Residents’ rights and nurses’ ethics in the Australian nursing home

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Background
This article is derived from a more extensive review of literature for a qualitative study that explored the meaning of truth-telling within the care provider – aged resident dyad in high-level (nursing home) aged care.

Aim
This paper describes through the literature, work practices and the culture of the nursing home as promoting instrumental care, therefore prioritizing doing-for over being-with. The nursing home, starved of time and staff, silences and isolates the aged care resident in an environment that is, arguably, rarely homelike.

Conclusion
The appraisal of the nursing home offered here means that a number of residents’ rights are at risk and care providers (notably registered nurses and the personal care assistants) risk contravening the Code of Ethics for Nurses in Australia.

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Introduction

Describing the nature of caring becomes problematic because no two caring contexts are similar (Phillips 1993; Ray 1989). Leininger’s influential work proposes that care is cognitively learned and also culturally specific modes of helping. This suggests that care in one organizational culture, in this case high-level (nursing home) aged care, may contrast to the sense of care understood and practised elsewhere (Bevis 1988; Leininger 1988).

The aim of this article is twofold. First, relying on the literature, it analyses the work practices and culture of the nursing home, with some emphasis on Australian research. Second, it proposes that the appraisal of the nursing home offered here means that a number of residents’ rights are at risk. Care providers (registered nurses and the personal care assistants) also risk contravening the *Code of Ethics for Nurses in Australia* (Australian Nursing Council 2002; Commonwealth Department of Health and Aging 2002a).

Background

Aged care in Australia

At the Australian census in 2001, nearly 2.4 million people were aged 65 years or older (13% of the population). Projections suggest that there will be 5.05 million in 2031 and it is estimated that by 2050 there will be 6.6 million people (around 25% of the population) aged 65 years and over. Furthermore, longer life expectancy means that the numbers aged 80 years and over will double during the next two decades and triple over the next 50 years to comprise over 9% or 2.3 million people in 2051. Clearly, both current and future care of the elderly is an issue for the Australian public and all care providers.

There are approximately 3000 aged care homes in Australia providing some 144 100 places. In 2000/01, 25.9% residential places were operated by private service providers. On average the resident is 83.2 years old. About 64% of high-level (nursing home) care residents enter from hospital, 26% from low-level (hostel) care and 10% direct from the community. The average length of stay is 36 months with 35% staying less than 1 years and 22% staying more than 5 years. Finally, 60% of high level (nursing home) care residents have dementia (Commonwealth Department of Health and Aging 2002b, pp. 4, 7, 9, 28–30).

Method for literature selection

This article is not a report of findings. Rather, this article is derived from a more extensive review of literature for a qualitative study that explored the meaning of truth-telling within the care provider – aged resident dyad in high-level (nursing home) aged care (Tuckett 2004). The following electronic data bases were utilized: Cummulative Index to Nursing & Allied Health (CINAHL) 1982–2003; Medline 1966–2003; PsycINFO 1985–2003; Sociological Abstracts 1963–2003. Each data base was searched using the keywords or phrase: truth, truth-telling, truth disclosure, disclosure and deception. Additionally, data bases were searched with the terms elderly, gerontology, geriatrics, geriatric patients, geriatric nursing, geriatric assessment, aged care, elder care, nursing homes, homes for the aged and health services for the aged. Furthermore, the literature reviewed relied on snowball sampling in order to identify papers (Bliss & While 2003). Articles were selected based on their relevance and an ability to inform about truth-telling and aged care and were limited to those written in English but no date limits were imposed.

Thinking of 'home'

Australian aged care policy advocates care in a homelike environment (Clinton et al. 1996). Even so, Australian research in aged care communication recommends that the activities of older people when in their own residential or nursing homes needs to be determined in order to establish '"normative homely"' data to conclude what is appropriate (Edwards et al. 1993, p. 256).A European survey across the lifespan concluded that, generally speaking, the essence of feeling at home is 'a feeling of being connected to significant others, significant things, significant places, significant activities, oneself and transcendence' (Norberg 2001, p. 157).

The transition of the older person (resident-to-be) into the aged care facility (nursing home) has been discussed as 'rarely . . . a positive life transition' for the resident or the resident's family members (Nussbaum 1993, p. 238). Similarly, the observation of resident–staff interactions raises concerns about the notion of the 'homelike' environment (Edwards et al. 1993). With an emphasis on tasks (technical aspects of care) and a 'paucity of social and supportive care', the nursing home has been characterized as a 'mechanistic warehouse model of long-term care' (Armstrong-Esther et al. 1994, p. 271; Clinton et al. 1996, p. 17) and 'dormitories for those who are near death' (Don Hughes, a resident in Gubrium 1993; Nussbaum 1993, p. 245; Fiveash 1998).

An analysis of home as a place for the care of the aged is important since how the care recipient and care provider conceive of this concept impacts on how persons perceive of their roles and interpersonal relationships (Wilmot 1995, cited in Nussbaum *et al.* 2001). If the older person in a

nursing home, acknowledges him/ herself as a resident in his/her home, they might expect that staff define themselves as 'companions, quasi-servants or caretakers' with the care focus on comfort and support . . . in a warm and empathic style'. In contrast, when staff perceive of the institution as a 'status-marked setting in which the concern is for professionalism and distance', they may avoid personal relationships (Wood & Kroger 1993, p. 270). If the older person perceives of her/himself as a patient in a medical facility, it might be expected by her/him that staff define themselves as 'nurses . . . whose primary goal is the technical, medical treatment of the patient' with the care focus on formality, the impersonal and efficiency (Wood & Kroger 1993, p. 270). In contrast, staff may perceive of their task as the provision of the homelike environment. Residents in one study declared that the aged care facility feels like home (Martha Gilbert, a resident); like home but not home (Lula Burton, a resident); never home (Myrtle Johnson, a resident) or a prison (Bea Lindstrom, Don Hughes, residents in Gubrium 1993). The tensions between the differing orientations to the same care circumstance underscore the possibility for miscommunication.

A number of defining characteristics add to understanding the nursing home. The 'changing face' of residency describes an older person who is at the end stage of his/her life (or illness) and therefore occupying the 'home' for a much shorter time than previously (Queensland Industrial Relations Commission cited in The Queensland Nurse 2002, p. 10). Universally, care provision is task-orientated (McCormack 2003; Oliver & Redfern 1991). Task-orientated care is the provision of instrumental care rather than affective care, the provision of physical care rather than psychosocial or communicative aspects of care, with the aim to get the work done. That is, to do rather than to be (Armstrong-Esther *et al.* 1994; Clinton *et al.* 1996; Edwards *et al.* 1993; Reed & Bond 1991; Shaughnessey 1989; Yates *et al.* 1995). The majority of this care is performed by the less educated, often untrained, personal carer (Australian Nursing Journal 1998; Burgio *et al.* 1990; Mezey *et al.* 1999; Patterson 1995). As described by a personal carer

> we are giving production line nursing . . . don't have time to sit and hold hands when people are dying . . . It's line them up, toilet them, shower them, throw them in the dining room, give them their food, back to bed and that is their day (Linda, carer at De Paul Villa Nursing Home, The Queensland Nurse 2002, p. 8).

This understanding of 'production line' care resonates with the view that the nursing home is a 'question of eat, sleep, eat, sleep and play bingo . . . You do the same all the time' (Tom and Jane Malinger, husband and wife, residents in Gubrium 1993, p. 135; Lyytinen *et al.* 2002; Shawler *et al.* 2001).

In health care settings where the work practices and culture takes precedence over individual's needs, older persons 'passively accept' help as doing what is ordered of them and fitting into ward routines (Roe *et al.* 2001; Sheldon 1982, p. 404). Care recipients who are perceived not to want to be informed may understand that it is not their role as a 'good patient' to question the 'doctor (who) knows best' (Leydon *et al.* 2000).

Time and tasks

Additionally, this home away from home (Thorman Hartig 1998) as with other nursing care contexts, is time-starved (Armstrong-Esther *et al.* 1994; Fry 1988; Irurita 1999; QIRC, cited in The Queensland Nurse 2002). A qualitative study of nurses caring across general hospital wards highlighted nurses' 'frustration at the lack of time', resulting in only attending to the patients' physical needs (Forrest 1989, p. 820). In the USA, Harington *et al*. (1998, cited in Mezey *et al.* 1999, p. 46) calculated the average registered nurse time per resident in a 24-h period to be 30 min with a median time of 12 min or less. The researchers concluded this was because few registered nurses are employed in nursing homes and 'spend little or no time in direct care'. The primary researchers added that as such, the nursing home is an inadequate site for communication and decision-making. Residents in one nursing home study identified their facility as both short-staffed and time-starved (Jake Bellows, Martha Gilbert, residents in Bowers *et al.* 2001; Gubrium 1993).

As early as the mid-1970s research sought to determine the duration of time nurses actually spend with their patients. Wells (1975, cited in May 1990) determined in a study involving elderly patients that 4% of nurses' time was spent in interpersonal care on a geriatric ward and 50% of the interactions lasted 0.5 min or less. Similarly, in another elder patient sample, the mean duration of a nurse–patient encounter was reported at 4–6 min (Keck & Walther 1977), whilst student nurse–patient interactions averaged 2–3 min (Faulkner 1980).

Further research reported that the time nurses spent with the patient was limited. Complementing the finding that 95% of the time elder patients had no contact with nursing staff (Armstrong-Esther *et al.* 1989), a study that observed nursing staff–patient interactions with lucid, confused or demented elderly patients concluded that, outside the expected routines of care, there were very low levels of staff–patient interactions (Armstrong-Esther *et al.* 1994). The researchers reported that 'at no time during the observation periods did staff engage patients in social activities or prolonged informal conversations', suggesting 'it would appear that nurses make strangers of their patients who become silent observers of ward/unit routine' (Armstrong-Esther *et al.* 1994, pp. 264, 270; Lyytinen *et al.* 2002).

During an observational study of 12 fee-paying elderly residents in a privately operated nursing home, every resident said informal talking was very helpful. As a source for this, nursing staff were not mentioned. Residents' data revealed that because of limited time, nursing staff did not engage in chit-chat, though the researcher noted that their free time was spent at the nurses' station talking amongst themselves. It appeared in this study that the role of the nurse in providing instruction and information to the residents was of less significance than other care tasks (Patterson 1995). However, the significance of talking and listening in care encounters is the way in which the patient comes to be known (May 1995; Wallace & Appleton 1995).

'Home' alone

In the Australian context, nurses are equally too busy, short of time and short-staffed (Fiveash 1998; Legge 2004; Yates *et al.* 1995). Serghis (1998) reported that in Queensland, in some instances, 'one Registered Nurse was caring for between 60 and 120 residents' and that assistants in nursing and enrolled nurses were being required to 'care for 16 residents each, including having to toilet, bathe and assist with feeding, all in one eight hour shift'. In dementia care, staffing issues such as staffing numbers accounted for 26% of the most frequently cited stressors (Clinton *et al.* 1996). A number of personal carers' testimonies concur:

> Residents ought not have to hear 'no, we haven't got time' . . .
> We are working with one Registered Nurse (RN) and seven Assistants In Nursing (AIN) to 95 residents (Frank)
> We always tell the resident 'you come first' but how can we do that if we haven't got the hours? (Rosemary)
> We have three AINs in the morning, two on in the evening for half the night and one for the rest of the night, that averages out to 15 min per resident to toilet them every two hours and help them with their showers (Justin, carers at De Paul Villa Nursing Home, The Queensland Nurse 2002, pp. 8–9).

Observations of nurse–resident interactions in one study, reported that 64% of their observations were identified as procedural or instrumental, 11% involved some discussion about the resident's fears or worries and 33% of the interactions lasted less than 9.5 s (Edwards *et al.* 1993). Care providers acknowledge that 'on current staff levels there are residents that we can't even see in a shift' (Justin, carer at De Paul Villa Nursing Home, The Queensland Nurse 2002, p. 9). Researchers report residents acknowledging that staff do not listen (Yates *et al.* 1995), that the nursing home is a place where rules of conversation silence the resident (Kaakinen 1992), that it is an unnatural environment conditioning residents to live with strangers, rather than family (Bitzan 1998), a place where the resident's 'life is lived in slow motion with shuffling, pushing, pulling and sleeping (Higgins 1998, p. 860) and that it is "well known that . . . residents . . . can be isolated and have limited interpersonal relationships"' (Edwards *et al.* 1993, p. 247).

It seems therefore, that the nursing home – described as a 'mysterious and depressing place' and 'negative' (Mullins *et al.* 1998) does exist as a place which tends to create formal structures that minimize interactions (Nussbaum 1993, p. 238, 241).

Risking residents' rights and nurses' ethics

This evidence leads to speculation about the adequacy of communication in care provider–resident interactions (Clinton *et al.* 1996). Additionally, evidence of this kind enables researchers to question the 'quality of carer–resident communication when most interactions are instrumental in nature' (Edwards *et al.* 1993, p. 256). If residents and residents' families are going to build trusting relationships, the care providers need to get to know the residents and their families (Lynn-McHale & Deatrick 2000).

Stemming from the description of the nursing home proposed in this paper, it can be argued that care providers (notably the registered nurses and the personal care assistants) risk contravening at least six of the residents' rights as described in the *Charter of Residents' Rights and Responsibilities* (Commonwealth Department of Health and Aging 2002b) (see Table 1).

Table 1 Charter of residents' rights and responsibilities*

A. Each resident of a residential care service has the right:
- to quality care which is appropriate to his or her needs;
- to full information about his or her own state of health and about available treatments;
- to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
- to freedom of speech;
- to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, his or her financial affairs and possessions;
- to be consulted on, and to choose to have input into, decisions about living arrangements of the residential care service.

*Taken from the 20 residents' rights, Commonwealth Department of Health and Aging, Australia (2002a)

That is, the nursing home, as depicted here, cannot convincingly claim to be able to know or meet another's needs; cannot claim to be able or prepared to fully inform, via adequate talk, the residents in care; cannot claim to actively consult with or allow residents control over their care decisions nor provide anything like what one might, at least intuitively, consider to be a homelike environment.

Additionally, from the description of the nursing home presented in this paper, it can be argued that the care providers risk contravening three of the five value statements as described in the *Code of Ethics for Nurses in Australia* (Australian Nursing Council 2002) and elsewhere (International Council of Nurses 2000) (see Table 2). Within these statements are, respectively, four core values, namely, respect for persons (statement 1), autonomy and advocacy (statement 2) and care (statement 3) (Johnstone 2004; Sherman 1998; Wilmot 1995).

Table 2 Code of ethics for nurses in Australia*

Value statement 1	Nurses respect individuals' needs, values, culture and vulnerability in the provision of nursing care
Value statement 2	Nurses accept the rights of individuals to make informed choices in relation to their care
Value statement 3	Nurses promote and uphold the provision of quality nursing care for all people

*Taken from the five value statements, Code of Ethics for Nurses in Australia, Australian Nursing Council (2002)

Relying on Johnstone (2004, p. 168), respect for persons includes not only treating the residents as ends in themselves but 'affirming their *personal identity* as dignified human beings, that is, affirming of *who they are*' (original italics). Additionally, respecting the resident means care providers ought to act so as to promote the resident's autonomy. A widely held view in ethical discourse is that autonomy means self-determination of, and self-governance over, one's actions (Downie & Calman 1994; Ells 2001). A person is self-determining by choosing for themselves as well as by formulating and carrying out their life plan.

Advocacy means that care providers should represent and support the residents' best interests. Melia (1994) proposes that nurses, rather than other health care providers, are usually more constantly with the patient (or resident) and therefore have some insight into what life is like from the vantage point of the resident in care. However, she does underscore that 'this vantage point should not be overstated: *only* the patient *knows* the patient's views' (italics added, Melia 1994, p. 10).

As suggested in the introduction, whilst the concept of care remains problematic because no two caring contexts are similar (Phillips 1993; Ray 1989), it is difficult to accept that the nursing home environment depicted here is able to 'care' adequately. Furthermore, treating the resident as more than an object upon which some task is performed; affirming who a resident is; facilitating a resident's decision-making and therefore *really* knowing the resident's views can only be accomplished by ascertaining – through speaking with, and listening to – the resident's goals, hopes and dreams.

Work practices and a culture that prioritizes doing-for (instrumental care) over being-with (empathic engagement) cannot claim convincingly to be able to advance the needs and values of the residents in high-level (nursing home) aged care. The nursing home as described here is incompatible with studies that have confirmed the importance of nurse–resident communication for quality of life of nursing home residents (Edwards *et al.* 1993).

It is not in this world of work that fully informed choices – requiring time and telling, that is, the sharing of information – can be made. Quality nursing care ought to be understood as not only practical and technical skills but also

> attitudinal factors such as a health care provider's attitude towards patients as human beings with needs and interests, who are entitled to participate in decision-making concerning their care (Johnstone 2004, p. 133).

Finally, care providers cannot convincingly address the residents' needs, interests and entitlement for decision-making in a time-poor, task-orientated, socially isolating environment with consequent limited opportunity for interpersonal relationships (Nay 1998).

Conclusion

Universally, nurses should recognize that inherent in their role is treating all persons with respect – that is, advancing the needs, interests and values of those they care for. This claim remains true for care providers in the Australian nursing home. However, the reality of the nursing home described here, by way of reference to the literature, stands in contrast to the ideals defined by the *Charter of Residents Rights* and the *Code of Ethics for Nurses in Australia*. In essence, there is a dichotomy between the ideal and the real. In reality, the appraisal of the nursing home offered here means that a number of residents' rights are at risk and the registered nurses and the personal care assistants risk contravening the *Code of Ethics for Nurses in Australia*.

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References

Armstrong-Esther, C., *et al.* (1994) Elderly patients still clean and sitting quietly. *Journal of Advanced Nursing*, **19**, 264–271.

Armstrong-Esther, C., *et al.* (1989) Attitudes and behaviours of nurses towards elderly in an acute care setting. *Journal of Advanced Nursing*, **14**, 34–44.

Australian Nursing Council (2002) *Code of Ethics for Nurses in Australia*. ANC, Canberra.

Australian Nursing Journal (1998) Survey reveals aged-care crisis. *Australian Nursing Journal*, **6** (4), p. 6. Available at: ProQuest data base (accessed November 27 2002).

Bevis, E. (1988) Caring: a life force. In *Caring: an Essential Human Need: Proceedings of the Three National Caring Conferences*. Wayne (Leininger, M., ed.). State University Press, Detroit, Michigan, pp. 49–59.

Bitzan, J. (1998) Emotional bondedness and subjective well-being between nursing home roommates. *Journal of Gerontological Nursing*, **24** (9), 8–15. Available at: ProQuest database (accessed November 27 2002).

Bliss, J. & While, A. (2003) Decision making in palliative and continuing care in the community: an analysis of the published literature with reference to the context of UK care provision. *International Journal of Nursing Studies*, **40**, 881–888.

Bowers, B., et al. (2001) Care-as-service, care-as-relating, care-ascomfort: understanding nursing home residents' definitions of quality. *The Gerontologist*, **41** (4), 539–545. Available at: ProQuest data base (accessed May 16 2003).

Burgio, L., et al. (1990) A descriptive analysis of nursing home staff behaviours in a teaching nursing home: differences amongst NAs, LPNs and RNs. *Gerontologist*, **30**, 107–112.

Clinton, M., et al. (1996) *Report on Stress in Nurses Caring for Residents with Alzheimer's Disease in a Dementia Unit*. Centre for Mental Health Nursing Research, Queensland University of Technology, Brisbane.

Commonwealth Department of Health and Aging (2002a) *Charter of Residents' Rights and Responsibilities*. GoPrint, Canberra. Available at: http//http://www.health.gov.au/acc/rescare/index.htm (accessed June 25, 2002).

Commonwealth Department of Health and Aging (2002b) *Aged Care in Australia*. GoPrint, Canberra. Available at: http://www.health.gov.au/ acc/about'agedaust/agedaust.htm.

Downie, R. & Calman, K. (1994) *Healthy Respects: Ethics in Health Care*, 2nd edn. Oxford University Press, Oxford.

Edwards, H., et al. (1993) *Communication Between Residents and Nurses in a Dementia Facility: An Issue Quality of Life*. Paper presented at the Alzheimer Association (Australia) 3rd National Conference, 2–5th May. Hilton on the Park, Melbourne.

Ells, C. (2001) Lessons about autonomy from the experience of disability. *Social Theory and Practice*, **27** (4), 599–615.

Faulkner, A. (1980) Communication and the nurse. *Nursing Times*, **76**, 93–95.

Fiveash, B. (1998) The experience of nursing home life. *International Journal of Nursing Practice*, **4**, 166–174.

Forrest, D. (1989) The experience of caring. *Journal of Advanced Nursing*, **14**, 815–823.

Fry, S. (1988) The ethic of caring: can it survive nursing. *Nursing Outlook*, **36**, 48.

Gubrium, J. (1993) *Speaking of Life: the Horizons of Meaning for Nursing Home Residents*. Aldine de Gruyter, New York.

Higgins, I. (1998) Reflections on conducting qualitative research with elderly people. *Qualitative Health Research*, **8** (6), 858–866.

International Council of Nurses (2000) *The ICN Code of Ethics for Nurses*. ICN, Geneva.

Irurita, V. (1999) Factors affecting the quality of nursing care: the patient's perspective. *International Journal of Nursing Practice*, **5**, 86–94.

Johnstone, M.-J. (2004) *Bioethics: A Nursing Perspective*, 4th edn. Churchill Livingstone, Sydney.

Kaakinen, J. (1992) Living with silence. *Gerontologist*, **32**, 258–264.

Keck, V. & Walther, L. (1977) Nurses encounters with dying and non-dying patients. *Nursing Research*, **26**, 465–469.

Legge, K. (2004) Nursing home staff numbers are 'dangerously' inadequate. *The Australian*, **August 12**, 4.

Leininger, M., ed. (1988) *Caring: An Essential Human Need: Proceedings of the Three National Caring Conferences*. Wayne. State University Press, Detroit, Michigan.

Leydon, G., et al. (2000) Cancer patients' information needs and information seeking behaviours: in depth interview study. *British Medical Journal*, **320** (7239), 909–913. Available at: ProQuest database (accessed November 22, 2002).

Lynn-McHale, D. & Deatrick, J. (2000) Trust between family and health care providers. *Journal of Family Nursing*, **6** (3), 210–230.

Lyytinen, H., et al. (2002) Older patients' first 72 hours in hospital. *International Journal of Nursing Practice*, **8**, 191–197.

McCormack, B. (2003) A conceptual framework for person-centred practice with older people. *International Journal of Nursing Practice*, **9**, 202–209.

May, C. (1990) Research on nurse-patient relationships: problems of theory, problems of practice. *Journal of Advanced Nursing*, **15**, 307–315.

May, C. (1995) To call it work somehow demeans it: the social construction of talk in the care of terminally ill patients. *Journal of Advanced Nursing*, **22** (3), 556–561. Available at: ProQuest database (accessed November 27, 2002).

Melia, K. (1994) The task of nursing ethics. *Journal of Medical Ethics*, **20**, 7–11.

Mezey, M., et al. (1999) Caring for caregivers of frail elders at the end of life. *Generations*, **Spring**, 44–51.

Mullins, L., et al. (1998) An examination of nursing home personnel's perceptions of residents' autonomy. *Journal of Applied Gerontology*, **17** (4), 442–461. Available at: ProQuest data base (accessed November 27, 2002).

Nay, R. (1998) Contradictions between perceptions and practices of caring in long-term care of elderly. *Journal of Clinical Nursing*, **7** (5), 401–408.

Norberg, A. (2001) Communication in the care of people with severe dementia. In *Aging, Communication and Health: Linking Research and Practice for Successful Aging*. (Hummert, M. & Nussbaum, J., eds). Lawrence Erlbaum Associates, Mahwah, NJ, pp. 157–173.

Nussbaum, J. (1993) The communicative impact of institutionalisation for the elderly: the admission process. *Journal of Aging Studies*, **7** (3), 237–246.

Nussbaum, J., et al. (2001) The older patient-healthcare provider relationship in a managed-care environment. In *Aging, Communication and Health: Linking Research and Practice for Successful Aging*. (Hummert, M. & Nussbaum, J., eds). Lawrence Erlbaum Associates, Mahwah, NJ, pp. 23–42.

Oliver, S. & Redfern, S. (1991) Interpersonal communication between nurses and elderly patients: refinement of an observation schedule. *Journal of Advanced Nursing*, **16**, 30–38.

Patterson, B. (1995) The process of social support: adjusting to life in a nursing home. *Journal of Advanced Nursing*, **2** (1), 682–689.

Phillips, P. (1993) A deconstruction of caring. *Journal of Advanced Nursing*, **18**, 1554–1558.

Ray, M. (1989) The theory of bureaucratic caring for nursing practice in the organisational culture. *Nursing Administration Quarterly*, **13**, 31–42.

Reed, J. & Bond, S. (1991) Nurses' assessment of elderly patients in hospital. *International Journal of Nursing Studies*, **28** (11), 55–64.

Roe, B., et al. (2001) Elders' perceptions of formal and informal care: aspects of getting and receiving help for their ADLs. *Journal of Clinical Nursing*, **10**, 398–405.

Serghis, D. (1998) QNU survey uncovers aged-care woes. *Australian Nursing Journal*, **6** (5), p. 7. Available at: ProQuest data base (accessed November 27 2002).

Shaughnessey, P. (1989) Quality of nursing home care. *Generations*, **13**, 17–20.

Shawler, C., et al. (2001) Analysis of key decision-making incidents in the life of a nursing home resident. *The Gerontologist*, **41** (5), 612–622. Available at: ProQuest data base (accessed May 16 2003).

Sheldon, M. (1982) Truth telling in medicine. *Journal of the American Medical Association*, **247** (5), 651–654.

Sherman, T. (1998) Public sector ethics: prospects and challenges. In *Public Sector Ethics: Finding and Implementing Values*. (Sampford, C., Preston, N. & Bois, C.-A., eds). Routledge, London, pp. 13–25. 5 1999).

The Queensland Nurse. (2002) New classification structure and rates of pay for nurses in aged-care. Report on findings of the Queensland Industrial Relations Commission (QIRC). *Queensland Nurse*, **21** (2), 9–11.

Thorman Hartig, M. (1998) Expert nursing assistant care activities. *Western Journal of Nursing Research*, **20** (5), 684–601.Available at: ProQuest database (accessed November 11 2002).

Tuckett, A. (2004) Truth-telling in clinical practice and the reasons for and against – a review of the literature. *Nursing Ethics*, **11** (5), 500–513.

Wallace, C. & Appleton, C. (1995) Nursing as the promotion of wellbeing: the client's experience. *Journal of Advanced Nursing*, **22** (2), 285–289.

Wilmot, S. (1995) Professional values and interprofessional dialogue. *Journal of Interprofessional Care*, **9** (3), 257–266.

Wood, L. & Kroger, R. (1993) Forms of address: discourse and aging. *Journal of Aging Studies*, **7** (3), 263–277.

Yates, P., et al. (1995) Pain: the views of elderly people living in long-term residential care settings. *Journal of Advanced Nursing*, **21** (4), 667–674. Available at: CINAHL database (accessed March 2