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# **Decision-Making Experiences and Patterns in Residential Care Homes for Older Residents, Family Members and Care Providers**

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Additional information is available at the end of the chapter

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## **Abstract**

**Aim:** To explore the decision-making experiences and processes taking place in residential care homes from older residents, their families and staff members, particularly how residents' needs were met and their degree of involvement in making decisions.

**Methods:** A constructivist grounded theory study was used to interview 28 residents, 22 family members and 31 staff. Results: Three processes illuminated the residents' approaches to decision-making over time. These processes demonstrated how residents settled into the homes and began to develop their decision-making approaches in conjunction with their family and staff members. The degree of negotiation and compromises in decision-making that was possible for older people could be captured in the data.

**Conclusions:** The influence of family members and staff in supporting or hindering residents from decision-making highlighted the subtle discussions, delicate negotiations and compromises that occurred. Findings presented will be discussed with the wider literature on caring for older people in these homes.

**Keywords:** decision-making, family, qualitative, residential care homes, residents, staff

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## **1. Introduction**

As residential care homes play a progressively more important role in the lives of Chinese older people it is important to ensure that the care provided 'in their new home' is of a high standard and that their multiple needs are recognized and met. Like other countries around the world, Hong Kong (HK) is faced with an aging population. However changing family structures and the

socio-economic context have made it particularly challenging for families to keep older people at home, even with supportive services. This has seen a growing number of residential care homes emerging. As these homes are becoming important for older people, it is pivotal to understand how they make decisions and how their family members and care providers support them, or not, to meet their wishes and preferences. Indeed, few studies have examined the roles of these key stakeholder groups (i.e., residents, families and care providers), their level of involvement in decision-making, and influences they have on decisions that determine older people's lives. By examining these various perspectives the aim is to understand the 'what' and 'how' of decisions; that is, the processes that drive decision-making and their subsequent outcomes. Currently, little is known about the respective roles adopted by key stakeholders, their level of involvement in decision-making and the influence they have on decisions that determine the residents' lives. If older people in these homes are to enjoy the same rights as those living in the community then a better understanding of how decisions are made in these homes is necessary.

A literature search conducted revealed a scarcity of work (both internationally and locally) that examined decision-making processes and experiences among residents, families and staff in residential care homes. Despite a general lack of literature about 'decision-making in residential care homes', there appears to be an abundant literature on clinical and treatment decision-making, and making decisions to enter residential care homes. Indeed, only two studies were found that specifically examined decision-making and family's experiences in residential care. There were studies on making transitions into residential care homes [1–3], yet in relation to decision-making per se, Edwards et al. [4] concluded in a literature review of 20 papers that there is a paucity of literature that documents the actual decision-making processes. It is known that once admitted into the homes, daily activities become an integral part of the residents' lives, and often involve waiting, daily routines and activities [5]. However, literature exploring how decisions about such matters are made is scant, but closer inspection of that which exists reveal that it is still possible to draw insights of aspects of life in these homes and how resident wish to live and how their lives can be improved.

### **1.1. Decision-making perspectives: relevance for long-term care residents**

In the general literature, the main focus of decision-making highlights the use of a range of strategies such as rational thought, intuition or prior experience in order to choose among the alternatives. Here decision-making is seen to involve a sequence of events or a course of action taken in order to decide what action to take [6–7]. Several authors support a view that decision-making involves using discriminative thinking to choose a particular course of action [6–7]. In this way, decision-making is seen as a complex process involving a series of stages that include observing a situation, evaluating the observed data, and taking actions to achieve the desired outcome [8]. It therefore involves the act of choice following consideration, deliberation and judgment of alternatives [9] through a process of information gathering. This locates decision-making as an active cognitive thought process of making up one's mind about something, and reaching a judgment or decision among a range of alternatives. This of course presumes that alternatives exist, and this may not be the case for many residents in residential care homes.

In the wider health care literature, the type of decision-making described above is usually clinically-oriented and professionally-driven [7, 10]. The main focus has been on making decisions

about treatment preferences, monitoring treatment effects, and ethical decision-making [11]. Such studies have contributed to the development of clinical decision-making models to aid healthcare professionals. However, these models have less relevance in residential care homes where decisions may not be primarily clinical, the range of options may be limited as may be the information available to inform decision-making. Another facet of decision-making involves using intuition and prior experience to take action based on the intuitive feeling of the decision-maker [12–15]. This perspective has some potential relevance in residential care homes particularly from the existing literature on the role of intuition in gaining expertise [16]. However, the value of such understanding on how residents make decisions is far from clear.

Of more use is the work of Circielli [17], who examined decision-making of family caregiving for older people. In this decision-making was defined as:

*‘a process where individuals do not always make decisions alone, but make them with others in dyads or groups’ (p. 33). It is therefore assumed to be an ongoing process between persons and involves ‘shifting from the micro level of the (individual) person to a macro level between persons’ (p. 49) in creating perspectives to minimize conflicts in the environment.*

This definition appreciates that decision-making is a process that occurs over a period of time, and that potentially involves a number of people. This is likely to be more consistent with the reality of life in a home and will inform the approach to be adopted here.

## 1.2. Levels and types of decisions in residential care homes

Residential care homes are known to be places where many levels and types of decisions can take place. Although the review by Davies and Brown-Wilson [18] found limited information on the decision-making processes, they mentioned that the types of decisions made in the homes can directly impinge on the lives of residents, families or staff, even though residents may not be directly involved in them. In exploring the range of decisions made in the homes, Rowles & High [19] identified a typology of decision-making approaches based on an ethnographic study of family involvement in several homes. These were ‘authoritative decisions’, ‘given decisions’, ‘negotiated decisions’, and ‘reflexive decisions’. While most decisions made in residential care homes will impinge on the daily experiences of residents, authoritative and given decisions are largely made with little input from older residents and their significant others. By definition they should have relatively more involvement in negotiated and reflexive decisions, and these should be the processes involved when decisions concerned with daily matters are made [19]. With reference to Rowles and High’s [19] typology of decisions, the last set of reflexive decisions seemed to define residents’ levels of control and ability to exercise choice, which may vary within each home. This is consistent with the definition of decisions as defined by Tversky & Kahneman [20], cited in Johnson et al. ([21] p. 359) as:

*‘choices or actions from which a person choose what to or not do, and are based on beliefs about what must happen to achieve goals’.*

It would seem that an understanding of decision-making can be retrieved by exploring aspects of daily life that concern older people from previous studies on perceived choice and control, and level of participation/involvement of residents, families and staff.

### 1.3. Defining the issues at play

In HK, the maintenance of family harmony and filial piety is still very much the core value of the Confucius Chinese traditional practice, despite evidence suggesting that the practice of filial duties has weakened [22–23]. Policy reforms have continued to affirm the view of the ‘warm, supportive and stable families are what counts in nurturing the healthy development of individuals’ ([24] p. 28). Potentially, there is an expectation that Chinese families still have an important role to play as providers of care, even after older people are admitted into the homes. However, there is very scant information available to understand the respective roles of families and their influences on the care of older people following entry into residential care homes in HK. Despite efforts to involve older people and their significant others in making decisions that affect their care, participation and involvement remain generally minimal and decisions are mainly made by staff based on what they consider to be in the older persons best interests [25]. This is further supported by work undertaken in HK which found that residents became dependent much earlier than needed [26]. It was found that staff acted on behalf of all residents, even for those who did not need their assistance, and perceived the tasks to be within their capabilities. Indeed, there is a need to develop mutual understanding about how to provide care which can truly reflect the competence of older people and minimize unnecessary dependence [27].

Growing old and living in residential care homes need not mean that making decisions becomes a thing of the past. Rather, being able to make informed decisions about personal choices and preferences continues to be important and should be promoted regardless of mental and physical frailty. If the ethos of caring is about understanding what is wanted from older people, merely getting things done for them will not enhance their satisfaction or quality of life. Identifying older people’s preferences and values on how care needs ought to be met and their capacity and capability to continue to make decisions about daily living will help to inform appropriate care decisions. Such information will enable staff to re-prioritize and re-organize their work patterns by responding to the older person’s expectations of care, and thereby involve those older people who wish to participate in decisions that directly concern their welfare. It is with this intention that this study was undertaken to explore the decision-making experiences and processes taking place in residential care homes from older residents, their families and staff, particularly how residents’ needs were met, and their degree of involvement in making decisions.

## 2. Methodological approach

### 2.1. Research design

Constructivist grounded theory (conGT) was adopted in this project. This approach was inspired by Rodwell’s [28] constructivism approach to research and Charmaz’s [29] work on ‘Constructing grounded theory: A practical guide through qualitative analysis’. Their writing provided a methodological map in clarifying the strategies and perspectives for understanding the phenomenon on decision-making in residential care homes for older people. In the research process, knowledge was co-created through the reciprocal relationship that

was formed between the researcher and participants as they worked towards exploring an interpretative understanding of the participants’ experiences and acknowledging they created multiple meanings of their worlds in which they live in [30].

## 2.2. Sampling and setting

**Table 1** depicts the participants and study settings. Purposive sampling was used to recruit the initial sample and to identify participants who were most likely to provide rich information about the experiences or phenomena of interest [31]. As data collection progressed I recruited people with diverse backgrounds to achieve maximum variation and ensure multiple perspectives [28]. Theoretical sampling followed to sample people, activities and events as guided by the emerging codes and categories. The selection criteria were:

- *Resident* refers to newly-admitted persons who were cognitively-intact, spoke Cantonese or Hakkanese and willing to participate. Those refusing to participate in the study and suffering from cognitive impairment were excluded.
- *Family* refers to immediate members such as daughters, sons, spouses or grandchildren who had been identified by the resident as a person of importance in their lives, and were involved in their care to deal with issues at the home.
- *Staff* refers to both professional (social and health care personnel) and non-professional care staff who provided or influenced the physical and/or psychosocial care of residents; at least one staff representative from each rank; and, a willingness to engage in an individual interview with the researcher.

Data collection used a 3 × 3 design with three datasets from residents, families and staff in the three distinct homes. Data collection in home one was completed before commencing concurrent data collection in the second and third homes. In home one, data were collected to provide an orientation and overview of the research problem from the three participant groups. These data informed the selection of another two homes and participants. Homes two and three moved from general discovery of issues to more targeted probing among the participants [28]. The emerging categories were refined to focus on the (co-) constructions that emerged in the data. Data collection terminated when in-depth information, with maximum

Home	Time period	Participants			Interviews		
		Elder	Family	Staff	Elder	Family	Staff
1	10 months	8	6	10	16	6	10
2	11.5 months	12	10	11	22	10	11
3		8	6	10	14	6	10
	Sub-total	28	22	31	52	22	31
	Total		81		105		

**Table 1.** Overview of participants in the three study homes.



variation in participants' views, and a high degree of consensus about the categories and constructions was achieved.

### **2.3. Interview procedure**

Interviews were the main data collection method used. The main emphasis of interviewing pointed to what, why and how questions were asked, and being able to listen to the participants answering the questions in order to understand the experiences, and deriving interpretations from it [32]. Interviews therefore provided a tentative impetus to make decisions about 'where to go', 'what to look for', 'from whom', and 'how to ask questions' ([28], p. 21). The intention was not to impose a rigid order to the interviews by following each question in a particular sequence, but to allow the interview content to unfold by following the lead of the participants who were telling the story [33]. In fact, the researcher and participants were allowed to go 'beneath the surface of ordinary conversation and examine earlier events, views and feelings' ([29] p. 26–27). The participants were asked to reflect deeply on their experiences and encouraged to talk more. Clarifying and encouraging more information helped to articulate intentions and meanings. Therefore, only a few broad, open-ended semi-structured questions were needed to focus the interviews. A guiding principle in framing the questions was to 'direct questions to collective practices first and then attend to the individual's participation in and views of those practices' ([34] p. 679).

Family and staff members were interviewed once, and residents were interviewed twice (at 2 weeks and between 2 and 3 months after admission). As the study examined how residents made decisions with the support from staff, residents' first interviews and staff interviews were conducted almost simultaneously. Families were interviewed after the residents' second interview. This allowed me to hear the residents' experiences and how staff responded to them before comparing the accounts of residents and staff with the families' to gain fuller perspectives of those experiences.

### **2.4. Analysis strategy**

Simultaneous data analysis and data collection occurred as far as possible. Constant comparative analysis was the method of data analysis used to generate concepts and to develop the theory through an inductive process of defining, categorizing, comparing data and, explaining and seeking relationships in the data [29]. Each interview was transcribed verbatim as soon as possible after each interview. Once the transcripts were checked for accuracy, the data were subjected to initial and focused coding. Initial coding enabled me to examine the fragments of data (words, lines, segments and incidents) and to give them a label that best summarized and described the data [29], using the participants' words to help me stay close to the data. A table of codes was compiled for each participant group, to which constant comparison of data was undertaken to check whether participants from each care home had identified similar concepts. The idea was to keep or reword existing codes, and only add new codes when new information was forthcoming [33]. The table was updated after changes were made to the coding scheme. The table at a glance helped to identify convergent and divergent opinions, and find gaps in the coded data to direct subsequent data collection [29]. Focused coding synthesized larger segments in the data by examining which significant initial codes could be

collapsed into broader categories [29]. Similar coded data were compared against the existing extensive data, and the incoming data from other transcripts. The identified sub-categories were compared with the verbatim data and codes to ensure that the 'emergent set of categories and their properties fit the data, work, and were relevant for integrating into a theory' ([35] p. 56). The researcher moved from specific incidents to abstraction, by comparing incidents to incidents and incidents to concepts to determine similarities and differences in an iterative process [33]. Once the codes were all collapsed to form categories, possible relationships among and between the categories were examined to establish a conceptual link between them [29] to theoretically explain decision-making experiences among the stakeholder groups.

## 2.5. Ethical considerations

Ethical approval was obtained from the Survey and Behavioral Research Ethics Committee of the University to conduct this study. The superintendents of the homes gave me permission to conduct the study. In upholding the ethical principle to respect autonomy, participants were well-informed about the inquiry, and were given time to ask questions before agreeing to consent to participate. The provision of informed information safeguarded the rights and respects the participant's choice to participate. All participants signed the consent form before being interviewed. They were informed of their rights to stop the interviews, refuse to answer questions and withdraw from the study at any time. They were advised that consenting to the inquiry was entirely voluntary and withdrawing from the study did not influence the care provided by the homes.

## 3. Patterns of decision-making and influences on residents

Based on the case analyses of the three homes, distinct patterns of decision-making and the influences on the residents' approach to decision-making could be delineated. The processes by which residents were facilitated or hindered from decision-making were strongly influenced by the pattern of decision-making that predominated in the homes. **Table 2** summarizes the three processes and six elements that were identified to capture the subtleties of the process of decision-making for residents that unfolded from entry into the homes to how they continued to make decisions to adjust to the living environment.

Residents proceeded through a fairly logical approach and had varying degrees of involvement in decision-making. These processes demonstrated how residents settled into the home by becoming familiar with it and then becoming more involved in the decisions that influenced their lives. As residents moved through these decision-making processes that were practiced in the homes, the degree of negotiation that was possible determined the extent to which they were able to negotiate successful, less successful and unsuccessful decisions. As residents engaged in these processes the extent to which the family and staff ensured that decisions were successfully negotiated to meet needs or needs were not met were also highlighted. In comparing the similarities and differences in these processes across the three homes, three decision-making patterns were identified as negotiated, partially-flexible and constrained patterns of decision-making. Through the interactions between the participant groups, negotiations and/or compromises occurred that either facilitated or hindered residents' involvement



Processes	Elements
Making the unknown familiar	<ul style="list-style-type: none"><li>• Being accompanied and supervised</li><li>• Being told and observing</li></ul>
Finding out what I can do and want	<ul style="list-style-type: none"><li>• Trial and error testing</li><li>• Asking and questioning</li></ul>
Negotiating-compromising the past to fit the present	<ul style="list-style-type: none"><li>• Suggesting and negotiating</li><li>• Compromising</li></ul>

**Table 2.** Decision-making processes matched against its elements.

in decision-making. Participants’ decision-making patterns and how they shaped the three processes of adjustment to decision-making will be discussed below.

**3.1. Negotiated patterns of decision-making**

Residents from home one undertook most negotiation in decision-making. Some residents from home two were also allowed to practice this approach provided that decisions did not disrupt the smooth running of the home. This approach was less evident in home three and, when it did occur, it caused conflict resulting in the resident terminating their stay.

*3.1.1. Making the unknown familiar*

During the settling-in period, residents’ abilities and desires were revealed through the processes of ‘being accompanied and supervised’, and ‘being told and observing’. Staff were predominately identified as key people in the process of getting to know the resident’s concerns, health condition, personality and personal preferences on which to base decision-making later on. As the weeks passed, the exchanges with accompanying and supervising staff allowed residents to gradually understand the operation of daily practices affecting their lives. Of concern to residents at this time was the ways in which baths were planned:

*Staff arrange baths for me. I do not bath on my own. I know the time to bath. If I bath today, I bath the day after tomorrow so I can prepare myself. But there’s nothing for me to get ready ‘cause they do it all for me. (POAH, elder, E5A).*

This process also enabled most staff to claim that they knew about 70–80% of the resident’s personal habits and preferences. The remaining 20–30% was attributed to the limited knowledge about family composition and support to give to them. This information was important in making a judgment about resident’s abilities to make decisions. Information about the resident’s mobility, level of independence and self-care abilities, capabilities, mental state, motivation to do own things, beliefs in one’s ability to do it, and ability to make sensible suggestions were helpful. When they were perceived to be unable to mobilize safely, negotiating to do tasks independently were often rejected by staff. This was frustrating for some:

*You need a clear mental state, or else how can you do the task? I can make decision whenever I need to. You cannot deceive me on anything. You cannot ignore what I am saying. The only thing is that I cannot walk on my own and this is killing me (POAH, elder, E5A).*

The process of being told and observing the daily routines enabled residents and families to learn the roles of staff and their expectations. Some residents quickly settled into a pattern of letting staff do things for them:

*They are good to me. I do not have to do anything. I am over 90. Staff help to prepare everything for me. They do not need me to do anything. (POAH, elder, E6A).*

The importance of families in maintaining relationships with the residents was emphasized by the staff from the outset. Families played a central role during this transitional period by providing supplementary baseline information to the staff about their relative's condition and usual habits that shaped the level of supervision needed and improved understanding of the resident. Indeed, the superintendents and staff, especially in home one, initiated contact with the families each time they visited. The family's contribution in this process was to make regular visits to observe and get to know the home, and what was happening in the resident's daily life, and what was acceptable to do. Families were keen to lend a helping hand and to reassure the residents that they had not been abandoned. Families also learned from staff and observed them to see whether their requests were followed up.

### 3.1.2. Finding out what I can do and want

The processes of 'trial and error testing' and 'asking and questioning' marked the beginning of negotiation in the decision-making experiences of residents. These processes were largely triggered by the discrepancies arising from what was being told and observed about the home's operation and from the people around them. They wanted to 'trial and error test' and 'ask and question' about the possibility of doing things by themselves.

In homes one and two, the process of trial and error testing was usually observed in physical care decisions, although the processes differed slightly. These decisions were examples of major initial concerns, such as who performed the hygiene care, or decisions about meal choices were requested by the residents or families. Of concern to residents were asking to change the order of taking baths and who performed it. Bathing routines tended to prioritize those whom staff felt were most pressing (e.g. wound dressing or medical appointments). On the spot requests like 'I want to be first today' without a 'good' reason were not entertained. In home one, an upfront request to bath alone was made by the residents to the superintendents and, if staff agreed, the level of supervision needed was assessed. In reality staff felt constrained by the need to rush through baths and safeguard those who bathed alone. Residents spoke of the embarrassment of asking for help:

*They do not really need to take care of me. If they do not call me (to help me), I bath myself. It's safe and simple. No need to ask others to help with things I can do. If I ask for too much help, I feel embarrassed and useless (POAH, elder, E8B).*

The main reason for wanting to regain independence and control over bathing was the dissatisfaction directed at staff for being too busy and rushing through the procedure. Instead of moaning, they proactively dealt with the problem:

*They bathed me and did not completely wash away the soap. I kept it a secret, or the seniors will condemn them. I told them I could bath myself, and thanked them for helping me. They said to call them if I could not handle it. (SH, elder, E4B).*

Some residents (influenced by roommates) initiated plans to bath alone, without telling the staff. Experimenting cleansing in secret led them to become confident to persuade staff to let them do it under supervision:

*They bathed me the first 2 weeks. How can you bath without them knowing? I saw a resident bathing alone so I bathed secretly a few times. I could do it. I did not know that before. They found out, scolded, observed me. Now I do it myself. (SH, elder, E11A).*

Families' views of residents' abilities to make physical care decisions were welcomed. There was a general agreement to allow them to partake in 'basic' daily life decision-making when they were capable and they were not too disruptive to staff or families. Indeed, while some families promoted such decision-making, they also believed that residents should only make decisions on things that were within their capability, even if they could do this slowly.

### 3.1.3. Negotiating-compromising the past to fit the present

The processes of 'suggesting and negotiating' and 'compromising' with staff and families about creating a way of life that was reasonably familiar and comfortable for residents marked the continuation of the negotiated decision-making process. The process of suggesting-negotiating arose after residents, who were successful in making some changes, continued to ask and question, and were more likely to discuss and further explore their needs: Everyday it's I see what I can do. I depend on myself all the time. (POAH, elder, E2A).

In both homes one and two, an activity enjoyed by residents was the ability to go out alone, and not to be supervised by anyone. Undoubtedly, the ability to go outdoors independently was a rule determined by the home's management and was made known to residents and families on admission. Although residents were able to maneuver freely around the grounds of the home, granting them the freedom to leave the home grounds as they pleased depended on their physical capability, mental alertness and independence. Such requests were carefully negotiated with the family who had to sign a consent form to accept responsibility. The freedom and independence to go outdoors was highly valued, although the outskirts of home one was an industrial area and it was potentially dangerous for elders to be out alone. They therefore spent time walking along the streets, in front of the home. Whilst this created administrative work homes one and two believed that residents should be given freedom to connect with the community, and encouraged to go out freely, providing it had been approved beforehand.

Another example of the process of negotiating-compromising pertained to food choices. This was a longstanding and difficult problem that was not easy to solve. Over time, the food served and timing of meals were not entirely suitable. Some residents questioned the food textures and tastes, and made requests for a change. As there were no resident meetings in home one, the matter was discussed with the residents on an individual level. Avoiding foods the majority disliked was the preferred practice in communal living, as opposed to boosting food tastes for the few who raised it as a concern. With the help of families and approval of staff in both homes, this was resolved by allowing residents to purchase small bottles of soy sauce, pickle onions or shredded pickle to enhance the tastes of foods. Other food issues were not always easily resolved.

As most families were in full-time work and visited during the weekends, they got to know about the residents' decision-making capabilities through the staff who took initiative to tell them about the daily happenings. They were delighted to know that residents were taking care of themselves and finding things to occupy their time. Negotiating about care that went beyond the usual home practice (e.g. preparing packets of drinks or snacks families have brought), and exploring items to purchase for bed unit) were some topics that were successfully discussed by the family on behalf of the residents.

### 3.2. Partially flexible patterns of decision-making

This approach was most apparent in home two, and sometimes evident in home one due to the constraints of staff and facilities. Few residents from home three wanted to let staff know their needs because they were reluctant to confront the rigid culture of the home.

#### 3.2.1. Making the unknown familiar

Compared with home one, the processes of accompanying and supervising elders was not as closely monitored by staff in home two, while the processes of telling and observing was given greater emphasis. The processes of accompanying and supervising involved staff helping residents to become familiar with the routine and physical care, particularly how they fitted in with the baths, meals and sleeping arrangements. Being a larger home, these processes identified issues that could potentially cause unharmonious relationships such as room- and table-sharing, and being prepared to minimize conflicts should they arise:

*The idea of decision-making depends on reciprocal relationship of elders to respect each other. It's communal living. You are not in a single room. Issues like over-using or not letting others use the air-conditioning and fans in the bedrooms, or asking to live on a specific floor. (SH, social worker, S8).*

Residents and families were not fully told about the roles of staff (due to many staff) and the pattern of work. Instead families were told of an appointed social care staff and to approach the care staff on each floor for enquiries. They only needed to be observant, oblige and accept what they had been told. Indeed, residents learnt more by observing other resident's behaviour and attitudes of staff towards them, particularly towards room-sharing and how they formed friendships. Unlike home one where residents had single rooms, a major issue in home two was the resident's uncertainties about forming relationships in a large home.

Here families' visits to the residents were confined mostly to the weekends, and there were less daytime/evening visits to lend a helping hand, because of work and family commitments. Families found out about the home's routines largely through talking to the resident, the majority in this home being cognitively intact. The opportunity to move freely around and outside the home, without the operation of a rigid documentation procedure, was viewed with initial surprise by families, although they liked the freedom it gave:

*The rules for taking residents out are a bit loose. I thought it was strange when no one asked me questions (visited biweekly). The home likes to give freedom and convenience to resident and families, and prevents a feeling of imprisonment. (SH, daughter, R8).*

### 3.2.2. Finding out what I can do and want

A policy that became more flexible in home two was a result of female residents' determined efforts to launder their own clothes (not an established home policy) by not approaching the staff first to ask for permission. There was considerable dissatisfaction with the laundry service that often produced creased clothes that were impossible to wear. Instead of openly expressing their dissatisfaction, residents chose to launder light clothing and balanced this by complying with the rules to let the home launder larger garments. Once it was clear that this did not cause major disruption, staff turned a blind eye and provided floor mats, fans and mops to ensure safety:

*I wash my clothes and hang them in the bathroom. I do not disturb the others. All elders in my room do their washing. Staff know it. It's no secret. We look after each other and consider safety. Dry the floor and turn on the fan if the bathroom is wet. (SH, elder, 6B).*

Home two had the most choice of social activities (e.g. small groups of elders with dementia playing mahjong, or in large group of 100 to 130 residents). Such activities required staff to make decisions about scheduled indoor activities, including group size, target groups, purpose, and venues. Residents learned about these activities when staff informed them in person, or roommates discussed these activities among themselves. Through these activities, some residents realized their abilities and developed new interests and friends. They preferred activities that taught them to learn new skills such as singing, writing Chinese characters, and the physiotherapy sessions. Activities that required them to communicate had low enrolment. Indeed, it was those residents who were cooperative and obeyed the rules that seemed to be allowed more personal requests. For example, residents who had befriended other residents would group together to ask staff's permission first before engaging in mahjong gatherings. Some residents with difficulties in mobilization aspired for more outdoor activities, or to be trained to walk or use the wheelchair, and were finding ways to make this happen without being seen as troublesome:

*I seldom go outside. It's what you can do when you go outside. I do not know how to use the wheelchair. They do not have activities to allow people in wheelchair to go out and sit under the sun. All the activities are indoors. (SH, elder, 3A).*

To increase resident's participation, special arrangements were facilitated by staff to maximize frail and less able residents to participate in different activities:

*We choose suitable time and venue for the residents. We know some residents come out and have their tea so activities are arranged at those times (SH, welfare worker, S5).*

Despite visiting less often than in home one, families still provided close support and encouragement in the course of decision-making. While families became concerned about safety, they supported resident's decisions to launder own clothes by offering to take larger-sized clothes home to wash, but thought it was unnecessary to intervene with the home's practices when the solution to deal with the issue was not entirely inconvenient.

### 3.2.3. Negotiating-compromising the past to fit the present

The processes of 'suggesting and negotiating' and 'compromising' with staff and families occurred in such a way that allowed requests to be considered before coming to a final decision. Like



home one, residents with prior successes in negotiation continued to make requests, however they were persuaded to take advice from staff, which was considered to be in their best interest, and thereby sometimes had to compromise their own expectations. For example, residents were highly influenced by the advice of their family members. Some residents were happy not to go outdoors unless accompanied by relatives. In such situation, they would not bargain with the staff. They would choose to wander in the home's premises and remain in the garden, which were acceptable alternatives:

*I will not go outdoors by myself. There're rules. I cannot go out whenever I want without telling them. I say, "I'm going to the garden. If someone wants me I'll be there." That's already good enough for me. (SH, elder, E6A).*

Some alert residents with physical limitations compromised by sacrificing outdoor activities they had previously enjoyed due the burden they felt would be placed on others to help them. The choice of outdoor activities was limited to those that required no companion:

*I have not joined the trips. I cannot walk. I need others to push me (on wheelchair), and it's hot outside. I join activities that do not need others' help. They said if my family can push me, I can go. I do not want to bother my family so I do not join. (SH, elder, E8B).*

Indeed, a resident's state of health seemed to be the determining criterion for having wishes granted. Staff were rather flexible and allowed negotiations when managing residents who insisted, for example, to go against relatives who forbid them from going outdoors. As this home had easy access to the shops, when such circumstances occurred, it was managed individually and flexibly by re-assessing the situation with the resident and family and coming to a new consensus that provided instructions for staff on the provision of care.

In principle home two was in agreement that residents should be accorded the freedom to do things for themselves, however there were contradictory policies that restricted their freedom. Continuing with the example of going outdoors, residents who wanted to go for a walk after dinner would be limited by the regulation to return by a certain time, and therefore limiting true freedom. Although it was difficult to check on the flow of people moving around the home, this issue was not addressed by confining residents to remain indoors to ensure their safety. Instead, strategies were developed to react positively to the resident's situations and still continue to keep the main entrance open to avoid feelings of being in jail or locked up.

In home one, while staff tried to maintain the resident's prior lifestyle of allowing them to keep hold of money and make decisions about small purchases, staff in home two did not fully facilitate this practice, although they welcomed appropriate purchases by the family provided there was minimal interference to the running of the home. Although some residents could keep a little money they had to negotiate help from families if they wished to purchase anything, and staff did not help to make any purchases. For residents with no relatives, money matters were handled by the resident until their health deteriorated and a guardian would be appointed.

The data highlighted that the type of decisions families made were guided by the expressed needs of the resident. Families would react in the best interest of these residents, who were less able to express personal preferences and tended to fit in with the majority. Families were also found to support residents to cooperate with the home's decisions and arrangements.

Some found themselves trying to reduce residents' dissatisfaction when they were prohibited from doing things. In the course of incorporating residents' preferences and exploring the best option to address their needs, the data revealed that families and staff had to first agree and, if necessary, compromise their own expectations before deciding on the best action to take to meet the residents' interests. For example dealing with residents' concerns such as returning home for a few days and purchasing accessories highlighted that an agreement between families-staff could be negotiated based on the resident's capabilities and provided that it did not unduly disrupt the home's routines. Indeed, only a minority got to go home to stay during the weekends, with the majority perhaps going home for a few hours. For others, going home to stay a few days was never discussed for fear that the elder would refuse to come back.

### 3.3. Constrained patterns of decision-making

This decision-making pattern was found across all the homes to varying degrees, but largely dominated life in home three.

#### 3.3.1. Making the unknown familiar

Like the other two homes, home three shared similar practices in the way that information was provided to the residents and families during the early days of admission. Some staff believed that residents should be fully involved in decision-making. In reality, they tended to closely supervise elders and not allow them to take risks:

*When residents have health problems, will their decisions bring maximum benefit? It'll be difficult to ask them to make a correct decision. I'll consider the requests of those in good physical and psychological health. Why 'consider'? They might have done it in a certain way for many years, does it mean it's free of risk? Yes, we should respect them, but we should provide adequate supervision. (NSH, RN, S10).*

As in home two, a key message disseminated to residents and families was the need to comply with the routines that dominated communal living. The processes of 'being accompanied and supervised' rather than 'being told and observing' was more evident in this home. Although the other two homes used these processes to enable newly-admitted residents to know how to 'behave' in the new home, and to acquire knowledge about the routines, home three continued to use these processes from admission and thereafter to strictly supervise residents, allowing far less involvement in the decision-making processes.

Close surveillance was welcomed by residents whose reason for admission was to have staff around to call them for help. However, for many, the level of supervision went too far. For instance, getting up from a chair to fetch a cane to try walking to the toilet was immediately supervised by a staff, who sat them on the toilet, only to return to help as soon as they had finished. Indeed, residents generally understood that close surveillance by staff was part of their training and way of doing things:

*It's their responsibility. They are taught not to allow residents to walk alone. They hold my arms, hold my clothes and go into the toilet with me. (NSH, elder, E5A).*

Although the efforts of staff to get to know and listen to new residents were noted, generally residents soon learned to accept and conform to the norm:

*Care staff walk around to see if we are eating safely, and collect feedback about the meals. As the social care staff is responsible for the kitchen, she'll keep walking around the tables to see residents' eating condition – how much is eaten and tastes of foods. When they complain about the dry and tasteless meat, we explain that meals are healthier and low salt, of course, it's tasteless (laughs). (NSH, RN, S1).*

However, very little effort was made to get to know the residents as individuals and communication with families was limited and often superficial:

*I rarely speak to the staff. I seldom have any problems. When I come, I greet them. They do not tell me about his condition. They are not fussy. I do not expect them to tell me. I have nothing to say. What else is there to talk about? (NSH, wife, R1).*

Consequently, the process of settling-in at home three involved far less open exchange of information and was an instrumental process based on informing residents-families about what was expected of them, as opposed to exploring their needs.

### 3.3.2. Finding out what I can do and want

Unlike the other homes, the residents rarely undertook their own physical care as bathing alone was totally discouraged, even if they were capable. Only three residents engaged in some negotiations about baths after declaring a clear need:

*I bath myself. I can do it myself. I do not need to ask for help with bathing if I can do it. If I cannot do it, there's nothing I can do except to ask for help. If I can manage for myself, I do it on my own. I am safe. (NSH, elder, E7B).*

Another resident made a strong request to bath alone but this was not granted because she believed that her independent nature was a threat to staff authority. This elder stayed less than 2 months and left because she could not fit in with the home's expectations. The above excerpt highlights the resident's generally obliging attitude towards fitting in with the constraints of communal living and following the schedule. It seemed that only personal requests that had no impact on the home were considered:

*They cannot completely make their own decisions. If it's dinner time and they want to bath, this cannot happen. They need to follow our arrangements. What I can do is to meet their personal requests, if it's not over-exaggerated and is sensible, we let them have their way, like exercising and going to church. (NSH, health worker, S9).*

Another attempt made by residents to find out their own capabilities was in relation to developing relationships with residents and learning how to pass the day. Unlike home two which had many social activities to draw residents together, in-house group social activities in home three (e.g. bingo and beach ball games) were not particularly enjoyable. Whilst these activities helped to 'pass the time' they did not help to form any meaningful relationships. As opportunities to develop meaningful relationships were limited, residents valued any opportunities to engage in activities that would help them to pass the time and the more able residents did much to try and encourage more options. Other activities were more therapeutic and enabled

residents to either make the effort to keep in good health or to choose to maintain contacts with the outside community. There was a high enrolment in the few in-house exercise sessions available and many of the residents made a conscious decision to include physical therapy sessions into their week to stay in good health.

In the constrained atmosphere of home three, families initiated and supported residents in the rehabilitation process and helped them to realize the capabilities by arranging elders to attend additional physical/acupuncturist sessions and organized private transport to take them. Indeed involvement of the family, whilst valued in all the homes, was especially appreciated in home three. As families became well-aware of their duties to visit and take residents out for meals, the phone calls lessened as their visit became a weekend activity:

*She does not want a lot – only asks when we'll take her out to have meals and dim sum. It's reasonable. She's stuck in the home every day and has nothing to do. (NSH, son, R4).*

Regardless of their abilities, residents were strictly prohibited from going out alone and moving beyond the vision of staff. Some families found this reassuring:

*They have a door bell and the code to enter the home. I totally agree with this arrangement. If not, they'll escape from the home. (NSH, son, R4).*

However such regulations and the general attitude among staff to do things for residents made some feel useless and ashamed:

*I feel ashamed when others help me to wash my face and brush my teeth. I am not very old. One brings me into the toilet on a wheelchair. One twists a towel for me. One holds the mouth wash cup for me. I feel useless. Now, I can only pull a blanket over myself. (NSH, elder, E6A).*

### 3.3.3. Negotiating-compromising the past to fit the present

Only the able and articulate residents could engage in efforts to negotiate/comprise and even then opportunities were limited. Indeed, action was limited even when a group of them joined forces and raised shared concerns. This is described below and highlights something approaching a sense of relative helplessness in the face of limited action by staff and the absence of realistic alternatives:

*A naughty resident always disturbs us with a stick when we are sleeping. She does not sleep and walks around with her stick. She keeps the five of us awake by playing with the remote control that raises and lowers the beds. What can we do? I do not want to change rooms – what if there's another naughtier resident? Staff have done nothing, only told her not to disturb us. What can they do? This is an aged home. If we are healthy, we will not be here. (NSH, elder, E6A).*

Another issue that elicited suggestions from residents related to food choices. Some comments about what to eat were sought in a resident meeting, which enabled the few 'smart and well-spoken' residents the liberty to express their food preferences and tastes. But the existence of structures to seek views at this home did not mean that action followed and the need for safety and conformity seemed to prevail.

*Do you think they have the right to choose what they eat here? Meals are set in advance. They suggest food they cannot eat. It's only their desires. We think of safety, difficulties eating it, and can others eat it, too. (NSH, health worker, S2).*



The monthly resident meeting (with low attendance) was a regular activity bringing together superintendent, social worker, nurses and families. But these were largely symbolic rather than actively managed to ensure optimal attendance and a contribution from all. Over time, families learned to recognize and approach individual staff with whom residents had forged relationships on a one-to-one level to get updates about the resident's daily care. While staff believed that families must be told of the resident's current lifestyle and condition, there was a perception among staff that building relationships with families was difficult because they were very busy people with little time to spend wanting to know about the home. In fact, to the contrary, some families were highly interested in what went on at the home, and took the limited opportunities to interact with the staff:

*I want to know what's happening here and its development, whether it'll build 10 more floors or cut the manpower. There's no channel to converse with them. (NSH, son, R2).*

Generally families were in agreement that residents should make their own decisions with the families' role being to present opinions and offer different choices to them:

*You must rely on yourself and make your own decision. The decisions are still made by the elders. Apart from meal times, things like resting, getting up, brushing teeth and washing face can be decided by him. (NSH, wife, R1).*

Overall, and despite the obvious limitations, especially in home three it was felt that the resident should still be given choice to make decisions:

*He can make many decisions and do things for himself. It's just the physical functioning of his upper and lower limbs are degenerating. There's no problem with his ability to be reason and think logically. When you give him choices, he can still make a decision on what choice he wants. (NSH, son, R2).*

In reality, there were few opportunities for discretionary choice in home three and despite the constrained-rigid leadership style that enforced staff to regularly report the resident's progress to families blunders did occur that affected family-staff relationships and impacted the families' level of confidence in staffs' decision-making. Unlike the other two homes which were praised for providing families with reassurance, unsatisfactory blunders in handling the residents' health and medical concerns, including mismanagement of follow-up appointments and communication breakdown among staff, were beginning to surface at home three and resulted in families becoming dissatisfied. Misunderstanding often arose when messages about the resident's care were not always correctly conveyed. Moreover, as families were not formally informed about different staff members' roles, they formed their own perceptions of staff's job responsibilities that were not always correct. This could result in further confusion and misunderstanding.

#### **4. Discussion: decision-making processes and patterns of residents**

The findings generated served to provide an in-depth understanding of the decision-making experiences of older people residing in residential care homes in HK, and the roles and level of involvement family members and care providers in supporting them, or not, to meet their wishes and preferences. Based on the vivid accounts of experiences that were described by the participants, the patterns of decision-making in the homes were shaped by three processes



and six elements. This provided an understanding of how daily life decisions were made, from entry into the home to continuing to be involved in decision-making after becoming familiar with the homes. At the heart of the findings lies the extent to which residents were able to negotiate daily decisions in their life or whether they were required to compromise their needs and accept the routines of the home itself.

Across the homes the decision-making processes and related patterns of Chinese residents revealed the influence of staff and family members, as opposed to residents solely making autonomous decisions. This supports the definition of Circielli [17], who defined decision-making as 'a process where individuals ... make them (decisions) with others in dyads or groups' (p. 33). This was true for most of the residents in this study. Residents proceeded through three decision-making processes: 'making the unknown familiar', 'finding out what I can do and want', and 'negotiating-compromising the past to fit the present' to become familiar with the home first before becoming involved in daily life decisions.

'Making the unknown familiar' was the first process concerned with assisting residents and families to settle in by using strategies to accompany, supervise, tell and observe. It marks the process of learning from staff to become familiar with the routines, rules and policies of what was possible and allowed. While this provided limited opportunities for residents to participate in decision-making, it was important in laying the grounds for different decision-making patterns that developed when residents were engaged in later decision-making. Practices across the homes were in place to facilitate the processes of telling and observing the residents. Whilst they varied somewhat across the homes, these systems were intended to enable more staff to know about the residents' health condition, personality, preferences, and desires to be involved, and thereby begin to form judgments of the resident's decision-making ability and potential, and the degree of supervision/help to provide. These systems emphasized interaction with the residents to get to know their needs. However, especially in the early period discussion and information exchange tended to be brief and superficial as both staff and residents described the challenges of finding time to talk in the busy regime. Indeed rather than focusing on individual needs processes served to reinforce the importance of group living and forming reciprocal relationships with everyone to maintain harmony and cooperation. It was in this interaction that the balance between negotiation, partial and total compromise emerged. It was not surprising for residents, especially in home three and to a lesser in extent in home two, to perceive that decision-making was primarily made by staff and there was no longer a need to make major decisions now that they were institutionalized. As families were new to the setting, like the residents they had to settle in, and relied on staff to tell them the 'rules'.

There is relatively more literature concerning the process of 'making the unknown familiar' compared with the other two processes, with literature highlighting the need to ease the transition to a care home for newly-admitted residents [36–39]. These studies emphasize that the pressure and losses surrounding the move into the home should be offset by providing appropriate information and support to enable residents and families to play a full and active role in the life of the home. In easing the transition, O'May [38] mentions being able to 'maintain ownership of decisions about the future', although says little about what these decisions can

include. She suggests that residents and families should be involved in initiatives to consider the homes as a positive choice, such as facilitating trial visits. Clearly this did not happen in the present study.

Of some resonance to this current study, but taking a different approach to 'familiarity' is the work by Reed and Payton [40] which described 'constructing familiarity' as an active process undertaken by residents to adapt to the new home environment over a six-month period. Based on the sparse information that was usually obtained on arrival, residents were found to actively create their own knowledge of the home and focused their efforts on constructing relationships with fellow residents in order to make the home less strange. The authors suggest that 'constructing familiarity' is a potential useful strategy for dealing positively with a major disruption in a person's life; in this case, moving into the homes. The findings were limited to a consideration of residents' knowledge of the physical locality of the home and residents who lived there, with other aspects of adjustment to daily life such as physical needs not being considered. In contrast to this study, gaining familiarity in the homes was primarily concerned with an overall understanding of their daily operation and its influence on all aspects of the resident's life, from which residents could begin to examine their own decision-making potential.

Clearly 'familiarity' is a potentially important concept that needs more careful elucidation as to its meaning and how this unfolds over time. This study focused on the period immediately following admission up until 3 months. The process of gaining familiarity may, as already noted, begins before entry and continues beyond 3 months. The literature would suggest that familiarity is important in a time period varying from a few weeks prior to a move to up to 6 months post-move [41–42]. There are benefits in involving residents earlier and becoming familiar with the home before becoming a resident.

'Finding out what I can do and want' was the second process in exploring residents' capabilities, expectations, and preferences in making some decisions through the processes of 'trial and error testing' and 'asking and questioning'. The processes of trial and error marked the onset of negotiation. While residents were still settling into the home, negotiating and compromising did not feature in the earlier processes of 'observing', 'being told' and 'trial and error testing'. Therefore, the key processes of negotiating-compromising emerged when they began 'asking and questioning'. An interesting finding was that not all residents had expectations to make changes, but they all aspired to find out their capabilities and when would they be able to perform activities alone, and when supervised assistance was needed. This suggested that it was less important for residents to make decisions solely on their own, but rather by knowing the possibilities they could make a choice about whether to pursue independent action or to let staff do things for them. The main activities residents liked was the opportunity to perform alone or with minimal supervision related to physical care, and making personal possessions/purchases. Only when residents had a chance to trial an activity and were absolutely sure of their competence, would they consider proceeding to negotiate with staff. In situations when they were less competent to go it alone or did not think that they would be allowed to do so, they allowed staff to intervene and compromises were made. Little is known in the existing literature about how these negotiations occur and

the findings from this study have important implications for those involved in determining resident's decision-making abilities and potential following entry to residential care homes. These findings challenge beliefs from other studies in HK that all residents are willing to accept help from staff, and are happy being passive recipients of care, and to conform to the dependent role [43]. This perception is inconsistent with Confucian ethics and moral obligations to assist and take good care of chronically ill Chinese older people in old age [44–45]. This did not seem appropriate to many residents in this study. Indeed, only those residents in home three were seen to be less active in seeking to perform personal tasks and apparently wanted to be cared for. But this may primarily have been the result of their early learning about the strict 'regime' implemented in this home. An exploratory study by Low et al. [46] had already indicated that many Chinese residents were using their own efforts to support themselves in the homes. Yet, there is again a tension here between residents wanting to maintain privacy in their lives and the Chinese cultural belief in maintaining balance and harmony in relationships. Such findings shed new insights into the creation of social identity and acceptable behaviors for older people in care homes within a Chinese cultural context.

In understanding resident's decision-making potential and abilities, findings of this current study demonstrate the delicate processes of negotiation and compromise necessary in order to successfully 'negotiate-compromise the past to fit the present' so as to create a way of life that would be familiar and comfortable for the residents. The actions of the resident, family and staff enacted within the dominant pattern of decision-making in the home shaped the extent to which the resident's wishes were either accommodated or compromised. Residents challenged boundaries of the rules and policies of the home to enable them to make judgments about how much flexibility and control they could have over aspects of their lives. In many circumstances, efforts were abandoned as they complied with the prevailing practice of the home. This often followed a process of negotiating and compromising with their requests until an agreed decision was reached. Findings from this current study revealed that when homes operated a rigid-constrained regime, discussions and negotiations were minimal and after experiencing early failure no more efforts were made by the residents to suggest further changes to their lifestyle. This raises important questions about the extent to which residents can operate with a degree of independence or whether in reality the needs of the 'home' will largely always hold sway.

A number of studies have explored the experiences and well-being of the resilient older person who is relatively active in retaining their unique identity when faced with major threats in later life [47–50]. Among older people receiving long-term community care, Janssen et al. [49] identified sources of strengths to buffer against stressful situations. These are:

- Individual domain: refers to a person's qualities (e.g. beliefs about own competence, efforts to exert control, capacity to understand own situation),
- Interactional domain: refers to an older person's cooperation and interaction with others to achieve personal goals, and.
- Contextual domain: refers to political-societal level (e.g. accessibility to care and available material resources).

The first two domains are of particular relevance to residents in the homes as they capture the dynamic interaction between individual and interactional elements of negotiation/compromise found in this study. An important consideration is the implicit dilemma of when to hold on and retain control of the situation and when to relinquish that control to others. Paying sensitive attention to understanding an individual person's personal qualities and attributes may be necessary to help assess resilience capabilities and enable residents to continue maintaining a degree of independence [49]. Home staff could learn much from this.

Similar to the results from this study Cook [47] concludes that 'participants (are) engaged in deliberate decision-making and careful planning to influence their life in the home' (p. 271); for example, modifying their own space, and introducing personal items. Whilst continuing to participate in the daily life in care homes, she revealed how frail residents tried to actively reconstruct their life to do the things that were important to them in order to retain their unique identity to 'live meaningful, purposeful and enjoyable lives' (p. 270). In the process of reconstructing a new home life, they implemented three resident-led strategies:

- Resident-initiated/resident implemented strategies: the person identifies what is needed to influence their life and takes action to achieve them.
- Resident initiated/other executed strategies: the person identifies what needs to take place and seeks support from staff, family and friends.
- Resident negotiation to identify possibilities for living in the home and ways to achieve these: the person participates in decision-making processes such as care planning and resident committees with staff to influence their home life.

These strategies above resonate with the decision-making patterns emerging from this study but in the Hong Kong context there appeared to be more emphasis on the second set of strategies. Cook [47] mentions that residents may know their needs, but their influence in meeting them may be reduced, and therefore there is a reliance on others to help them to follow up on the negotiated issue or to compromise their decisions. Conversely, in situations where residents were less competent to go it alone, they allowed staff to intervene and compromises were made.

## 5. Conclusion

The wider literature on decision-making highlights the analytical deductive or the intuitive decision-making approaches to reaching decisions [51]. While the intuitive approach is a quicker, relies on non-analytical reasoning, and makes association with prior learning/memory of similar situations that is context based, the analytical deductive approach is in contrast slower, rule based, systematic logical thinking and context-free [52]. Findings of this study identified that daily lifestyle decisions were residents' main concerns and that in reality decisions involved a combination of both approaches. Residents have to learn the new 'context', compare it with similar experiences (usually often limited) as well as becoming familiar with the rules, both implicit and explicit operating in the homes. If things are to improve there is a need for far greater awareness among families and staff of the delicate processes at play. It

is to be hoped that this study has begun to provide just some insights for instigating future improvements in residential care homes for older people.

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## Conflict of interest

No conflicts of interest.

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