I can’t walk as far as I used to.” Maree described her experience as:

But I’m not as well as I used to be now because the arteries in my legs have blocked and I’m having trouble walking. Yes, it only happened all of a sudden, I suppose, and I did have a nasty fall. It was really, it was after that fall .... I can’t go shopping on my own like I used to and you can catch the bus from there and go up and do all the shopping and have it delivered. I can’t do that any more because I have to have someone with me.

For many, poor health had become a major life changing event, requiring the older persons to make compromises or obtain assistance. Many older persons described giving up things and making compromises. John spoke about how he had to give up his driver’s license due to his health and is now restricted to going to places near the train line. He said, “Previously when I was driving I had freedom to go wherever I wished.” Similarly, Ellen said, “I had to give up my license since this cataract operation so I’m pretty dependent on (-) [her husband].”

In addition to personal style and personal health, accessing support was the third intervening condition influencing whether the older persons were able to keep persisting in the process and remain living at home.
Accessing support

The relationship between the older persons and others in their family and community was the third factor influencing their capacity to persist. The level of support each older person had accessed and established with others required different responses and impacted on the actions and interactions they used.

Accessing support incorporated the type and the quantity of support secured. When utilised as a facilitating condition, the types of support commonly included that of a husband or wife, family, neighbour, or government assistance. Family was determined to be the most important support for many older persons in this study. When describing her experiences of accessing support to remain living at home, Rose said, “I couldn’t do without my family …. I am very lucky.”

The older persons who had family or community support were more able to hold momentum. However, one participant described her experience of accessing support from her family as a constraining situation. Marjorie talked about how she was determined to remain independent and autonomous living at home, but her family became more determined than she when making decisions about her. She said, “I’m determined but I don’t get anywhere.” This highlights the fact that family support can sometimes prevent autonomy and restrict an older person’s ability to persist in being at home.

Alternatively, for the older persons who lived at home with little or no family support, their ability to remain at home was limited and dependent on their ability to establish and maintain support networks with others in the community. Sustaining relationships with others influenced the degree to which actions and interactions facilitated persisting.
Older persons without access to family or other informal support had acquired more formal support available through the community. David described how some older persons access support through formal channels to stay living at home when he said, “A friend of mine had a stroke …. Council volunteers mow his lawn.” Anne said, “I think we’ve got more services now. I think older people are more cared for now … than they were in my mother’s day.”

The older persons identified the major constraining condition with regard to accessing support was living alone, as Anne said, “I don’t see anybody anymore.” Irene stated, “On your own you’ve got no one to talk to.” Jane described living alone without support led to isolation when she said, “When you can’t drive and you haven’t got anybody to take you anywhere, that gets very difficult, people often leave their homes because they become too isolated.”

For some older persons, the inability to access support was due to the fact that they did not have family assistance or because their community had changed so much that they had lost support from others in the community. The older persons described this as being “forced into independence,” and they became accustomed to having no one do things for them. Kathy described her experience as: “I have to look after myself.” Although Irene had been involved in many associations in the past, she now feels alone and the many losses have made her lonely. She stated, “I can’t understand why I’ve got to be alone after so long … see I lost my husband, I lost my children when they got married.”

Having no one to provide support as a consequence of changes in the community network included not getting replacements for neighbours or friends that they had known for a long time but had either moved away or died. This was expressed by
Rose as: “Most of them [neighbours] are gone … people on the corner, they’re all right … all I do is just say hello and how are you and that sort of thing.” Anne talked about the changes that make it most difficult to remain living at home and stated, “More or less the change of neighbours I think … the environment has changed … when I first went there I had lots of good neighbours …. I don’t see anybody anymore.” Irene stated, “I’ve got bad neighbours …. I used to have wonderful ones, but … other ones that came, they don’t want to mix … not socially.”

The longer the older persons sustained knowing and persisting, the greater the effort required, as they have less capacity to address new complex situations. Eventually, to compensate for these limitations, the older persons make compromises and rely more heavily on the resources of others, and trust family, friends, neighbours and health professionals to give them assistance. In this way, they devote less attention to the small occurrences that do not matter and focus more attention on the important situations. Throughout the cycles of persisting, the older persons increasingly rely on others and less on their own capacity to do tasks. This frees up their personal energy as they devote more time to engaging others to do their work and this makes it easier for them to sustain living at home in the short term.

If the intervening conditions are not too demanding, the older persons can continue implementing actions and interactions and continue to persist in a cyclical way. To avoid total depletion of their personal energy, they move into another cycle of the process to further combine actions and interactions. However, this requires the use of more effort. To be able to persist, older persons give up some things and learn to trust others to do them. The length of time in one cycle of the process is also dependent on the individual’s capacity to continue persisting when intervening conditions become restrictive. The greater the length of time the older persons can
persist, the longer they are able to sustain living in their home. Each time the older persons enter a new cycle of ‘holding momentum,’ they are required to draw on additional personal and community resources to sustain their living at home. To achieve their goal, the older persons aim to persist and prevent moving along a continuum. When engaging actions and interactions against new conditions, they use more effort and lose more energy. With time and persistence the older persons gradually lose their source of personal energy. When the older persons are no longer able to continue persisting, they review their situation and relocate.

9.2.3 Reviewing and making a move
The third characteristic of the process ‘holding momentum’ identified describes when the older persons review their situation and exit the process of ‘holding momentum,’ moving out of their home. Reviewing occurs at the exit point shown in Figure 2 on p. 226 when the older persons are no longer able to continue persisting and renewing actions and interactions against intervening conditions.

Eventually, the older persons drain their personal physical and emotional energy, are unable to access their community resources, and require more effort to maintain their domestic routines. When their capacity is reduced and they become tired from persisting, it becomes too difficult to endure and sustain the effort required to hold momentum, and they make a conscious decision to exit the process. If they do not make this decision at a timely point, the exit point may be determined for them by others. The older persons commence the process when there is a threat to their optimal level of health and resources and these are depleted by the exit point.
Exit point from the process to stay living at home

There is no common exit point as the older persons have different experiences of the process. Knowing the disadvantages of remaining at home, some evaluate their situation, prepare for and later make a conscious decision to move out of their home into assisted living, preventing relocation into residential care. For others, the strong significance of the meaning of home results in them refusing to move out of their home and they stay there until their death.

Similarly, as the entry into the process of ‘holding momentum’ was at times a gradual one, for some older persons the exit was also a gradual process. Tim said, “Well, this is hostel care where I am” and he described the gradual events leading up to his exit from the process as:

Gradually getting old … it doesn’t happen overnight. You just sort of gradually get stiffer and you tire more easily …. I suppose it was about three years ago I started thinking to myself well, I’ll have to move into another place, somewhere I’d be well looked after.

Although his exit from the process occurred over time, it was a sudden health incident that forced Tim to make the move. He discussed how he kept deferring the decision to move out of his home and described it was a change in his personal health that pushed him to make the decision to exit the process and move into a hostel. He said:

I was finding it hard to live on my own, although I kept putting it off … and then I had a bad fall and I had to go into hospital for some time and so I knew I’d never manage on my own again … so I asked (-), my sister, to see what she could do and she arranged for me to come here.
This decision was compounded by a lack of support. Not having immediate access to support at home forced Tim to make the decision to move. He said:

Well it [fall] made me make a definite decision … I thought well, it’s no good me going back there, couldn’t manage before … and of course, there’s a little bit of a risk living on your own … you fall over and can’t get up, with no one to help you, and you might lie there for two or three days … if I fell over here and couldn’t get up … you’d get help straight away.

Maree described her experience of persisting over a long period of time and spoke about the events that influenced her decision to move. When describing how everyday things that were out of her control became too demanding for her to negotiate to stay living at home she said:

I didn’t want to move, I was quite happy there and it was only … after we were not getting rain and we had to go out and water the garden at certain times and I had a big yard and a big front, and the weather was stinking hot, and I thought to myself well, I’ve had this. So, when my daughter came around one day I said look, I’ve really had it now, I’m ready to move … that really was something that said get out of here. I didn’t want to otherwise.

Although Ellen had not exited the process, she anticipated her exit point in the future would relate to accessing support. Ellen believed if her husband was no longer able to provide support she would move into alternate accommodation. She said, “If anything happens to him I’m going to go into a serviced apartment and that way I won’t have to depend on my family. But if you go into those you don’t have to worry about cooking.”

Although she was not ready to exit the process, Ellen talked about the need to anticipate and be prepared to move out of her home as:
I think you’ve got to weigh up the pros and cons … the advantages and the disadvantages … you’ve got to face these things and with my eyesight the way it is, well I’d better make sure that I know what I’m going to do …. I have a friend who’s just shifted into the (-) [retirement village] … she’s given us some information. However, we’re not ready to go in yet. We want to know exactly what our plans are … instead of waiting for something to happen and think what am I going to do? If we know what we’re going to do it’s much easier on the kids too.

9.3 The storyline of older persons sustaining living at home

The following storyline explains the process the older persons engage in to stay living at home. It describes the central category and process ‘holding momentum: sustaining living at home’ and the relationships existing between the central category and other categories. The three main characteristics of the process, realising, knowing and persisting, and reviewing and making a move relate to implementing strategies to hold the momentum of change by marking time and prevent forward movement. Increased length of time in the process places great demands on the individual and their resources, and the consequences are physically, socially and emotionally draining. The way the intervening conditions impact on the success to stay in the process, and the strategies used in response to these conditions are described. Throughout the storyline, the words of the participants have been included in ‘italics’ and inverted commas. The labels given to concepts by the researcher are presented in italics.

The older persons start realising age is ‘creeping up’ on them. They recognise the need to prepare for the future, even if it is ‘not a long future.’ If their health is ‘good for their age’ they can do things, but they have been aware of gradual physical changes occurring and sometimes they ‘don’t have the energy’ to get things done or
they are just ‘not up to it.’ Each time they have a fall or suffer a collapse or feel they are ‘getting slower,’ they think about how they are going to keep persisting in the future and renewing their strategies. It is at this point the older persons begin realising they have ‘reached a certain age.’ It is an age everyone knows is inevitable and it is at this point in their lives the older persons realise they must put strategies into place to be able to stay living at home. This is the entry point into the process of ‘holding momentum’ to sustain their living at home.

The older persons want more than anything and have never been more ‘determined’ in their lives than they are now to remain living at home. They want the remainder of their lives to have purpose and they achieve this by anchoring self and remain living in their own homes. It is impossible to ‘imagine being anywhere else.’ The older persons have built up a long term relationship with their home as they have lived there a long time. It is their home because they ‘own it,’ they have taken a house and transformed it into a home. Home is who they are, they have created their own home, and the personal mementos kept at home reflect who they are. Home therefore is their source of identity. The older persons invest everything into establishing and securing this identity at home and now defend their right to remain living there. They confirm they want to stay living at home, knowing home creates ‘work’ to do and it gives them enormous purpose for living.

The older persons are aware that one of the benefits of living at home is that home enables freedom and so they want to stay living there. They embrace this freedom because it enables them to manage their own work and time, to do what they want to do, when they want to do it, in their own space. There are no strict rules and regulations to follow when living at home and this allows them to keep shaping their approach as they keep creating own rules, and plan, organise and prioritise.
their day. It enables them to persist. The older persons are aware that having freedom allows them to continue setting their own pace and do their own things as they want to do them. Sometimes they have a routine and at other times they do tasks when they feel like doing them. The older persons control their own time as they do not have to ask for anyone’s permission and are not required to tell anyone what they are doing or where they are going. They eat when they want, go to bed and get up when they want and do the washing and shopping when they feel like doing it. In this way, they do not have to consider anyone else and ‘others don’t interfere.’ They continue knowing that having this freedom in their own home gives them ‘independence’ and assists in ‘maintaining autonomy.’ Living at home provides a focus, a reason to keep busy and they feel proud and personally satisfied they can undertake essential tasks. The older persons can do these things and will persist with them while they can.

Staying at home also facilitates being comfortable and the older persons continue knowing they can secure comfort by living at home. Home is a place where they have their ‘own space,’ it is nice and quiet inside the home, and peaceful out in the garden. Home is a place where they have ‘space’ to rest and relax to ‘read a book’ or ‘watch television.’ The older persons have been busy going out, and home enables them to persist, as they return for revival and restoration. Home is a refuge, the older persons feel ‘happy’ living there and ‘enjoy’ living there. Although many may not have much, they feel content with what they have, and ‘have everything’ they want at home. They forget about their worries which seem less overwhelming at home. They feel happy reflecting on the ‘memories’ they have living at home. When their adult children visit, they still call it ‘home.’

As they grow older, the older persons recognise living at home is not enough in itself and they need to spend time with others socially and have their support. They know
it is sometimes hard to get out of the house and into the community. However, living at home provides the older persons with a means for ‘connecting with others,’ including their family, friends and neighbours. It is important for them to know that they have these people close by and they are there when they need them. They often provide support for others and get that support back too. In this way they are being there for each other. They spend time helping each other out, a mutual arrangement, often reciprocated; and they have secured support for the future. The older persons are aware of the unspoken rules accompanying this arrangement, particularly with neighbours and therefore ‘don’t impose’ on each other or invade each other’s privacy. Having access to readily available support also means they have someone to talk to and socialise with, and this enables them to continue living at home. At times, when renewing their strategies, they call on this support to get assistance with tasks they decide they need help with.

The older persons know they must find a way of ‘connecting with others,’ a way of staying in touch to get out of the house to see others and spend time with them. Home is a stable familiar place when their community is changing around them. It is uncomplicated living there as they know where everything is. It is familiar territory and enables them to get out into the community and return home, to continue persisting. The older persons rely on public transport if they do not drive or have had their license taken away because they are now too old to drive their car. Living at home means they can use the bus if it is convenient to where they live or organise ‘local community transport’ to take them to places where they can spend time with friends or engage in activities.

The older persons also understand as they age that it is important to remain keeping well so they can continue persisting and do things themselves. Without ‘good
health’ the older persons have nothing, ‘it goes without saying.’ Many keep persisting to ‘protect self’ from ill health by living healthily, eating healthy foods and avoiding bad habits, such as smoking and drinking alcohol. They are aware they must keep ‘busy,’ that is, busy going out, keeping their mind and body active. Whether it involves participating in activities such as ‘bingo’ or ‘bridge’ or simply talking to others, they do these things to keep their mind active. They go ‘walking’ or ‘play bowls’ and engage in gentle exercise to keep their body physically well. The older persons enjoy going to the centre to do these things, after all these are the reasons everyone attends the centre, to ‘do activities’ and be with others. So they keep persisting and keep active to stay living at home.

The older persons know they need to continue relying on health professionals for their advice and monitoring to help them remain healthy. These are usually familiar people they have known for many years, people they can trust, and ‘have faith’ in to ensure they are keeping well. They need a GP who will do ‘home visits’ if they are unable to get to their practice, preferably one who knows them, who knows their history. Some older persons also draw on the services of the OT to help maximise mobility and ‘independence’ in the home to ‘protect self.’ These professionals organise to remove structures from the home, such as a ‘bath’ or ‘steps’ and have structures added to the home such as ‘railings’ or ‘lighting’ to help prevent a fall or injury. Sometimes the older persons refuse these suggestions by the health professionals as they are aware they need to make their own decisions and continue ‘maintaining autonomy.’ This enables them to continue persisting.

The older persons ‘protect self’ from harm from others in the community. They have been realising the world is a ‘different world’ than the one they once knew so well. They are cautious not to become victims of crime. So they ensure they continue
staying safe and ‘don’t go outdoors after dark.’ They only go out to unfamiliar places if the family takes them and brings them home. They are attending to perceived risk as they ‘keep the doors locked,’ particularly after dark and are fortunate if they have good neighbours looking out for them. They continue persisting to remain ‘independent’ by minimising any risk of injury through using simple aids such as a ‘walking stick’ or ‘VitalCall’ for emergency.

To be able to stay living at home, the older persons know they need to ensure they have others there, to have support of family, friends or neighbours available, ‘somebody to call on’ whenever they need them. Sometimes this is when needed or other times it is because they need to have someone there always, someone readily available. If they are lucky, they have family to provide the support they need to persist. If they do not have family, they have friends or neighbours they can call on, otherwise they keep renewing their strategies and organise formal support through local government or community services for tasks they can no longer do themselves, such as home maintenance or transport. They outsource work in this way as they are conscious that they do not want to become a burden on their family or others.

For those living alone, they do not see anyone. They know it is easy to become isolated, so they continue persisting and make sure they get out of the house regularly to be with others. For some, this means going out every day. If the older persons are unable to get out of the house by themselves, they make sure they have someone to take them to places or a means of getting there. The older persons go to other places so they can spend time sharing with others, just to socialise. They know that spending time with others regularly gives them companionship and prevents them from feeling lonely.
So the older persons continue living in their own home where they position themselves to get out into the community, to be a part of the community and stay in touch with others. They are aware they must have somebody to talk to so they are ‘not by themselves all day worrying.’ They try not to think about what will happen in the future and never complain. They sometimes get frustrated when they think about the things they used to be able to do and cannot do now. When they are with others, they forget about these things and do not worry, others do the worrying for them.

The older persons continue depending on their learning from past experiences. Through depending on experiences, the older persons have learned to look after themselves. They continue using their personal attributes: they’re ‘practical’ and ‘organised.’ They can get along with people because they have a ‘friendly’ personality. They try to have a ‘positive’ outlook and they have learned to cope by ‘adjusting and adapting’ to situations. They have done a lot of learning, learning as a child, as an adult and from recent experiences of others. Some of these experiences have been difficult as they have watched people close to them die or move out of their homes to be cared for in facilities, such as nursing homes. Through these experiences they have learned to keep persisting so they can continue living at home.

So they continue persisting to do things and using their ability to adapt. They ‘take their time’ and ‘have little breaks’ in between doing things, just so they can continue to do things themselves. They feel proud, it gives them self-satisfaction and a sense of accomplishment. If the older persons cannot get things done at home, they renew their strategies and arrange for someone else to do it for them. They know they need to start making compromises and give up some things, so they don’t have to give up everything.
As their community is changing, suddenly they find their support has gone. If they are ‘lucky,’ they get good replacements. They want to keep **persisting** to stay living at home amongst their community. However, many of their friends and family are now gone. As they get older, ‘it’s harder to make friends’ but living at home amongst the same community means they still have some family or friends around them. They watch family and friends ‘go into nursing homes’ because they were unable to manage living at home due to their **deteriorating health** and they have ‘no one to look after them’ or provide the level of care they need. These people were unable to continue to do their daily work anymore because they had a fall or injury or became a danger to themselves, it became unsafe to stay living at home. The older persons begin facing their own reality, through seeing others age.

The older persons do not want to move out of their home and ‘go into a nursing home.’ It would make them ‘feel useless,’ they would have to ‘depend on others’ and ‘get permission to do things.’ It would make them ‘depressed.’ They do not want to be a ‘burden’ on anyone, so they continue **persisting** to do whatever it takes to stay living at home. They keep renewing their strategies to stay ‘independent’ and continue ‘**maintaining autonomy,**’ making their own decisions. They ‘**protect self**’ by looking after their health, **keeping well** and **staying safe.** They feel safe and secure living at home. They are not bored or lonely as they get out of the house to be with others, to ‘**connect with others**’ in the community. They are aware this keeps them motivated to sustain living at home.

So they continue **drawing on inner self.** They are **utilising resolve,** they are strong and ‘**determined,**’ they have ‘**always been that way,**’ they are ‘**determined they are going to get there.**’ The older persons are motivated to keep **persisting** to ‘**get on with life**’ as long as they can. They continue **knowing** the way to persist is to do what
they have to do to stay living in their own home. They want to stay living at home until the day comes when they just collapse and die. Home is who they are, they cannot leave it as it gives them purpose.

At times during the process, some older persons review their situation and make a conscious decision to make a move out of their home. It requires too much effort to continue persisting and renewing their strategies. This is their exit point from the process. For other older persons, they want others to understand that they keep persisting. It takes great effort, but they have been ‘brought up’ that way and they are not afraid of hard work. They have been ‘doing it for so long’ now that they just get in and do it. They are ‘holding momentum’ of change and sustaining living at home while they can.

9.4 Chapter 9 summary

This chapter presented the substantive grounded theory ‘holding momentum: sustaining living at home’ explaining the process of navigating and negotiating by older persons to stay at home. A description of the process of ‘holding momentum’ and its three main characteristics, realising, knowing and persisting, and reviewing and making a move used to address the phenomenon to sustain living at home was presented. ‘Holding momentum’ is the process of controlling change as the older persons experience sustaining their living at home. A model depicting the process and a storyline demonstrating how the major categories are embedded into the process were included in this chapter.

The following chapter presents a discussion of the study findings and the theory ‘holding momentum: sustaining living at home,’ in relation to the literature. The
implications of these findings and recommendations for future research are also presented.
Chapter 10 – Discussion and Conclusion

Many older persons want to remain living at home but have to face the changes in their lives that ageing brings. This study, in exploring the experiences of 21 people over the age of 65 years living independently in the community, identified the processes and strategies they used to manage age-related changes and remain living at home. Specifically, the study informed the development of a substantive grounded theory of older persons sustaining living at home. The findings suggest that to sustain their living at home, older persons require insight into the changes occurring and in doing so they consciously draw on their individual resources, and respond by implementing a range of strategies.

This final chapter discusses the findings in relation to the extant literature in accord with the grounded theory approach. It commences with a discussion of the decision making processes about residency, drawing on the push-pull theory from relocation literature to help explain the major decisions made by the older persons. A discussion of the meaning of home for the older persons in this study follows, using the contribution of the literature to confirm the main concepts describing home as central to their identity and sense of self. This section is followed by a discussion of the everyday strategies drawn on by the older persons and discussed in the context of the literature. The chapter concludes with a section identifying limitations of the study, implications for older people, healthcare policies and services, and recommendations for further research.
10.1 Central process: ‘holding momentum: sustaining living at home’

It is argued that the process of ‘holding momentum’ is a continuous, cyclical process. It is not a dynamic process because there is limited forward progression to a different state and the older persons work hard to stay in the same place. The complex process ‘holding momentum’ consists of three main characteristics, namely realising, knowing and persisting, and reviewing and making a move.

Despite many points of similarity, each older person’s experience of the process is individual and variable, which leads to a perceived need for flexibility in policy and service provision. Collective experiences of people belonging to particular generational groups also impact on shaping their attitudes to and expectations of ageing. Thus, a comprehensive understanding of these issues and implications can assist policy makers, healthcare professionals and older persons themselves to sustain living at home.

10.2 Decision making processes

The decision making process about residency is centered on the major decision whether to stay living at home or to relocate to other accommodation. Vital in the decision making process was the place of the older person as the decision maker who had autonomy and control over the complex decision to remain living at home and stay engaged in the process of ‘holding momentum.’ It is a process of continual decision making, re-evaluating and making new decisions.

The decisions made by the participants were situated within the three main characteristics of the process ‘holding momentum.’ They were realising the need to make the decision to stay living at home, knowing and persisting with the decision
to continue to implement strategies to remain living at home, and **reviewing and making a move**, deciding to relocate into alternative accommodation. Examining these decisions helps identify what other older persons, policy makers and health professionals can do to assist older persons to stay in their homes for example, strengthening neighbourhoods and providing community services.

In the current study, decision making was influenced by many factors that may be explained by the push-pull theory, a framework often used in relocation decision making (Stimson & McCrea, 2004). Based on the subsequent development of earlier theory by Bogue (1969), push factors are those that push or drive people out of a place so they make the decision to relocate, and pull factors are those that pull or draw people towards a place (Stimson & McCrea, 2004). Both push and pull factors can relate to a place, such as the home or other accommodation, and to people, such as their health status or level of social support. In this study, participants’ decisions were influenced by push and pull factors. The major push factors to exit the process of **‘holding momentum’** are the older person’s deteriorating health and lack of support. These factors influenced the amount of effort required by the older persons to maintain their home and attend to IADLs such as washing, cooking and shopping. Similarly, Tsang et al. (2004) found poor health was a major push factor to relocate to hostel living. In the current study, for a few participants only, the pull factors are explained by the attractors relating to alternative accommodation, for example less home maintenance or the provision of care.

A recent Australian study of the decisions regarding where to live in later life, found the top five factors influencing the decision to stay living at home were comfort, financial viability, good location, safety and security, and easy access to services (DOHA, 2009). Although there are some differences, similarity to the current study
lies in factors relating to the meaning and benefits of living at home. In other research, Stimson and McCrea (2004) focused on the decisions to move to retirement village living. They found push factors to relocate included the desire for a change in lifestyle, such as wanting more free time, difficulty in coping with home maintenance, social isolation relating to death of a partner and loneliness, and deteriorating health and mobility requiring assistance. The pull factors influencing the decision to relocate were the built environment such as design, facilities and services provided, affordability, the location of villages such as access to public transport and social activities, and the desire to maintain an existing lifestyle such as the village is located close to family, friends and services already being used (Stimson & McCrea, 2004).

10.2.1 Making the decision to stay
Despite similarities and differences in their personal circumstances, all the older persons in this study had the same goal: they wanted to continue living at home. They had a vested interest in this long term goal as it is intricately bound up with who they are as an independent, autonomous person. It is therefore not surprising that what was common about the participants’ experiences was that all the older persons had made the decision to enter into the process of ‘holding momentum.’

The desire to remain living at home by the participants in this study as discussed is consistent with that found in other studies (e.g. Green et al., 2005; Leith, 2006; Stimson & McCrea, 2004; Swenson, 1998). It is also congruent with and supported through the Australian government policies to age in place (Chandler, 2007). Through the implementation of the Australian Aged Care Structural Reform package in 1997, ageing in place was adopted to keep the older person living in their normal residence with the provision of care and services in the home when needed.
Tanner, Tilse and de Jong (2008) caution that Australian policies may be insufficient in supporting the future needs of the older person to live at home and claim that recent research has been directed towards existing housing and modifications that benefit older persons and support their independence. Whilst acknowledging the importance of the person’s home environment, and recognising it needs to be a major research focus, the findings of this study demonstrate that the older person’s personal style, health and access to support, and not just a sustainable environment, influence their decision making and the strategies they use, and are vitally important in sustaining their living at home.

No participant in this study expressed a desire for relocation to other accommodation, particularly to institutional living. Almost all older persons described they would feel worthless if they were unable to sustain their living at home. This is despite studies having found that relocation to a retirement village has many benefits. In an Australian study, Gardner et al. (2005) found QoL was enhanced by relocation to a retirement village through increased activity, social life and health support, and an easier to manage dwelling. However, in the current study, the older persons believed relocation would take away the benefits of independence and autonomy gained from living at home, that were highly valued, had been secured over a lifetime, and critical to retain. In this way, the pull factors relating to a better QoL in other types of accommodation did not have as much precedence as the perceived greater independence and autonomy when living at home.

Another interesting aspect of this study relates to the meaning of the term home as both a positive and negative concept. As indicated, the home had important meaning for the older persons and was viewed positively. In contrast, meaning related to the nursing home was only seen in a negative way. Despite this, some of the older
persons when talking about a nursing home, referred to it as a home. Irene highlights this contradiction in the following quote when she said, “I don’t want to go into a home.” Throughout data collection and analysis, it became clear that many older persons considered there were only two choices, that is, living at home or in a nursing home. This lack of acknowledgement of alternative accommodation may be explained by the fact that they had intended to stay living at home until they required a very high level of care. Quine and Morrell (2007) also found the participants in their study did not refer to any other forms of alternative accommodation.

However, as the older persons are more than likely influenced by the negative stereotypes of ageing relating to loss, decline, frailty and a burden on society, and the negative view of nursing homes in the 20th century, clearly they believed the nursing home did not afford the same characteristics or benefits of their own home. Researchers have found that moving to a nursing home was associated with fear (Nilsson et al., 2000; Quine & Morrell, 2007; Sixsmith & Sixsmith, 2008), negative feelings (Cheek et al., 2005a; Hearle, et al., 2005; Nilsson et al., 2000; Tuckett, 2007) and loss of independence (Quine & Morrell, 2007). It is likely that these findings relate to the influence of Australian government policies throughout the 1960s and 1970s when care was concentrated away from the community, and the nursing home was the only service providing care (Howe, 1997). Consequently, these earlier experiences may have produced fear in relation to relocation to residential care, and the older persons resist any forms of alternate accommodation for as long as they can. These findings also reflect the complexity of the meaning of home and the influence it has on the decision to remain living there.
**Entering the process**

The older persons in this study shared some common experiences and decisions relating to ‘holding momentum.’ The characteristic **realising**, relates to the awareness of a change in health and its effects on everyday living. The findings revealed a problem or event such as a decreasing capacity or sudden inability to perform daily activities was the trigger for the *entry point* into the process. This “moment of reckoning” (Chater, 2002, p. 125) occurs when the person accepts their ageing.

For some, the *entry point* was described as a gradual process, occurring when there was a steady deterioration in health, involving feelings of getting slower or a general feeling of being unwell, when the older persons noticed subtle changes, a slowing down, or simply losing their energy. Chater (2002, p. 128) found ageing was viewed as “wearing out,” an experience that differed from being sick as it did not require treatment, unlike being sick. Similarly, Kendig and Duckett (2001) suggested that, although younger people use physical indicators such as appearance to label a person *old*, older persons use an interior feeling. In the current study, deteriorating health strongly influenced the decision to enter into the process to sustain living at home.

**Realising** then, is when the older person understands that they have to respond to changes in their health and it is emotionally draining for them. Decisions have to be made about what they will and will not accept and do, with the realisation that they have to relinquish control over some responsibilities and renegotiate others, such as the frequency of visits to others. Compromise is involved in giving up things that do not matter as much, in order to keep the things that do, such as giving up long distance travel to prevent a health problem or crisis.
The participants appeared to relate the *entry point* to a specific age. Most of the older persons in the current study described significant changes affecting their everyday living some time between the ages of 75-85. Similarly, Nilsson et al. (2000) found people started to *feel old* when they were aged between 80-90 years. This phenomenon has also been recognised in Australia (Byles et al., 2006) and Korea (Shin et al., 2003), but at an earlier age around 60-70 years. Furthermore, Stimson and McCrea (2004) claim relocation is more likely to occur after the age of 75.

In the current study, decision making was an individual process (except when there was a spouse involved) relating to personal choice and greatly influenced by the older person’s historical and social context. Once the individual engaged in ‘holding momentum,’ the decision to stay at home was continually renewed throughout the characteristic of *knowing and persisting*. A possible reason for the variation amongst the experiences and decisions made by the older persons to stay in the process relates to the distinct expectations that exist amongst the different generations. The ages of the participants in this study spanned four decades and although they had commonly experienced major events such as World Wars and the depression, each decade conveys a different historical context. Therefore, the needs of the older persons in this study may be influenced by the life experiences common to generations and not experienced in the next generation (Donald, 2005). It is thought that the postwar generation, the next generation of older persons who have had better education and better health awareness will have different expectations and therefore different experiences of living at home. The Age Stratification Theory proposed by Riley et al. in 1972 explains that age cohorts share similar experiences, beliefs and expectations and this may account for the variations that existed.
Common variations in this study related to age, with persons over 85 years generally more determined to remain independent and less willing to relocate.

10.2.2 Making the decision to move
Other decisions about residency relate to the decision to move out of the home and cease ‘holding momentum.’ The exit point from the process was embedded in the characteristic of reviewing and making a move. During this study, only three older persons reviewed their situation and perceived that living at home was unsustainable. It was at this time that the push factors of ill health and lack of support, and the pull factors relating to the provision of support and care in alternative accommodation were stronger than the inertial forces keeping them at home. These factors influenced the older persons to move out of their home, relocating to a retirement village or hostel. Tsang et al. (2004) also found the pull factor relating to relocation was based on the need for care, when the older persons considered they would be no longer able to care for themselves.

Push factors
The decision to move was brought about by a significant deterioration in the older person’s health resulting from a fall or feeling a depletion of energy, and an awareness of the consequences this had on their everyday living. When the deterioration was accompanied by a lack of support or a change in the existing level of support, the decision to move became inevitable. The study’s findings are supported by the work of Gattuso (1996) who found the decision to relocate for some was due to frailty or widowhood. Similarly, Stimson and McCrea (2004) found the most common reason for relocation was a health issue and the need for assistance, and the second most common reason was the death of a partner. Schultz, Morton and Weckerle (1998) found the main push factor for the decision to relocate was health
and attitudes to the benefits of living at home. The DOHA (2009) report those with poor health were more likely to think about relocating.

It is not surprising that the push factors were more dominant over the pull factors in this study. With ageing, the push factors are more likely to keep changing, particularly when health issues increase and make it more difficult for the older person to continue to implement new strategies to stay at home.

The decision to relocate occurred when it became clear that home no longer provided benefits. After reviewing their situation, the older persons understood that if they stayed living at home they may risk isolation. Irene stated, “If you stay at home, you do nothing and see nobody.” There was also the threat of a loss of autonomy and independence if they remained at home. In Australia, others have found that those who choose to relocate usually do due to decreased autonomy (Rowland, 1996; Stimson & McCrea, 2004).

It is important to acknowledge that despite similarities, there were variations in the decisions made by the participants. These were mostly related to the differences amongst individuals in their health and resilience. Living at home presented the older persons with everyday challenges, for example, experiencing difficulties with ADLs such as showering and cooking, or IADLs such as shopping and getting to venues. They were generally able to negotiate these activities on a daily basis but when the challenges of deteriorating health accumulated and became excessive, the older persons were prompted to move out of their home.

These findings concur with psychology literature on daily hassles describing how everyday challenges from dealing with one’s surroundings can threaten independence because there can be many events to cope with on a daily basis
(Newall et al., 2006). These hassles become daily reminders of the inability to do things, and create an emotional sense of dependency (Newell et al., 2006). Hockey (1999) describes these hassles as *cumulative trivia* specific to older persons and how seemingly minor incidents wear down resilience, so that the accumulation of these everyday challenges gradually threatens independence (Newall et al., 2006). These threats to independence provide further reasons why the older persons secure and control the boundaries of their home to stay living there.

**Timing of the decision**

The timing of the decision to move out of the home was critical, as appropriate timing had major consequences. In the current study, the decision to move was not a quick or hasty one. It was a gradual process, one that was thought about over a period of three to four years. During this time, the older persons had determined they were not yet ready to move and used the time to plan for their move, accepting that relocation would be inevitable. Having time appeared to assist the older persons to decide what conditions they would or would not accept while living at home and in alternative accommodation, it gave them choices and time to consider their options. Therefore, it seems ‘holding momentum’ long enough to make decisions about relocation was a key element in the process.

Other evidence suggests that older persons generally view independence as having the capacity to undertake ADLs, and as people develop functional limitations, they often lose their independence (Leith, 2006). The older persons in this study appeared to have insight into their own situation and the importance of the timing in making the decision to move before becoming what they saw as a burden on others or before others made the decision for them. This has been identified in other literature.
describing how older persons feared being a burden on their families, as this would indicate they had lost their independence and autonomy (Minichiello, Browne, & Kendig, 2000), and that older persons in their 80s wished to die rather than be a burden on their children (Shin et al., 2003).

Sustaining living at home was hard work and one of the biggest obstacles the older persons faced influencing their decision to stay or move was interference from significant others. Family or health professionals such as the GP, although appearing to have good intentions usually based on the best interests of the older person’s safety, often tried to influence the older persons to move earlier than they were prepared. Similarly, in other studies Cheek et al. (2005a) and Gattuso (1996) found that often pressure is applied from family or professionals to relocate. Other researchers have found older persons do not usually participate much in the decision (Cheek & Ballantyne, 2001; Johnson, Popejoy, & Radina, 2010). The timing therefore relates to the influence of push factors with the need to prevent interference from others, reduce the risk of isolation and maintain autonomy. The implementation of the ACAP has assisted in preventing early relocation and supported older persons to stay at home (AIHW, 2007; Stein & Morse, 1994).

The extent of the influence of the push factor relating to changes in health status, coupled with the attractors or pull factors of the new residence, appeared to affect the choice of the place of relocation. The decision for the new type of accommodation was based on the level of support or care required. In the current study, the two participants experiencing only minor health changes moved into a retirement village and the participant requiring more support and care relocated to hostel living.
Pull factors

Other decisions made by the older persons in the current study relate to the influence of the pull factors of alternative accommodation. Current main alternatives to living at home include moving in with family, retirement village living, and residential care accommodation including hostel and nursing home.

Although living with other members of their families was an option for some, it was not an attractive option or pull factor. Other than the few who already lived with a family member, no older person in this study wanted to relocate to live with their family because interference from family undermined autonomy and threatened independence. Alternatively, living at home was associated with freedom, independence and the ability to control interference from others. Adding validity to these claims, other research has found the home to be a barrier against others interfering and making decisions that affect the older person’s freedom (Gattuso, 1996). Marjorie’s situation is a good example, as when she stays at her daughter’s home during the night, her independence and autonomy are restricted. She said, “She [daughter] cooks. I’d love to but they won’t let me there.” This finding concurs with other research which reported that older persons do not want to live with their family or others as it placed them under their influence (Gattuso, 1996).

In comparison to living with family, retirement village living is another option. In Australia in recent times, retirement village living has increased in popularity (Byles et al., 2006) and it is expected that this trend will continue. In this study, the decision to move into retirement village living was made in response to push factors relating to declining health and the inability to renew and sustain energy levels to get things done. This finding is consistent with the literature that describes moving into a retirement village as a means to manage functional limitations and non-acceptance of
ageing (Heywood et al., 2002; Tulle-Winton, 1999). Other researchers describe the dominance of pull factors relating to the retirement village, and claim retirement village living offers greater overall satisfaction (Gardner et al., 2005; Stimson & McCrea, 2004) and an environment that supports the changing needs of older persons through access to leisure activities with others, better social life, more secure manageable housing, less housework and gardening (Gardner et al., 2005). However, there needs to be caution, as such living situations further segregate older persons from their wider community and they may become more invisible behind the walls of the complex. The DOHA (2009) found some older persons did not want to move to a retirement village because the residents were all similar in age. Furthermore, Stein and Morse (1994, p. 42) likened retirement villages to institutions because those living there must conform to “social and behavioural norms.”

In contrast, the consequences of moving into residential care, in particular into a nursing home are vastly different when compared to a retirement village. All the older persons in the current study had traded-off things to prevent losing complete independence and autonomy by being placed in a nursing home. The nursing home was feared by all and assumed to be the last option when there were no other choices available. Consequently, there were no attractors or pull factors relating to nursing homes or living with family. It is not surprising residential care was viewed in this way, as the participants in the current study have lived through many decades of segregation of older persons in residential care influenced by Disengagement Theory (1961) where the older person withdrew from society. Furthermore, the current average length of stay in a nursing home before death is 3.5 years for women and 2.3 years for men (Cullen, 2007). These findings are supported by others who found older persons were afraid of moving to nursing homes because they perceived
relocation would be irreversible (Quine & Morrell, 2007) and the nursing home was “a ‘waiting house’ for the dying” (Tuckett, 2007, p. 125). Other research shows that moving into a nursing home is generally not a positive experience as there is increasing dependence (Hearle et al., 2005; Kendig & Duckett, 2001) and loss of autonomy (Tuckett, 2007). Thomas (1996) suggested that “loneliness, helplessness and boredom” are three problems of residential care (Shotton, 2003, p. 12).

10.2.3 Renegotiating the environment

The consequences for the older persons who made the decision to relocate were that they were able to renegotiate their environment to an extent to undertake ADLs and maintain some aspects of their environment, such as comfort, while making concessions, particularly relating to freedom. In this way, they could recreate the valuable aspects of their home and the new residence then became a new home. These findings are supported by the work of Leith (2006) who found those who moved from their home into congregate housing renegotiated a new environment.

The acceptance of a new residence as a new home enabled the older persons to feel comfortable, as it provided the same benefits of comfort as home. However, despite retaining comfort, they experienced a loss of freedom and the ability to stay in touch with the wider community. This was mostly due to the constraining systems in place, such as those relating to set meal times and the availability of assistance to go out into the community. Therefore, the ability to renegotiate a new environment may depend on the flexibility of the facility and its systems, and not just the older person’s ability to adjust. Furthermore, it is argued that sustaining living in a new residence of choice may again require a similar process of ‘holding momentum.’ This is because renegotiating the new environment requires a sustained effort of physical, social and emotional work.
However, the older persons in this study who made the decision to remain living at home renegotiated their environment by implementing strategies to enable them to persist against intervening conditions, rather than move. Living at home afforded them more benefits accompanying their renegotiated level of independence in comparison to residential care. These findings are supported by other research that has demonstrated that those older persons living independently at home were confident and self-sufficient compared to those living in residential care (Hearle et al., 2005). Therefore staying at home is more than a passive decision of allowing the present to continue, it is an active decision.

The active decision to hold momentum means that the older person is entering a continuous, cyclical process with limited forward progression other than sustaining living at home, they are treading water, actively stagnating. Persistence is necessary but it can be draining, particularly physically. The continual renegotiation of change in everyday living is ameliorated by the familiarity of staying at home enabling them to implement familiar routines and maintain a level of competency. A benefit is that this capacity requires less energy to sustain the effort physically, socially and emotionally. ‘Holding momentum’ gives the older persons time to review and renew; to make decisions about their self-management, what they will and will not accept.

To understand how the older persons remained living at home, it is necessary to understand their motivation for doing so. In the following section, insights into the meaning of home described by the participants are examined in the context of the literature.
10.3 The meaning of one’s own home

Living at home was critical for all older persons in this study, as home was the centre of their everyday living and existence. For all 21 participants, living at home was vital to positive ageing. The extent of the meaning is summed up by one participant, Irene, who when asked to describe what home meant to her, she said, “Everything.”

Ginsberg (1999) suggests that residence is where people live but home is how they live as they make their homes and organise their living space in their own way. In their study of the very old living in Sweden, Dahlin-Ivanoff, Haak, Fänge, and Iwarsson (2007, p. 27) found home had a “central place” in the older person’s lives, as home is where people live and spend their time every day. Similarly, Roush and Cox (2000, p. 392) exploring the relationship between home and hospice care described home as “the center of everyday experience” because home “centres the person in time” and social life. They suggest this involves allowing time in the past through memories, as well as time in the present through social relationships within their neighbourhood. Home is a place to depart from and return to.

In the current study, living at home provides purpose and enables the older person to assert control to sustain their identity, freedom, comfort and contact with others. Additional benefits include feeling great pride and personal satisfaction from living at home, having readily available support, and preventing loneliness. Consequently, home symbolises autonomy and independence (Swenson, 1998). When combined, these benefits motivate the older persons to seek and implement strategies enabling them to remain living in their own homes. It is these benefits of living at home which anchor the older persons to their homes; they are what keeps them living there.
The phrase *Home as Centre* has been used by a number of authors to capture the meaning of home. The following discussion suggests that home as centre has four interrelated components: (1) Home as centre of identity, (2) Home as sanctuary: familiar and secure; (3) Home means freedom and autonomy, and (4) Home as the base for social interaction.

Imrie (2004), and Saunders and Williams (1988) provide suggestions for these multiple meanings of home, as they argue the meaning of home is temporary, and changes with time and experiences that impact on the lives of those living there. They suggest there are different meanings and experiences according to a person’s age, their gender and the geographical context within which the home is situated.

10.3.1  *Home as centre of identity*

The older persons in this study described their home as *everything*. Home was central to personal or self-identity. Their home shaped and reflected their identity and their experience of everyday life. It appeared to facilitate a sense of personal comfort with themselves and their life. This concept of home has been the focus of other research (Heidegger, 1971; Heywood et al., 2002; Mallett, 2004; Shenk, Kuwahara, & Zablotsky, 2004). In a study of older Swedish women, Swenson (1998, p. 384) used the phrase “home is the center of self” to describe the connection of home with self-identity. Home facilitates the older person’s link with the past (Annison, 2000; Després, 1991; Heywood et al., 2002; Leith, 2006; Mallett, 2004). While living at home, the older person is able to reflect on people and events that have been important in shaping their identities as partners, parents and families. Home holds fond memories of life, memories of significant others who had died or of children who had grown and moved out. For many, it was easier to recall memories when they had lived in the same place for many years. Swenson (1998) identified that
home facilitates a connection with older women’s past and present through story-telling and keeping possessions close to them. Shenk et al. (2004) found there was a connection with the older women and good memories at home.

Swenson (1998) reported that this connection between home and self was situated in the everyday and the familiar, as the older women organised their everyday living by anchoring their everyday life to familiar things, places and routines. Dovey (1985) also found the home to be a place where identity can be preserved and adds that the way people use the areas in their home is an expression of their identity.

In research on the impact of home modifications, Tanner et al. (2008, p. 195) suggest home becomes a place of meaning created through the “dynamic, reciprocal relationship” people have with their home. They used the term “the personal home” to capture the importance of home for identity and self-expression (Tanner et al., 2008, p. 199).

Similarly, other authors describe home as an expression or symbol of the self (Imrie, 2004; Leith, 2006; Sixsmith & Sixsmith, 1991; Swenson, 1998). The home conveys a message about them as people to others in their community. Older persons in this study had made an investment of themself in their home and similarly their home had become a part of themselves, as Tanner et al. (2008, p. 199) describes “the personal home” where the older persons made a house a home. Over the years, they had built or created a home that held a part of themselves. Dahlin-Ivanoff et al. (2007, p. 29) describe individuals and families “leave one’s own mark,” as home is a place where they have private possessions showing what they like. For some authors such as Imrie, home is a part of the older person themselves. Imrie (2004, p. 745) states that people’s perceptions and emotions about home cannot be “dissociated from their
corporeality,” that is, home cannot be separated from their known embodied self. Imrie’s work helps explain how a developing physical impairment challenges the positive aspects of home. He claims that the design of the home is not always suited to a person’s needs and can prevent self-care and worsen a person’s condition.

The meaning home holds may also be influenced by gender and thus different for women and men. Many of the older women in this study related their personal identity to their role in maintaining their home and their roles in the family as a mother, and in the community helping neighbours. In contrast, the older men in this study defined home differently. Home was a base from which they could access support from their partners or children as well as offering the freedom to go out into the community, and to return.

Contemporary authors claim that some older persons held traditional gender roles when they were younger, and the role of the woman was to maintain the home and family (Leith, 2006; Shenk et al., 2004). Home has been described as an anchor that maintains women’s past roles and their identity as mothers, wives and members of the community (Shenk et al., 2004; Swenson, 1998) and their main focus was on domestic duties (Leith, 2006). This attitude may be explained by Riley et al.’s Age Stratification Theory (1972) which places ageing in a historical context and suggests that generations experience significant events that have shaped their lives, and that it is these experiences that influence the roles and expectations of older persons in society (Grossman & Lange, 2006).

For participants in this study, living at home meant that the older person maintains this personal connection with their home and in doing so maintained their identity or sense of self. With self-identity so connected to home, it is likely then that moving
out of their home and living in alternative accommodation may result in a loss of identity. Moving to a new residence may require the older persons to share their living space and have little opportunity to create an environment that expresses their identity to others. This is largely because unlike home, most other living environments are defined by others.

10.3.2 Home as a sanctuary: familiar and secure

Participants spoke of their own homes as quiet, free from disturbances and away from the busy outside world. Home was a sanctuary. Dahlin-Ivanoff et al. (2007) reported that home offers the opportunity for reflection, where it is peaceful and quiet, and as a place to meet socially.

Home as sanctuary also reflects the personal comfort derived from living at home in a familiar place, where living was straightforward and the older persons knew where everything was. Having this knowledge gave the participants peace of mind, stability and a feeling of competence. This feeling of competence through familiarity contributes to the older person’s decision to stay living there. Relocating to other accommodation means living in unfamiliar territory. A fear of the unknown and loss of security and competence are therefore major reasons why the older persons do not want to move out of their home. Lawton’s theory relating to the fit between the person and their environment supports these findings, as the longer a person lives in their home, the more predictable it and its community becomes (Lawton, 1985).

Roush and Cox (2000) described home as familiar and comfortable because living at home is predictable and requires less effort as people have routines. Although ADLs generally become more difficult to undertake with age, Shenk et al. (2004) explained stability at home assists the older persons to create a sense of order to complete tasks
with little effort. Others such as Dahlin-Ivanoff et al. (2007) and Green et al. (2005) described familiarity as leading to a feeling of security. They discuss how comfort is derived through living in a familiar neighbourhood where people know what is available, and there is someone familiar around to help when needed. Furthermore, it is functional as people can be independent as home can be adapted to the needs of the person.

Swenson (1998) found the older women in her study created a sense of order and stability in their home as they ordered their living space by implementing familiar routines and places in their daily living. Dovey (1985, p. 42) termed these ordered living spaces “mnemonic anchors.” Maintaining control through order and routines anchors people in their environments (Swenson, 1998). This explains why restrictions on living space and control over space are problems often associated with living in other types of support or care accommodation, such as nursing homes. Furthermore, rules and regulations imposed when living with family or in care accommodation often place restrictions on freedom. These constraints obstruct the older person’s autonomy (Tuckett, 2007) and capacity to shape their own approach and determine what compromises are to be made.

However, Jackson (1995) asserts that while home provides security, it can also be a confining experience. Mallett (2004, p. 70) states this is because home is lived as a tension between the concepts of what is real and what is ideal and that both concepts are “mutually defining.” In this study, the older persons described they risked isolation when living at home if they were unable to get out of the home. However, for most participants the comfort and familiarity afforded from living at home outweighs the risk of isolation.
10.3.3 Home means freedom and autonomy

Despite Jackson’s claims above, many authors report the importance of home as facilitating freedom and control (Annison, 2000; Després, 1991; Mallett, 2004; Means, 1997). When living at home, people have the freedom to choose what to do (Leith, 2006; Mallet, 2004; Means, 1997) when they want to do it. In this way, the older persons have control over their daily lives (Dunér & Nordström, 2010; Leith, 2006; Means, 1997), where they can control the demands or outside interference of others. It is a hub of existence where things are managed according to ones conditions (Dahlin-Ivanoff et al., 2007) as they control personal boundaries (Somerville, 1992). As a consequence, older persons are able to maintain their independence (Annison, 2000; Després, 1991; Dunér & Nordström, 2010). Thus, at home people have the freedom to be themselves, to do things, rest and make decisions without interference from others.

The study participants in general demonstrated a strong focus on maintaining their personal privacy, their sense of autonomy and control. As supported by other research (Annison, 2000; Després, 1991; Green et al., 2005; Means, 1997), participants worked hard to maintain their home as a private space, free from public scrutiny or examination. To ensure their privacy, the boundaries of home were secured and controlled by the older persons, as they determined who entered their home and for what purpose they did so. Roush and Cox (2000, p. 393) also suggest that the home is a “protector” where spaces such as windows function as barriers from the outside world, “between public and private, allowing regulation of social interaction within the neighbourhood.”

It seemed that a more liberal or relaxed approach to this private space may have risked someone or something else defining the meaning of home. This may help
explain why most of the older persons in this study often negotiated support and services commercially rather than relying on informal assistance from their family. A study in Sweden found many older persons want more formal help and less informal help, and there were differences in what the older persons and others expected (Dunér & Nordström, 2010). Others found older people found it difficult to ask their family members for help as they did not want to be a burden (Cheek et al., 2005a; Nilsson et al., 2000).

In this way, home differs from some other types of accommodation providing support or care, as when living at home the older persons have privacy and space away from others, and they are not confined to an area or a room, as in care accommodation. Although some alternate accommodation such as retirement villages may offer privacy similar to home, the older persons in this study remained at home because they knew they could control the boundaries and were unsure of exactly how much control they would have in a new residence.

It appears once the interference or intrusion from family or health professionals into their home becomes too much and outweighs the benefits of living there, the older persons make the decision to move out. Too much intrusion reflects diminishing health and has important implications for the significance of home and the ability of the older persons to age successfully. This highlights the need to determine whether home facilitates or constrains the negotiation of services.

The older persons in this study balance two conflicting interests, privacy in their home and social connection with others outside the home. They are willing to give up some privacy and allow others to intrude into their private lives because they can still control the amount of interference, and they are aware that they could not remain
at home without this support or assistance. Cheek et al. (2005a) found some older persons described reduced privacy due to the intrusion of others providing services in their home. This illustrates the tension between home as a private place facilitating independence and home as facilitating social support. By getting out of the home, it appears they are successfully able to avoid isolation and loneliness, and limit the amount of interference by family, neighbours and health professionals into their privacy at home.

10.3.4 Home as the base for social interaction

Home is also the point of entry into the public world, the base from which the older person engages in social interaction, a centre for establishing and maintaining relationships with family and friends (Heywood et al., 2002; Leith, 2006). Some authors have described home as “the center of reach” (Swenson, 1998, p. 389), providing a base that facilitated movement away from and back to the home, maintaining relationships and activities (Després, 1991; Gattuso, 1996; Leith, 2006; Swenson, 1998). While the older persons work hard to maintain the boundary of their own home (figuratively), they also recognise the importance of social interaction and the risk of isolation when living independently at home. This is the point where the public and private worlds of the older person meet, and accounts for some of the complexity, diversity and at times contradictions emerging from the data. Participants in this study were comfortable at home but they knew they needed to move beyond the boundaries of their home and locate themselves within their community of neighbours, friends and others.

In the current study, living in one’s own home enabled existing local friendships to continue and people to contact each other easily. Living at home made it possible for the older persons to have someone familiar to talk to, and to spend time with others.
In particular, home facilitated informal family and neighbour support, and remaining socially connected helped prevent loneliness and isolation. Similarly, Dahlin-Ivanoff et al. (2007) and Means (1997) found that older people wanted to stay living at home to remain close to their neighbours and friends. This appears to be particularly important for those living alone, as in her study Gattuso (1996) found single women aged between 60 and 97 years worked hard to maintain closeness with family and neighbours.

When changes occurred in the local neighbourhood, and family, neighbours or friends moved away, the older persons in this study had to venture out to less familiar venues in the local community to maintain social connections and prevent isolation. Living at home enabled the participants to use home as a base, from which to have transport and have somewhere to go every day, engage in activities and time to spend in the company of others. If older people have access to public or community transport, using home as a base enables independence and autonomy (Mallett, 2004), and prevents isolation. The participants attended the centre to engage in activities because they knew the people there, particularly because those familiar to them would be there on a regular basis. Similarly, Swenson (1998, p. 389) claims that through going out of the home to attend social activities, the older persons in her study experienced “reach” beyond the boundaries of their homes as they used home as a point from which to go and participate in activities outside the home.

Some explanation for the importance of social interaction is provided by Havighurst and Albrecht’s Activity Theory (1953) as it proposes that life satisfaction is gained through being active and involved in society, and that keeping active enhances successful ageing (Evans Madison, 2000; Grossman & Lange, 2006).
Through using home as a base for social connection to get out and be with others, the older persons are able to avoid dependence on others, maintain self-esteem and endure some challenges. This is supported by the concept of successful ageing where the older persons maximise their wellbeing through activity and participation in society (Wells et al., 2009). However, when managing significant health changes becomes too challenging, reviewing and making a move becomes a necessary option. As home involves many meanings, moving out of home into other accommodation may be influenced by how the older person saw home, that is, what meaning home had for them. These different meanings therefore, may explain why the majority of the older persons in this study worked so hard at implementing strategies to remain living in their homes and why a few accepted they needed to move out and relocate into other accommodation.

The findings of the current study concur with the literature that describes older persons experience many changes associated with ageing and chronic illness, and that remaining at home assists in maintaining a feeling of normalcy (Gitlin, 2003; Rubinstein, 1989). Other research has identified that living at home promotes the older person’s wellbeing (Gitlin, 2003) as it assists functional ability and prevents loss of autonomy and independence (Gitlin, 2003; Langan, Means, & Rolfe, 1996; Tanner & Harris, 2008). In the current study, living at home promotes QoL as the participants were able to maintain their wellbeing by keeping active and healthy, remain independent and autonomous, and sustain relationships with others.

Thus, the meaning of one’s own home was central to the lives of the older persons. Home had many meanings and through living at home the older persons had developed an embodied connection. Home was their self-identity and identity to the community. Home gave comfort and familiarity which assisted with competence.
Home provided a private space where people could be themselves, rest, relax and retreat from the outside world. Home was also a base for social connection to others and activities outside the home.

As home means so much to the older person, they implement various actions and strategies to stay living there. The following section examines the main strategies commonly used by the participants in relation to the literature.

10.4 Developing strategies

A major focus of this study was to obtain a holistic view of the strategies used by older persons in their everyday living to stay at home. The older persons in the current study had unique experiences based on their previous life circumstances, personal knowledge and practices. They had developed a sense of survival and worked hard to negotiate the process, and this was demonstrated in the way they had put many different strategies into place. Despite these variations, they also had things in common and they shared many strategies. These strategies were depending on inner resources, maintaining wellbeing, and negotiating relationships and services. They were combined under three major actions and interactions, namely ‘maintaining autonomy,’ ‘protecting self’ and ‘connecting with others.’ The strategies were not used in any particular order or amount and were largely individual, as the older persons individually made decisions to implement the necessary strategies in response to the changes they experienced and hold momentum.

10.4.1 Depending on inner resources

In the current study, the older persons depended on their inner strengths to endure pending and unforeseen challenges or circumstances and remain living autonomously
at home. They wanted to continue to make their own decisions and stay in control of their daily living and did not want others making decisions for them. This is because they had endeavoured to remain self-reliant and avoid being dependent or a burden on others. In their study, Dunér and Nordström (2005) also found the need for independence focused the older persons’ actions. This desire for independence and self-reliance can be explained in part by the high value placed on independence found in government policies (Newall et al., 2006). At the turn of the 21st century, the Australian Government’s National Strategy for an Ageing Australia, identified Independence and self-provision as one of the four themes to support the participation of older persons in society (DOHA, 2002b). Subsequently, independence is a concept that is still highly valued by older persons today (Sixsmith & Sixsmith, 2008).

Some participants appeared to have greater inner resources than others. This determination and motivation can be equated with the concept of resilience, which is according to Wagnild (2003) one of the concepts of successful ageing. Throughout the literature, a resilient person is generally considered to be someone who can rise above adversity (Hardy, Concato, & Gill, 2004; Hildon, Smith, Netuveli, & Blane, 2008; Richardson, 2002; Wagnild, 2003). Resilience incorporates hardiness, self-efficacy and stability through social support (Hardy et al., 2004). Hence, harnessing resilience can provide individual and social resources to draw on (Gilgun, 1999; Hildon et al., 2008), making it important for maintaining wellbeing (Hardy et al., 2004). These findings are further supported by psychological perspectives on ageing acknowledging the influence of a person’s attitudes, behaviour and personality including learning, feelings, motivation, adaptation and adjustment in order to age successfully. They may account for individual differences and explain why some
older persons can hold momentum and live at home successfully and others have great difficulty.

It is generally viewed that health, QoL and wellbeing are affected by a person’s life experiences (AIHW, 2007). In the current study, the older persons depended on their learning from their past experiences as a child, adult and older person. They used this learning to build their inner psychological resources and sustain the effort to hold momentum and stay living at home. The literature on successful ageing supports the use of this strategy, describing the learning from past experiences as useful for present experiences of ageing (Bowling & Dieppe, 2005). This research supports the argument that experiences become more valuable as people age and it is therefore important that health professionals understand how the past has created the present so that older persons can have choices (Shotton, 2003). According to life course theories, the past assists in understanding present needs for services.

The Continuity Theory developed by Neugarten et al. in 1968 proposed that personality is consistent throughout life and people adjust when they become older (Miller, 2009). Individual coping is developed before ageing and older persons use past coping strategies. This theory together with Jung’s theory of individualism (1960) explaining the individual’s ability to accept the past, current reduced capacity and adjust to functional decline (Grossman & Lange, 2006; Miller, 2009), support the suggestion that the older persons in this study are ageing successfully.

To maintain autonomy, it was essential to secure control and freedom by developing a desired lifestyle and preventing others from determining everyday activities. Strategies used by the participants included setting the pace to manage their own time and determine the timeframe to undertake daily activities. This included doing
things more slowly, taking short rests in between tasks and adjusting existing routines, such as those relating to domestic duties. Whilst it is acknowledged that routines are highly valued and essential to maintain (Tanner & Harris, 2008), the findings of the current study argue that it is more important to have insight into how and when to adjust or abandon routines to hold momentum and stay living at home.

In this study, sometimes maintaining existing routines required a lot of effort. As the older persons were in control of the space in their home, they could set limits on the amount of time and energy for each task. When routines became too demanding they would make adjustments. This strategy can be explained by other literature describing self-care practices. Similarly, the literature states that the ability to undertake self-care relies on individual resources such as individual style and the ability to adjust to circumstances (Backman & Hentinen, 1999). These findings are supported by Dunér and Nordström (2005) who found older persons adapted to their impaired function. Perhaps requirements of adhering to rigid routines determined by others in alternative accommodation becomes too energy depleting for older persons and they are unable to sustain the effort required to remain independent and autonomous.

10.4.2 Maintaining wellbeing

A major priority for the participants was to protect themselves by minimising problems relating to their general wellbeing. The two ways the older persons did this were by *keeping well* and *staying safe*. Government policies on healthy ageing, such as the National Strategy for an Ageing Australia (2002), support the use of these strategies, recognising that good health maximises independence and functional capacity, attributes to a positive QoL, and results in less demand for services (AIHW, 2007).
In the current study, health was a personal resource considered essential to stay living at home. Despite its importance, it was interesting that health was not discussed at any length during data collection. This avoidance may be related to a generational belief or expectation that health is something that was taken as a given and is a personal aspect that was usually not discussed in front of others. Cheek, Ballantyne, and Roder-Allen (2005b) found some older persons hide their health issues from their families as they believe disclosure may put their independence at risk.

Despite the presence of illness or co-morbidities, almost all older persons in the current study rated their health optimistically and confirmed this by comparing themselves to others their age. These observations are supported by the work of Chater (2002) who found ageing was often measured in reference to others. This is an interesting finding considering that the older persons acknowledged their own ageing by relating it to a personal feeling or physical event yet based their health status on comparisons made on chronological age and the appearance of other older persons.

Strategies used by most participants to keep healthy included maintaining good nutrition, keeping busy and occupied in the home, and remaining active by engaging in activities in the community. In particular, keeping mentally active by doing activities which stimulate thinking, and walking to keep physically strong were main concerns. This finding corresponds to other studies which identified healthy eating and keeping active as major behaviours for ageing well (Byles et al., 2007), as keeping physically and mentally well was essential to stay at home (DOHA, 2009). Similarly, other research has found attending clubs or aged centres to prevent deterioration in cognitive function (Shin et al., 2003) and taking regular walks,
gardening and participating in other challenging pastimes, enhanced wellbeing and were highly valued (Green et al., 2005). Furthermore, research has found that keeping physically active enhances psychological health (Buys & Miller, 2007; Mummery, Schofield, & Caperchione, 2004), and engagement in physical, mental, social and leisure activities could be linked to a decreased risk of dementia (Buys & Miller, 2007; Wang, Karp, Winblad, & Fratiglioni, 2002).

It seems that keeping healthy promoted the ability to age successfully. These findings support the argument by Rowe and Kahn (1998) that those with good lifestyle habits including a healthy diet, physical activity and mental activity, age successfully. Knight and Ricciardelli (2003) further claim that most Australians believe successful ageing is about having good health and keeping active, and is more valuable than longevity. The older persons in this study appear to be ageing successfully as they continue to maximise their wellbeing by having control over their environment. Consequently, due to a lack of perceived control in other living environments, wellbeing may be achievable in the home environment but may be more difficult to achieve when living in other types of accommodation.

However, research in Australia shows that engagement in leisure activities by older persons is made difficult by problems with health, transport and safety (Buys & Miller, 2007; Howat, Iredell, Grenade, Nedwetzky, & Collins, 2004). As previously identified, for those attending the centre, poor health was currently not a barrier to keeping active. To overcome any transport problems, a strategy used by the older persons was to undertake activities within a familiar local community. They did this by using public transport or locally provided community transport services to get to venues and facilities. In this way, the older persons have somewhere to go everyday and can get out of the home and engage in activities with others. Similarly, COTA
(2001) has identified that as people become older their immediate neighbourhood and facilities within walking distance become much more important to them. In support, other research has shown that available transport is essential to access services and facilities (AIHW, 2007; Cheek et al., 2005a).

To overcome safety fears and attend to risk when out in the community, the participants engaged the assistance of others. Older person’s perceptions of personal safety are that generally they feel more vulnerable due to their decrease in physical function (Sixsmith & Sixsmith, 2008; Weaver, Martin, & Petee, 2004). Despite being a low risk for victims of crime, generally older persons change their behaviour and avoid risk by not going out into the community at night (Sixsmith & Sixsmith, 2008).

In the current study, the older persons avoided going out into the community alone at night, and organised community transport and family assistance to get to venues safely. Engaging in activities situated at familiar local places, such as the centre, made it safer and easier for the older persons to get to the venues.

Other strategies relating to personal safety and attending to risk were to prevent falls by using physical aids, such as a walking stick or frame. This finding has been identified in other research where persons who were less mobile valued the use of mobility aids (Green et al., 2005). Although the literature describes new technology may provide support to live at home (AIHW, 2007; Horner, Soar, & Koch, 2009), a finding of this study was that technology was only minimally utilised to enhance personal safety. De San Miguel and Lewin (2008) and Fisk (2003) found personal alarms provided emergency assistance and a sense of security which increased confidence to engage in activities, contributed to increasing independence and facilitated living at home. In this study, only one person used a personal alarm, perhaps because many others did not perceive themselves to be at risk. Another
factor could be the cost associated with such technology. Interestingly, one person used speed dial on her phone in case of an emergency. This simple technology may be a very useful strategy for others to consider. In their study, Cheek et al. (2005b) found personal alarms gave a feeling of security for some but others thought the use of alarms were an indication of dependency. Horner et al. (2009) state simple assistive technology will be important in the future for self-care, QoL and to keep older persons out of residential care for as long as possible. Other research has found older persons may not use assistive technology due to cost, health issues (AIHW, 2007; Horner et al., 2009), complexity, or privacy concerns (Horner et al., 2009).

10.4.3 Negotiating relationships and services
Negotiating and maintaining relationships with others in the community was a strategy commonly used by the older persons. This included relationships with health professionals, family, friends, neighbours and others at the centre. The study found it was essential to secure relationships with others to have support and assistance when needed for immediate and future security, self-esteem, to avoid isolation, loneliness and relocation to other accommodation. However, it is important to note that these were negotiated relationships. This finding relates to the theory of Gerotranscendence developed by Tornstram in 1994, describing a desire for a connection to others and selective, meaningful relationships (Eliopoulos, 2001). It also supports the 2002 WHO active ageing policy recognising the importance of older persons participating in society. Furthermore, it is argued by Peck in 1968 when he further developed the Eighth stage of Erikson’s theory ego integrity versus despair that older persons develop satisfaction with their social interactions and in contributing to others. In support of these findings, it has been suggested that living
at home and engaging assistance helps maintain a capacity for health and wellbeing (AIHW, 2007).

Negotiating relationships with health professionals such as the GP and OT was a strategy designed to facilitate wellbeing. This included having a GP that the study participants had faith in, to monitor their health closely, preferably the same one for a long time, and one that makes home visits when required. Goh (1997) suggests that GPs need to be aware of the effects of ageing so they can assist in improving QoL. Other research has found that access to a GP can assist older persons to stay out of the hospital system (Cheek et al., 2005b).

Drawing on the services of an OT was essential for some older persons to ensure safety. Making changes and modifying the home to maintain a safe environment by removing existing structures which were considered unsafe, and adding new structures to promote a safer environment and prevent injury such as ramps, railings or improved lighting were strategies used by participants in this study. This finding supports the importance of the UN Principles for Older Persons in 1999 that older persons have the right to live in an environment adaptable to their changing capacities and preferences. Similarly, Green et al. (2005) noted housing adaptations were essential in promoting activity and independence as they enabled people to remain in control through living in a safe and secure home. They found participants appreciated the contribution from the OT who maintained the person’s wishes to stay in control of their everyday living. Furthermore, design professionals, architects and interior designers have the responsibility to ensure the home supports disabilities and independence, and prevents institutionalisation, as an inappropriate design may cause accidents and lead to older persons moving out of their home (Spanbroek, 2005).
Understanding the necessity to maintain relationships with family, neighbours or others at the centre was an important strategy used by the older persons. Through securing these relationships, the older persons had ensured support they could depend on and they had others available to call on when needed. In this way, the older persons had secured relationships with others they could trust. This included allowing observant and caring neighbours to keep watch over them. In support of these findings, the AIHW (2007) and Gallagher and Truglio-Londrigan (2004) found major informal support was through family and friends.

In this study, both the length of time the support had been established and the type of support were important features as they influenced a sense of trust or goodwill, and at times camaraderie. Subsequently, support was easily available and there were others that shared a concern for the older person’s wellbeing. However, it seems that participants were generally not so trusting of formal support or anything that was unfamiliar. A lack of trust toward unfamiliar people was also found by Sixsmith and Sixsmith (2008) in their research based on qualitative data collected as part of the ENABLE-AGE Project 2002-2004 on older people in the UK. Ward (2000, p. 562) claims “the informal care sector is absolutely vital in maintaining older people in the community.” However, current changes in family structure and community showing high rates of divorce and more people living alone have implications for support and community care in the future.

Relationships with neighbours were in place for some participants to ensure reciprocal support, where they helped each other out. This finding is supported by other research that found older persons received and gave support to family and neighbours (Dunér & Nordström, 2005) and that single women work hard to maintain close relationships with family and neighbours as the only way for some
women to stay living at home was to assist each other (Gattuso, 1996). Most interestingly, in the current study, conditions were imposed on neighbour support and these included respecting and observing the unspoken rules of neighbours by supporting each other but not encroaching on too much time or the privacy of the neighbour. In this way, support was conditional and perhaps helped to prevent the older person from becoming a burden on their neighbour. Furthermore, having ever present neighbours to provide support when required, and access to support from each others’ resources, was like an insurance policy for support for the future. Similarly, other research found older persons put informal arrangements in place so that they will have help when needed (Clark & McCann, 2003).

Getting replacements for support provided by neighbours or friends that had moved away or died was found to be an important strategy, particularly if living alone. This importance was highlighted by Gilleard and Higgs (2005) who suggest that changes in community or local networks can lead to reduced participation and isolation. Additionally, the AIHW (2007) suggests that older persons living alone are at a higher risk of loneliness and social isolation. It is therefore essential that older persons have the opportunity to attend community venues as they provide a support network.

Very importantly, not moving away from existing support was another strategy that was identified. The National Strategy for an Ageing Australia (2002) confirms this suggestion and recognises the positive outcomes from engaging with others through social networks and activities which may be lost through housing relocation (Andrews, 2002). In support, other research has found that some participants wanted to stay living at home to remain near friends and neighbours (Means, 1997). An Australian study found women who had relocated from rural to more urban areas for
health reasons or access to services, experience less social support than those who had remained in their rural home (Byles et al., 2006).

Maintaining relationships to have friendships and companionship with others in the community was essential. Common strategies included communicating and socially engaging with others, in particular through attending the centre. These findings have also been reported by researchers who found socialising was highly valued by older persons (Green et al., 2005). They support the suggestion by Rowe and Khan (1997) and Shotton (2003) that it is vital that older persons can engage with society and that society engages with them. Other literature describes social interaction and social network have many benefits including preventing decline in functional ability (Avlund et al., 2004; Buys & Miller, 2007), enhancing health (Clark & McCann, 2003) improving QoL (Hearle et al., 2005) and sustaining wellbeing (Kendig et al., 2000). Furthermore, it is suggested that those who engage socially, age successfully (Miller, 2009; Rowe & Kahn, 1998). It was also interesting to note, that some talked about the necessity to be around movement, that is, to seek out places where others were actively engaging. Although engagement was passive for these people, it appeared to be important to be in close physical contact to others in society.

The older persons in this study recognised the importance of having friendships with others, both new and old, and generally of a similar life stage. Gattuso (1996, p. 174) states having long term friendships help the older persons “stick it out.” Membership at the centre for many participants ensured friendship. However, a recent study found a decrease in participation in groups such as attending Senior Citizens as the people aged (Byles et al., 2006). This may be due to the changing demographics of ageing people. In contrast to these findings, in the current study the older persons described an increase in their participation in social groups as they aged. However, this finding
may be related to the fact that all participants were members of a seniors’ centre and lived at home.

The older persons maintained relationships with others in the community so that they had friendships or companionship and they did not become isolated at home. This finding is in contrast to the Disengagement Theory (Cumming & Henry, 1961) where the individual and society withdraw from each other to the benefit of both. Alternatively, it does support the Activity Theory originally proposed by Havighurst and Albrecht in 1953, describing older persons are active and involved in society and experience successful ageing. However, in contrast to the Activity Theory, the older persons in this study did not maintain their own middle-aged attitudes and lifestyles and generally did not have the resources to continue to do so. The older persons in the current study took on new activities to accommodate their changing capacities as they aged and made new friendships at the centre. These new networks assisted in ‘holding momentum’ as they created a commitment from the older person to sustain effort for social interaction.

_Getting help_

It is sometimes argued that accepting services can undermine the older person’s “sense of self” (Chater, 2002, p. 127). Therefore, to remain independent, engaging services needs to be a negotiated process. Sixsmith and Sixsmith (2008) found the older persons felt independent when they negotiated and controlled the services they received. For some, getting help with ADLs may lead to fear and insecurity (Jacobsson, Axelsson, Osterlind, & Norberg, 2000) and suggests dependency (Cheek et al., 2005a; Hellström et al., 2004). Heywood et al. (2002, p. 57) cite Clark, Dyer, and Horwood (1998, p. 55) that most older people wanted “help” not “care” to
maintain their independence. Wanting help implies they are in control. However, services prevent loss of independence and they are important to maintain health so that older persons can stay living at home (Chater, 2002; COTA, 2002).

The older persons in the current study negotiated services by outsourcing the work they were unable to do. This strategy included using informal unpaid assistance engaged from the family or neighbour, or outsourced at a formal service level for an affordable price. Types of assistance included housework, home maintenance, shopping, getting to GP appointments and transport. Similarly, the ALSWH found women required assistance with home duties and home maintenance and this need increased as they aged (Byles et al., 2006). In support, Bridge, Kendig, Quine, and Parsons (2002) and Gardner et al. (2005) state that older persons often require assistance with IADLs such as housework, home maintenance and transport.

In the current study, the older persons made the decision to outsource this work and engage services rather than move out of their home. Newell et al. (2006) argue that home cleaning or shopping services reduce physical demands and assist older persons to maintain their independence. This is an important consideration as selective use of energy is essential to sustain effort and hold momentum.

One of the problems the older persons in this study negotiated relates to changes in urban design and the replacement of accessible small corner shops with large and impersonal shopping complexes. Where possible, the participants retained the services of smaller local shops, which accommodated telephone orders and a home delivery service. The availability of food and access to shops are risk factors for malnutrition, where the prevalence is high in older persons (Green & Watson, 2006). In support, Cheek et al. (2005a) found changes to local shops affected care.
(2003, p. 10) highlighted this problem describing “the destruction of urban communities” caused by the creation of shopping complexes requiring access by car, replacing more easily accessible local corner shops. Although some large shopping complexes have made modifications to be older person friendly, they continue to present challenges for older persons regarding transport, and the use of stairs and escalators.

Therefore, by implementing these various strategies, the older persons determine, manage and negotiate the process to remain living at home. They make and evaluate decisions to determine the best approach, decisions which are self-generated and motivated by the meaning of home. This sustained physical, social and emotional work that older people undertake to remain living at home explains the process of ‘holding momentum.’

10.5 Limitations of the study

This study set out to develop a theory that would explain how people stay living at home as they age. Although there are some limitations, it is thought that they will not bias the study. The findings are trustworthy as the issues of credibility, dependability, transferability and confirmability of the data have been addressed and identified in Chapter 4.

It is acknowledged that the grounded theory ‘holding momentum: sustaining living at home’ generated from the data could be further enhanced by the collection and analysis of more data to seek more divergent cases, specifically those from other cultures and different living arrangements. Additionally, as this was one group of older persons in one particular context, the transferability of the findings is limited to similar groups. Furthermore, as the study progressed, some of the participants had
died before the end of the study and it was not possible to follow up with an individual interview. Finally, it is recognised that the grounded theory generated in this study is an interpretation by the researcher and the participants.

10.6 Implications for older people, policies and healthcare services

This study raises a number of issues that have implications for an ageing population. As a consequence of the Australian government policies to age in place, increasing longevity and an ageing population, in the future larger numbers of older persons will be making the decision to stay living at home. There will be more people over the age of 65 years sustaining their living at home under very diverse circumstances and potentially striving to hold momentum. An increase in the ageing population will mean an increased demand for health and social services, and more flexibility will be needed in service provision in the future.

While policies are developed for the population, it is essential that services meet individual needs (Kendig & Duckett, 2001). Hence, when creating support services, service providers need to look at building on the strengths of the older person (Kendig & Duckett, 2001). This is of particular importance as it appears that personal style is a condition which facilitates or constrains the ability to hold momentum.

The study findings highlighted the importance of the older person’s control over the decision making process. A major decision relates to the entry into the process, found to be commonly between the ages of 75-85. This finding has important implications for policy relating to the marker used for classifying older persons in Australia, and to the provision of services in the home. It would appear that after age 75, different types and levels of services may be required by the older person to stay at home.
Other findings relate to the timing of the decision to enter and exit the process. ‘Holding momentum’ gives the older persons time to review and renew; to make decisions about their self-management, what they will and will not accept. There are implications when deciding to enter the process for the older person’s family and for health professionals who need to understand the process and to ensure that the renegotiation occurs on the older person’s terms. This means that GPs, practice nurses and community nurses have a role in educating the community, not just older persons, about the provisions available. Older persons need to know what they are eligible to receive, and what is available to suit their particular needs.

Other decisions relate to the exit from the process and place of relocation. In this study, the decision for relocation to the type of new accommodation was based on the level of support or care required. This finding supports the Australian government’s implementation of the ACAP providing referral for appropriate placement when relocating from home. The implementation of this program has removed decisions regarding relocation from families and other health professionals, and assisted in providing more appropriate services and care for the older person at home and in other accommodation.

Although the older persons enjoyed having their family visit, they did not want them to control their living environment or make decisions for them. No older person in this study wanted to relocate to live with their family because interference from family undermined autonomy and threatened independence. This finding presents future challenges as currently the Australian government relies heavily on families to provide support and care. It has implications for government policies relating to increasing the role of families in the provision of informal support, and access to and affordability of formal service provision. The availability of more accessible and
affordable services will be required for those older persons living in the community and requiring only a very low level of assistance or care. Governments will have to consider different approaches regarding family support and care, particularly for those who do not have family support or do not want family support.

The older persons wanted to be around others and not just other older persons. Hence, there needs to be caution with retirement village living, as such living situations further segregate older persons from their wider community. It would therefore seem necessary that other types of accommodation, such as retirement villages would need to make changes to make relocation a more attractive option for older persons.

Rules and regulations imposed when living with family or in care accommodation, such as hostels or nursing homes often place restrictions on the older person’s freedom. Although there have been attempts made to address issues relating to the rigid routines that exist in some types of residential care accommodation, such as more flexible meal and hygiene times, the level of freedom is not comparable to living in one’s home. Furthermore, requirements of adhering to rigid routines determined by others in alternative accommodation may deplete the energy of older persons and they may be unable to sustain the effort required to remain independent and autonomous.

Furthermore, the benefits associated with being socially connected with the community described previously are frequently lacking in many residential care facilities. Despite other types of institutional accommodation providing opportunities for social networks, these companions are generally not those chosen by the older person themselves, and they are usually limited to those within the boundaries of the
facility. In addition, in residential care, the inability to go out into the community and use the facility as a base to come and go when you please means that the boundaries are fixed and not conducive to independence or autonomy and may foster isolation.

Other major findings relate to developing strategies and these include drawing on their own resources such as inner strength, good health, and support and services. Because successfully ‘holding momentum’ to sustain living at home is largely a personal achievement, dependent on the older person’s degree of resilience, the implications drawn from the study for people in this situation are centred on maintaining their health. It is not surprising that the push factors were more dominant over the pull factors in this study. This suggests that addressing push factors relating to health and support may assist in keeping older persons in their home.

Older persons need to stay healthy, preventing the complications of chronic disease by having specific management plans for their condition. The GP in a team care situation with allied health staff should work with the older person or their carer. Recognising that older persons, health professionals and service providers may have different priorities, it is the health professional’s role to ask the older person what their priorities are. In this way, there is quite often some overlap or common ground to manage what the health professional deems is the priority. It is vitally important that the older person feels they have not relinquished control over their own circumstances.

In this study, the older persons did not discuss their own health, possibly thinking disclosure would undermine their independence. This may have implications for families who endure frustration knowing that there is a health related problem but are unable to encourage the older persons to seek the help that is required. It could pose
problems for health professionals regarding preventative health and chronic disease self-management as they may have difficulty identifying health issues and planning appropriate health resources and services for older persons.

The findings highlight the importance of having health professionals that older persons can trust to include them in making decisions. In this way, the older persons can maintain autonomy and make decisions over what they wish to change or relinquish. Having a GP that the older persons had faith in and one that makes home visits when required was important. These findings suggest that it is essential for health professionals to have an understanding of what the older person perceives to be important and foster a self-management approach. The role of the GP will need to change in the future and more services will need to be based within the community as part of the GP practice. However, changes may be difficult as general practice is a small business so further funding may be required.

The findings also indicate that most older persons wanted some assistance particularly with meals and domestic duties, not care, to stay living at home. This has implications for the future as currently women are high users of services. However, with greater numbers of older men living longer, in the future there may be a need for more assistance in the home domestically and support for engaging in social networks.

Getting replacements for support provided by neighbours or friends that had moved away or died was found to be an important strategy, particularly if living alone. It is therefore essential that older persons have the opportunity to attend community venues as they provide a support network. However, spending time with other people of a variety of ages requires transport services for them to get to health and social
hubs to access services and facilities. This finding highlights the necessity for accessible and affordable transport for older persons to maintain their wellbeing.

In addition, although some large shopping complexes have made modifications to be older person friendly, they continue to present challenges for older persons regarding transport, and the use of stairs and escalators. Large complexes will need to become more user friendly.

In this study, very few persons made use of assistive technology, such as personal alarms, perhaps because many did not perceive themselves to be at risk. Another factor could be the cost associated with such technology. Interestingly, one person used speed dial on her phone in case of an emergency. This simple technology may be a very useful strategy for others to consider.

Overall, there appeared to be a lack of trust toward people unfamiliar to them. This has implications for service delivery as local community venues would appear to be the place to market health care and support services.

The older persons value their privacy and control of their home but also they need to spend some time interacting with others, and experiencing activity around them. In this way, the risk of isolation is outweighed by the benefits of navigating and negotiating the process to hold momentum.

10.7 Suggestions for future research

This study describes the process by which one group of older persons sustain their living at home. There are several suggestions for further empirical research as a result of the outcomes of this study. These include:
Research to assess the suitability of the strategies presented in this study for other older persons.

Research that replicates this study using a greater number of older persons with more diversity in characteristics such as culture, living in different areas such as rural, or other settings, for example assisted living, as they may have different experiences.

Research on older persons living with their children to determine support requirements. Although the older persons in this study did not want to live with their families, it is inconceivable in many cultures that older persons would live anywhere other than with their family.

Longitudinal studies, as older persons will live at home for a long time, and longitudinal studies will assist with identifying changing needs. In particular, longitudinal studies commencing prior to the age of 65 years to determine prerequisites for sustaining living at home may be useful.

10.8 Conclusion

This study set out to explore the experiences of a group of older persons living at home. The purpose of the study was to understand the reasons why older persons want to stay living at home and how they achieve this experience. The main objective was to develop a grounded theory explaining the process a group of people over the age of 65 years engage in to sustain their living at home.

The findings of this study have demonstrated that it is a sustained effort to persist despite change that enabled the older persons to sustain their living at home. However, it is important to consider that the process to hold momentum is a complex
one, achieved largely through individual endeavour and related closely to individual health. Living at home is by no means an easy decision but having the ability to renegotiate makes it worthwhile for these older persons.

This study is significant because it makes a valuable contribution to knowledge on contemporary ageing at home. It brings together the findings of an empirical study and the historical, theoretical and policy perspectives from various disciplines including nursing, medicine, psychology, sociology and environmental gerontology to create an interdisciplinary understanding of ageing at home today. Through synthesis of demographic literature and findings of other empirical studies, it reinterprets separate but interconnecting concepts related to independence, ageing in place, healthy ageing, positive ageing and successful ageing to explain the strategies used by the older persons.

These findings can inform older persons, policy makers and health professionals about the significance of the process of ‘holding momentum,’ in particular, the cyclical nature of the process, its reliance on individual competencies, and the differences in generational attitudes to ageing are all to be taken into account. Through greater understanding of the process by all concerned, older persons in the community will enjoy longer, more happy and fulfilling experiences in the later years of their lives, staying in their homes which mean so much to them.

*****
References


313


Shotton, L. (2003). The role of older people in our communities. *Nursing Ethics, 10*, 4-17. doi: 10.1191/096973303ne570oa


Appendix A  Focus group information sheet
and consent form

Study Information Sheet and Consent Form to Participate in Research Project
‘The Experiences of Older People Living in the Community’

The University of Western Sydney Human Research Ethics Committee has given approval for the research project titled “The experiences of older people living in the community” to be conducted in Western Sydney. The purpose of the project is to explore and describe the experiences of older people remaining in their home in an urban community. The findings from the project may not be of direct benefit to you. However, the research may help other older people to remain living in their home in the community. A summary of the project will be sent to each participant at the conclusion of the study.

If you volunteer to participate in the project, you will be asked to participate in a focus group discussion that is expected to take approximately one and a half hours. The focus group discussion will be about your experiences of living in your home in the community and will be held in a separate room at the [centre] located in [suburb]. The focus group discussion will be audio-taped. You may stop the focus group at any time. Towards the end of the session you will have the opportunity to confirm the main points of the discussion. If you disclose anything of an illegal nature during the focus group, the researcher is professionally responsible to report it to the appropriate authorities.

If you agree to be part of the research project, your name will not be used in anything written about the research. The information from you will only be seen by the researcher. It will not cost you anything to take part in the project.

You can refuse to take part or withdraw at any time during the project. This will not have any effect on you, your family, friends or your involvement at the [centre] or in the Senior’s Forums.

Thank you for your participation.

Deborah Hatcher
Doctoral Student
University of Western Sydney
Telephone: 02 4570 1922
I _________________________ of _______________________________

[Name of participant] [Street]

__________________________   ___________   ________________________
[Suburb] [Postcode] [Contact phone number]

have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that the researcher may contact me via telephone to arrange a suitable time to conduct the focus group discussion. I agree that information gathered for the study may be published, provided my name is not used.

Should I have any problems about the way the research was conducted and I do not feel comfortable contacting the researcher, I am aware that I can contact the Executive Officer, Human Research Ethics Committee, University of Western Sydney on telephone number 02 4570 1688.

.........................................................................................   ................................

Participant or authorised representative                          Date

.........................................................................................   ................................

Investigator                                                  Date
Appendix B  Interview information sheet and consent form

Study Information Sheet and Consent Form to Participate in Research Project

‘The Experiences of Older People Living in the Community’

The University of Western Sydney Human Research Ethics Committee has given approval for the research project titled “The experiences of older people living in the community” to be conducted in Western Sydney. The purpose of the project is to explore and describe the experiences of older people remaining in their home in an urban community. The findings from the project may not be of direct benefit to you. However, the research may help other older people to remain living in their home in the community. A summary of the project will be sent to each participant at the conclusion of the study.

If you volunteer to participate in the project, you will be asked to participate in an interview that is expected to take approximately one hour. The interview will be about your experiences of living in your home in the community and will be held in your home or at another location that is convenient and suitable to you. The researcher will use the contact phone number on the Consent Form to contact you to arrange an interview time suitable to you. The interview will be audio-taped. You may stop the interview at any time. If you disclose anything of an illegal nature during the interview, the researcher is professionally responsible to report it to the appropriate authorities. After the interview you will be given the chance to read the researcher’s interpretation to see if you agree with what was said.

If you agree to be part of the research project, your name will not be used in anything written about the research. The information from you will only be seen by the researcher. All records will be treated as confidential and locked in a filing cabinet at the University of Western Sydney. It will not cost you anything to take part in the project.

You can refuse to take part or withdraw at any time during the project. This will not have any effect on you, your family, friends or your involvement at the [centre] or in the Senior’s Forums.

Thank you for your participation.

Deborah Hatcher
Doctoral Student
University of Western Sydney
Telephone: 02 4570 1922
I _________________ of _________________

[Name of participant] [Street]

____________________  ___________  ________________________
[Suburb] [Postcode] [Contact phone number]

I have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that the researcher may contact me via telephone to arrange a suitable time to conduct the individual interview. I agree that information gathered for the study may be published, provided my name is not used.

Should I have any problems about the way the research was conducted and I do not feel comfortable contacting the researcher, I am aware that I can contact the Executive Officer, Human Research Ethics Committee, University of Western Sydney on telephone number 02 4570 1688.

.........................................................................................   ................................
Participant or authorised representative Date

.........................................................................................   ................................
Investigator Date
Appendix C  Participant personal profile form

Please answer the following questions as accurately as possible. These questions will provide information that will be helpful for my study. Do not write your name on this form.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Age: ____________________</td>
</tr>
<tr>
<td>2.</td>
<td>Gender: Male ☐  Female ☐</td>
</tr>
<tr>
<td>3.</td>
<td>Country of birth: ____________________</td>
</tr>
<tr>
<td>4.</td>
<td>Main language spoken at home: ____________________</td>
</tr>
<tr>
<td>5.</td>
<td>Marital status: Married ☐  Widowed ☐  Separated ☐  Divorced ☐  Never married ☐  De facto ☐</td>
</tr>
<tr>
<td>6.</td>
<td>Number of living children: ____________________</td>
</tr>
<tr>
<td>7.</td>
<td>Highest level of education: Primary school ☐  High school ☐  Trade ☐  TAFE ☐  University ☐  Other ☐</td>
</tr>
<tr>
<td>8.</td>
<td>Previous occupation: ____________________</td>
</tr>
<tr>
<td>9.</td>
<td>Present status: Retired ☐  Employed ☐</td>
</tr>
<tr>
<td>10.</td>
<td>Household income range: Less than $15,000 ☐  $45,000 - $59,999 ☐  $15,000 - $29,999 ☐  $60,000 - $75,000 ☐  $30,000 - $44,999 ☐  More than $75,000 ☐</td>
</tr>
</tbody>
</table>
11. House type:  
   - House  
   - Townhouse  
   - Retirement Village  
   - Unit  
   - Other  

12. How long have you lived in this dwelling?  
   ___________________________  

13. Household composition  
   - Live alone  
   - Live with partner  
   - Live with partner and children  
   - Live with other relatives  
   - Live with children  
   - Live with friends  
   - Other  
   ___________________________  

14. List the people you count on most when you need someone  
   ___________________________  
   ___________________________  
   ___________________________  
   ___________________________  

330
Appendix D  Focus group discussion schedule

General introduction by the researcher
- Introduce self
- Purpose of the study
- Confidentiality issues
- Rules for group discussion

Participant introduction and ice-breaker question
- “Introduce yourself and state where you live and why you like living there.”

Opening question
- “Tell me about the things that make it possible for you to remain living in your home in the community?”

Areas to cover
- Home
- Community
- Independence
- Health and wellbeing
- Resources
- Social network
- Support

Conclusion
- “Have we missed anything?”
- “In what ways could this focus group be done better?”
Appendix E  Interview questions

Interviews 1-5

• What are the most rewarding aspects of living in your home?
• In what ways does your health enable you to live at home?
• What do you think are your personal attributes (qualities) that enable you to stay living at home?
• What are the things that make it possible for you to stay living there?
• How does being in a community assist you to live at home?
• What are some of the challenges of living in your home?
• Have you thought about what you will do in the future?
• When do you think you started to think about remaining living at home?
• What do you think would be a reason that you may not be able to stay living in your home?

Interviews 6-10

• What is it about your home that makes you want to stay living there?
• What are the things that have helped you to stay living there?
• What are the things that sometimes make it difficult for you to live there?
• Were there times when things happened and you had to make changes so that you could stay?
• Do you ever think about the future and what might happen to make you move out?
• What are the attributes you have that help you stay at home?
• What are some things you do to stay at home?
• What support do you have and how often do you use it?
• What support do you give to others?
• What work do you get others to do for you?
• What are some of the negative things about living at home for you?
• What are some of the positive things about living at home for you?
## Appendix F  Participant profile

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Household type</th>
<th>Country of birth</th>
<th>Marital status</th>
<th>Highest education</th>
<th>Household income</th>
<th>Household composition</th>
<th>Focus group</th>
<th>Support person</th>
<th>Interviewed</th>
</tr>
</thead>
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<td>1A</td>
<td>Maree</td>
<td>F</td>
<td>81</td>
<td>House</td>
<td>Australia</td>
<td>Widow</td>
<td>Primary</td>
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<td>Lives alone</td>
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<tr>
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<td>F</td>
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<td>Unit*</td>
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<td>Widow</td>
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<tr>
<td>3A</td>
<td>Tim</td>
<td>M</td>
<td>75</td>
<td>Duplex**</td>
<td>Australia</td>
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<td>Yes</td>
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<td>Household type</td>
<td>Country of birth</td>
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<td>Support person</td>
<td>Interviewed</td>
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<td>Daughter</td>
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<td>Primary</td>
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<tr>
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<td>Sri Lanka</td>
<td>Married</td>
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<tr>
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<td>M</td>
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<td>Retirement village</td>
<td>Indonesia</td>
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<td>Lives with wife</td>
<td>C</td>
<td>Son</td>
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* Participant moved to retirement village before end of study
** Participant moved to hostel before end of study
Appendix G  Summary of participant biographical data at commencement of study

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<th>Characteristic</th>
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