

TRANSITION INTO CARE:
EXPERIENCES OF THE ELDERLY AS THEY MOVE TO RESIDENTIAL AGED CARE

Roz McKechnie,¹ Chrystal Jaye,² Beatrice Hale,³ June Tordoff,⁴
Linda Robertson,⁵ Jean Simpson⁶ & Mary Butler⁷

ABSTRACT

A move to residential care represents a significant transition for older people, between their former independent and autonomous lives, and dependence, frailty and death. The concept of transition is valuable in considering the quality of care. We argue that a successful transition to residential care is one measure of quality in care. We used an ethnographic approach that emphasises participant-observation and qualitative interviewing. Analysis of the transcripts revealed several themes, one of which, transition, is discussed in this paper. Transition theory, along with the concept of liminality, i.e. the betwixt and between status of the mostly unanticipated move from home to Residential Aged Care Facilities identifies and explains the complexities involved in the move into residential care for older people and their families.

Keywords: aged residential care; transition; liminality; quality

INTRODUCTION

In 2012, we conducted a small research project to explore staff and residents' concepts of quality care in two Residential Aged Care Facilities (RACF). This project developed from our attention to media reports in the late 2000s and early 2010s on failures of care in some New Zealand residential aged care facilities (see for example, Blundell 2013; *Marlborough Express* 2010a, b; *New Zealand Herald* 2009, 2010).⁸ A recent report from the Health and Disability Commissioner (Davidson, Elkin, and Carey 2016) documented 514 investigated complaints about care received in New Zealand residential aged care facilities between 2010 and 2014, and indicated that around 100 such complaints are received each year (p.1). Around the time we planned this project, several reports on the direction of ageing in the New Zealand context were in circulation

within the aged care sector and policy space. These included the Ministry of Health's *The Health of Older People Strategy* (2002), which highlighted health promotion, disease and injury prevention, and timely, equitable access to health and disability support services, including residential care.⁹ The need to meet anticipated increased demand for residential aged care services, including built facilities and workforce, developing regulatory frameworks to ensure quality care, exploring alternative models of care, and the cost of residential aged care were highlighted in subsequent documents including the Labour and Green Parties' 2010 *Report on Aged Care: What does the Future hold for Older New Zealanders*, the New Zealand Aged Care Association's 2011 *The Future of Aged Care*, and Grant Thornton NZ Ltd's 2010 *Aged Residential Care Service Review*.

In answering questions about the characteristics of quality care, residents, staff and managers made frequent and explicit connections between residents' former independent lives in their own homes and the adjustment to institutionalised care. We have presented our key findings on what quality care looks like for staff and residents elsewhere (Jaye *et al.* 2016). As we analysed and discussed our data, our attention was also drawn to a component of quality care that encompassed the process by which new residents come to feel 'at home' in their RACF (Jaye *et al.* 2015). In this article, we complement our previous analysis by focusing on transitions to residential aged care, using transition theory (Hofmeister 2002; Meleis *et al.* 2000) and the concept of liminality (Turner 1990; van Gennep 1960) as a basis for understanding the experience of moving into such care for older people.

In New Zealand, older people can choose to move into transitional facilities such as retirement villages – a move that usually requires significant financial investment. However, most older people move to residential aged care facilities through the gatekeeping of needs assessment services (Ministry of Health 2015). This frequently occurs following a sudden trauma such as a fall and is not always of the older individual's choosing. The transition from an independent life to the RACF is a passage experienced by many older people given that nearly 32,000 people resided in residential aged care facilities in 2013 (Statistics New Zealand 2015). Although the transition into residential aged care can be a positive one for many, it is also a disruptive experience in an individual's biography and often accompanied by stress, fear, grief and bewilderment (Lagacé *et al.* 2012; Lee, Simpson, and Froggatt 2013; Pirhonen and Pietila 2015). One consequence of moving into care is an increased risk of social isolation (Pirhonen, Tiilikainen, and Pietila 2017). The majority of people in RACF at the time of the 2013 census had resided there for less than five years (Statistics New Zealand 2015), and this is strongly suggestive of the liminality associated with

aged residential care – a place that occupies the space between an independent autonomous life, and death.¹⁰

THEORETICAL FRAMEWORK

Transition and liminality

Liminality as a theoretical framework was developed to explain what is accomplished through ritualised lifestage transitions; van Gennep (1960) identified three stages characterised by separation, liminality and emergence that marked the transition of the individual into a new social identity. During this passage, ambiguity characterises the social status of people as they pass from one social position to another, often with passive behaviour, accepting and obeying instructions, as a way of seeking understanding of the new situation (Turner 1969). Turner noted that while in this liminal space, individuals tend to develop a comradeship with those sharing the experience, which he termed ‘*communitas*’.

Liminality offered us an obvious lens through which to consider the transition of older individuals into residential aged care. Having been independent and autonomous, notably living in one’s own home according to one’s own routines, the individual becomes separated from their former social self and emerges with a new identity. This can mean becoming resigned, accustomed to, or adapting to life within the institutional RACF.

The main focus in previous studies of transitions of older people into and within care settings has been on the movement from one site of care to another, from home to hospital (Hirst 2002), to residential care (Shield 1997), between facilities within residential care (Diamond 1992), and into assisted living (Frank 2002). A more recent exploration of transition is that of Hale, Barrett and Gauld (2010) who recognised the liminal processes in accepting care at home, and acknowledging the move from independence to partial dependence.

Transitions between time and places are spaces of intense alteration where an individual’s social relationships and connections to localities and specific sites are fractured and in which uncertainty and disorder reside (Hofmeister 2002, 105; Hogue 2006, 5). This is reminiscent of Goffman’s (1961) description of total institutions (which specifically included RACF (p.313)) as ‘forcing houses’ that have an express purpose of altering selves (p.316). Upon entry to such institutions, the individual is stripped of the identities, attachments and supports of their previous life.

Because of the indeterminate nature of transitions, they can become disordered economic, sociocultural and ecological spaces (Parr 2003). Understanding the passage or movement into care requires identifying spaces which are not always mapped onto geographical places, examining what is occurring in these spaces, and teasing out the relationships between those who inhabit these spaces. Liminal spaces may extend beyond liminal places in terms of geographical and temporal boundaries, and the three clear demarcations of ritualised lifestage transitions described by van Gennep (1960) may be more opaque – or even unresolved. Purves and Suto (2004), for example, argued that patients in a discharge-planning unit waiting for placement in residential care could leave the liminal *place* of the unit, but could not escape the liminal *space* of biographical disruption because they were never likely to return to their homes and their former lives (p.180).

Moving from one liminal space to another can be tainted by past experiences and fear of the unknown (Hurlock *et al.* 2008). Purves and Suto (2004) noted that individuals inhabiting liminal spaces generate meanings about their experiences. Similarly, Jeyaraj (2004) found that new forms of knowledge emerge from those (technical writers in this case) transitioning between different communities and socio-cultural fields. This is relevant to the experiences of older people who move into RACF who are dealing with the loss of their familiar lives and the challenges of an unknown future.

As these authors exemplify, transition theory teases out the elements of change – particularly relevant to the experience of a major illness or disability that might initiate a series of changes, moving people from one identity to another. Meleis *et al.* (2000) described this as complex, with such changes affecting a person's life in a multidimensional way. This includes what are described as essential properties of transition experiences such as awareness, engagement, change and difference, timespan, critical points and events. 'Transitions are both a result of and result in change in lives, health, relationships, and environments' (p.13) during which time individuals are vulnerable. To recall van Gennep's (1960) observations, transition processes included emotions of anxiety, uncertainty and bewilderment – often ameliorated by a guide who eases the individual's passage through this 'in-between' stage with its unsettled social status and suspension of normal social contact. Our own previous research has indicated that successful adaption to life in the residential aged care facility was frequently facilitated by RACF staff assisting the new resident to feel at home in their new circumstances (Jaye *et al.* 2015).

METHOD

The project was informed by a social constructionist orientation previously used in ethnographic work in aged residential care in the United States (see for example, Diamond 1992; Gubrium 1997) and in New Zealand (Kiata-Holland 2010). This perspective holds that normative societal values around ageing, age-related disability, and aged care both reflect and produce discourses within the aged care sector and broader society. In New Zealand, the majority of residents in RACF are *Pākehā*¹¹, while staff and careworkers are more ethnically diverse (Kiata and Kerse 2004; Statistics New Zealand 2015). One strong normative discourse in the New Zealand context is the acceptability of residential aged care as a final chapter in the *Pākehā* individual's biography. While around five per cent of people aged sixty-five and over live in residential care at any point in time, overseas data suggests that between twenty-five and thirty per cent of people aged sixty-five and over can expect to live in aged residential care facilities before they die (Ministry of Health 2002, 4).

Residential aged care facilities in New Zealand can be distinguished by operational characteristics and by the level of care offered. Operational characteristics include the number of beds (over or under thirty which has a bearing on the operational complexity of the facility), whether the facility is part of a larger national or international chain or is independent, and whether the facility is run for profit. These variables were included in the research protocol in order to identify discernible differences between the experiences of residents, family members and the staff who manage and work in these facilities. Facilities can also be distinguished by the level of specialised care offered; rest home, long stay hospital, dementia and psycho-geriatric (Ministry of Health 2018).

Participating RACF

Two facilities were involved in this research project, A1, and A2. After meetings were held with managers in both RACF to explain the purpose of the research, access was granted to both facilities for the research team. The first facility [A1] was part of a large national not-for-profit organisation. This was a large residential facility with 135 beds, which included hospital level dementia and acute wards, and over 100 staff. The other facility [A2] was a small family owned and run-for-profit facility with twenty-nine beds, fifteen staff members, and no hospital level care. The current audit system does impose a degree of homogeneity upon facilities through the Health and Disability standards against which it evaluates compliance. While we cannot claim that the latter facility was fully representative of other small residential aged care facilities in NZ, the

former almost certainly was representative of larger facilities, regulated by and compliant with its national parent organisation.

A1 is spatially complex with a number of different care areas, including semi-independent units, hospital level care and specialised dementia care. The facility also hosts a day centre for elderly who live in the community. It has a separate activities room (with staff) as well as a small library. Although there are communal spaces, few people are to be seen walking around, or sitting in the lounges, although mealtimes draw many out of their rooms. These rooms consist in one wing of several self-contained units with a bedroom, lounge, kitchenette and bathroom, so residents tend to spend their time there rather than in the communal areas. Other wings have bed-sitting rooms, each with a comfortable chair, often from the resident's own home. Family photographs, familiar and special ornaments are often prominently displayed. Pets are important here; there was at least one dog and several cats. The overall effect is one of space, peace and attention to privacy. Staff ensure their accessibility by taking coffee breaks in the communal lounges, and when not in evidence there, a staff member can usually be found in the reception office at the entrance of each unit.

A2 is located on a busy road in a densely populated city suburb. Architecturally, it belongs to the same era as A1, but it has not been custom-built as was A1. Instead, it is set among a row of suburban houses. The rooms are single bedrooms, only a few with en-suites, and so residents tend to use the communal areas more. As with A1, there is an unhurried pace. There are two communal spaces (a large living/dining room and a TV lounge) occupied by residents and staff alike. Again, ensuring accessibility, staff take coffee breaks in the living room with residents. The interior is sensually rich with art, floral arrangements and bric-a-brac displays. The administration offices are upstairs in the smallest and most out of the way rooms. The reception area is unmanned although staff are not hard to find. This RACF has a strong family atmosphere because it is owned and run by three related couples. Household activities are very much in evidence. There is a courtyard and garden borders which display favourite plants brought to the rest home by new residents from their own gardens. At the time of this study, the outside area was being remodelled so that residents could be enticed to spend more time outside in the fresh air.

Data collection

Data collection methods had to be flexible to fit with the purpose of the care facilities and their staff and not to interrupt care. Such flexibility fitted well

with the chosen methods of participant-observation and individual and group interviewing. Over a four-week period, two teams comprising MB and RM in one team, CJ and BH in the other, spent several hours conducting participant observation within each rest home. These pairs swapped field sites after approximately twelve hours of participant observation. This team crossover provided triangulation for observations. Participant observation meant exploring the layout and movement of people in each facility, 'hanging out', helping with household chores such as making beds, engaging in informal conversations with staff and residents (both in private rooms and common areas), and identifying people to interview. Thirteen formal interviews were also conducted with twenty-one people. All were face-to-face interviews except for one interview with an auditor conducted by telephone. A variety of interview strategies were used to accommodate the capacity of each rest home to release staff, and to be flexible. To this end, three group interviews were conducted with the management team at A2, and with care workers at both homes. The Registered Nurses who supervise care work in each facility, the acting Manager at A1, and an auditor were interviewed individually.

Interview strategies were developed for residents and their nominated family member(s); this resulted in three dyadic interviews being conducted with two residents and their daughters in A2, and the family (son and daughter in law) of one resident from A1. The other two residents and one daughter in A1 were interviewed individually and separately to their family members. Family members who were interviewed separately from their parent appeared to be more candid in their responses than those interviewed with their elderly parent present. Ethnographic field-notes based on participant-observation augmented the interview data.

Managers and RNs in both facilities appeared to be in the forty to sixty year age group. Care workers tended to be in the twenty-five to forty-five year age group. Residents were all over eighty years of age, and their nominated family members were in their late forties to mid-sixties. All residents and family members were *Pākehā*, as were the RNs. The care workers appeared to be more ethnically diverse.

During the data collection phase, weekly meetings of the research team explored emergent themes arising from field notes and interview transcripts. As part of this process, all field notes and interview transcripts were then analysed individually by all members of the research team, each of whom took responsibility for exploring one emergent theme; such as the transition to RACF life which forms the basis of this article. We used an immersion/crystallisation

analytical approach to examine our interview data with the assistance of the qualitative data analysis software Atlas.ti.

The research team represented a variety of disciplines: anthropology, social work, nursing, occupational therapy, public health and pharmacy, thus giving a wide angled and multi-disciplinary approach. In addition, several members of the team had already worked closely with older people in independent and assisted living in the community and in residential care facilities, providing a breadth of knowledge that united practice and theory. All had experienced family members transitioning into aged residential care, and had also observed changes in provision of care for the elderly from the historically negative view of ‘rest homes’ to the proliferation of home care, retirement villages and more transitional facilities which include self-contained serviced units through to full hospital care within the same building. Ethical approval to conduct the study was gained from the University of Otago Human Ethics Committee.

RESULTS

An individual’s passage into a care facility marks an intense period of relational, spatial and temporal transition. We discuss each of these transitions in turn.

Relational transitions

An impending transition to residential care for residential participants in our study was predicated by one of two pathways. The first pathway involved hospitalisation following a fall at home, while the second pathway was frequently signalled by decreasing mobility and functional ability to navigate the basic daily tasks of self-care in their own home, and increased reliance on adult children who more closely monitored their parent and took over responsibility for chores such as banking, shopping, and paying bills.

This second pathway was often accompanied by reliance on social agencies to provide cleaning and care services. This situation is indicative of supported independence (Hale, Barrett, and Gauld 2010) – a life stage associated with changing care needs of the older person. Supported independence involved changes in responsibility and authority so that the adult child assumed a parenting and protective role, where this was permitted by the older individual. Supporting the independence of their older family member was time consuming for family members and it was during this period that they became increasingly concerned about their parent’s safety, security, nutrition and isolation. One family member reported:

She didn't have the security, she wasn't as secure and then her – she wasn't feeding herself properly in the end, the anxiety was too strong. Even though as a family we all had a day and made sure that she was eating, but if you popped in at a different time you would find, like we used to do Sunday night on purpose and she would just be making a piece of toast whereas she had just come out of hospital and she was supposed to be having good meals.

The passage into residential care was a significant move, whether the older person moved from hospital or supported independence to residential care. Families were usually involved in the decision, being supportive and careful to respect their parent's autonomy. One resident reflected on this, saying, 'I came here from hospital and there was a family meeting and a discussion, and it was decided I should come here which made me very happy. I have got a lovely room – sunny' (Resident). Another resident's daughter acknowledged her mother's ability to make her own decisions, 'She said, "I don't want to go home". She said it, nobody in the family said, "Mum do you think it is time?" She said, "I don't want to go home", so she had made that decision like that there'. Another female resident indicated her willingness to relinquish responsibility, independence and autonomy to her daughters in the transition from home to care, by saying: 'The girls, they packed up everything, got rid of everything for me. I like my wee room [in the RACF], I like out here, I love looking at the birds, all the things I had sort of gathered over the years and that'.

Other relational changes involved interactions with a variety of different health professionals, including the needs assessors who established eligibility for formal care. The assessment experience can give rise to a variety of emotions: concern, anxiety, embarrassment, humiliation and anger. It involves admitting prying strangers into one's home and represents a threatening experience because of its potential to change one's life (Janlov *et al.* 2006). Fears such as 'losing self-determination and control over daily life' (p.333) mean facing the possibilities of becoming more helpless and vulnerable. Several participants reflected these views, such as one resident who remarked, 'I like working around the house and in the garden and everything but by the time I came here I couldn't seem to do all that. I did have home help for a wee while, but I really like doing the work myself'.

The assessment process for residential care in New Zealand constructs old age in ways similar to those described in the Swedish context by Olaison and Cedersund (2006), where the assessed individual becomes the subject of aged care discourses including the older person as frail and vulnerable, or the ra-

tioning of residential aged care. The assessment process clarifies the pathways into aged care (one of which is the inability to perform the normal activities of daily life), in the process offering older adults new identities associated with disability, frailty and vulnerability. This process constructs normative standards of self-care expected of competent autonomous adults living independently, by establishing that the elderly person is failing to meet these.

Once in residence, the new RACF resident makes connections with others such as care staff, activities staff, the manager of the care home and other residents, all of whom act as guides to move the individual through the liminal phases of connection and renewal. In discussing the move, one resident, while recalling the past, identified her reconnected state:

Don't get me wrong, I am not trying to give the impression that I want to go back there [to my own home], I know I can't just now, so therefore I am very contented here. I have made some beautiful friends, both the staff and the residents.

In another instance of this easing the passage into residential care, the researcher had noted a sign on the door of one female resident, and learned during a subsequent interview with her daughter that she had alerted the manager to the vulnerability of her mother who had hearing and visual impairments. The sign asked people to clearly identify themselves before they entered the room – a strategy that helped this resident to retain a sense of privacy and security as she got used to her new environment.

She doesn't know if people are looking at her and talking to her which is difficult of course, hence the sign on the door. I made them put that up a few weeks ago. Some of the girls pop in and say, "Hi [name], its Chris here – I'm bringing your laundry back", "Hi [name], its Chris – I am bringing your milo". Some of them come in and say nothing and if you can't see, that's a bit creepy to have somebody [in your room]. (Family member)

These relational transitions reflect Jackson's (2005) work on the 'othering' of people who inhabit liminal space, who become liminal subjects moving around in an ambiguous way on the margins, temporarily out of place because they are seen to be attacking the natural order of things. The majority of people in RACF have been resident for less than five years (Statistics New Zealand 2015) and this reinforces their liminal status – they are passing through aged care residential facilities on their trajectory towards death. Residents are frequently

moved between different areas in a facility as they continue to decline – often from a larger unit to a smaller room, or from the rest home to the hospital or dementia ward. If their rest home does not have hospital-level care (like A2), they may be transferred to another facility that does. Residents, family members and staff find this additional displacement stressful.

Even the ones that have been here a long time, if they do become sick, we have to shift them out of here [to the hospital] and I really, really struggle with that. They don't like it. Their families don't like it. I hate it when we have got to move them on and I just wish sometimes that there could be a better way of managing that too. We have to shift them on because we don't have the staffing levels to cope once they become ill. (Staff member, A1)

The inevitable transience of residents can be emotionally unsettling for staff and other residents (Jaye *et al.* 2015). However, the way that compassionate care can assist the settling process is potently illustrated in the following excerpt where a resident reflects on the kindness she received from a staff member when she was in a liminal position as a new resident.

I remember one night being taken ill and being taken to the hospital and she [Nurse] ... reminded me of how my mother always treated us. It was the look on her face and the tone of her voice. She was so compassionate and so caring ... I was quite surprised because I was fairly new here then and quite a stranger really. (Resident)

Spatial transitions

A second form of liminality – spatial transitions – begins with the space inhabited by the body (Hale, Barrett, and Gauld 2010). For example, in this instance a family member refers to the place where the older person lives, and to the upheaval associated with moving from a family house to a small room within an institution: 'She had been in hospital for three weeks and she had had little periods in hospital prior to that, you know a week here, a couple of weeks there, but yes, it would be a huge upheaval to go from a house with rooms and a big section to one room.'

This move offers a rich text for spatial analysis of an autobiographical life: what to take from home to furnish this one room? What furniture is already there? Which is the favourite and most comfortable chair, and perhaps small table? What to put on the walls in order to retain memories through photographs and

special ornaments? The decision around what to keep and display signifies the past and the personality of the individual.

Where residents were accustomed to regular shifts of habitation, the anxiety associated with spatial liminality was decreased as possessions were regularly reviewed pending each move.

You are used to moving from one place to another although it is a worry still, I don't think it would be as bad for a person who has done that as to a person who has never moved in their whole life and then they have got to move, I think it would be tougher for them.
(Resident)

The shift to the RACF meant that the care of residents' bodies became the work of others. Residents found that privacy and solitude were compromised because their room was also the space where carers perform 'cares' on residents' bodies. One resident commented that adjusting to a new life in the RACF involved, 'Getting used to having people in your space when you are not used to that'. However, perceiving this care space in medical terms, and calling carers 'nurse' made this more acceptable for some residents.

Even if it is just the nurses – well we call them nurses, the carers, it is just having people do things for you when you are not used to that. I mean mother was used to me doing stuff and that's different, your own is different, but when you are in here and somebody is showering you or washing you or that sort of thing. (Resident)

Participants indicated that receiving care from carers in the context of the RACF was less problematic to their older relative than receiving care from adult children in the adult child's home. This perhaps indicates the fact that they pay (either entirely through a government subsidy, or a combination of government subsidy and personal contribution) for their room and care in the RACF so are more willing to accept care as a service. One family member recognised the burden of care that might have occurred if their relative had gone into a family member's home by saying: 'It's the best thing for her because if she had gone in to someone's home ... she would have been always saying, "I don't want to put you out, I don't want to be a burden", and that would then cause friction.'

In bodily terms, the intimate intrusions associated with care were difficult for some residents to accept. Hale, Barrett, and Gauld (2010) reported similar findings: being seen naked in the shower, or helped on the toilet, helped to dress

and undress, helped with prostheses. The following excerpt from the present study describes how carers accommodated an older man's discomfort with the compromised privacy and dignity that resulted from his care needs.

Being a single gentleman and never having had a female go anywhere near him in the bath(room), that was always a very private ... So we do have a man on the staff which is great ... Yes, we could get him to (let us) go in to set it up and get him under the shower and then leave so there was none of this hanging around looking. (Registered nurse)

Moving away from one's home-town to an RACF in another region – quite common in rural New Zealand – added another level of complexity to spatial liminality. This transition required leaving familiar landmarks and one's emplaced prior life. Bewilderment and anxiety is evident in the following quote that describes a move from a small town to the nearby city with better hospital facilities: 'I was shifted purely because I was coming to town for hospital so often they thought I would be better near a main hospital, but I am good now, I don't know why I am here now. I really don't' (Resident).

Spatial liminality can evoke a variety of fluctuating emotions, relief, confusion, bewilderment, anxiety, angst and unhappiness that may be exacerbated in RACF residents with cognitive impairment. Working towards fostering a sense of emplacement and belonging in RACF residents is therefore essential.

Temporal transitions

The third component in the transition process is that of temporality. Bülow (2003) noted that people used various forms of time for different purposes. The use of time changes as new strategies are required to manage time, especially after a diagnosis (Jackson 2005; Rittman *et al.* 2004)(Rittman *et al.* 2004). In the following quote, the manager refers to institutionalised temporal rhythms, taking care to distinguish the more relaxed RACF from the strongly routinised hospital.

Normally [new residents] come via hospital, so there is a crisis and things are totally different with going to hospital. So then they come in here and we are so much more relaxed [with regard to routines] than being in hospital. It is a *home*, it is not a hospital. (Manager)

While acknowledging that they were an institution with scheduled meal times and staff shifts, both RACF emphasised the autonomy that residents were able

to exercise around the institutional schedule. A family member also observed:

She can plan her week as she wants. She can go for a drive on a Friday, she can go and she can sit at home and do her crossword puzzle or she can go out and play a game with the rest of the residents, what she wants, so she can actually plan her week and she quite likes doing that I think. She knows where she is going and she has got something to look forward to whereas if she couldn't do that and everything is done for you.

One of the residents interviewed identified the temporal change as, 'it's an adjustment from your own home where you are free to do what you want when you want'. Another family member noted the adjustment needed with meal times being at a different time than the resident was used to, 'You have to get used to having – well mother did – having the main meal at midday. We would always have our meal at night and we would have a light lunch' (Family member). From the team's observations, flows of people occurred according to the institutional schedules – to the dinner tables, to the lounge, (and activity room or chapel in A1), back to one's own room.

DISCUSSION

We have argued that the passage for older adults from independent life into residential aged care can be usefully conceptualised in terms of liminality, refracted into relational, spatial and temporal components. Many elements of this passage are consistent with van Gennep's (1960) description of lifestage transitions as *rites de passage*. The separation of the older person from their independent life may be precipitated by a fall, or declining ability to perform activities of daily life in their own home. The consequent assessment by a government-approved agency constitutes a *rite de passage* that permits their passage into residential aged care where they have the opportunity to reconnect – reshaping their life in accordance with the institutional rhythms and their own functional capacities.

In classic descriptions of liminality, the liminal phase ends when an individual takes up a new social identity (Turner 1969; van Gennep 1960). Our analysis left us unclear about the new social identities taken up by our participants. It was evident that new residents became woven into the RACF institutional identity through storytelling – a process that included biographical and reminiscence work about completing one's life (Randall 2004), as well as the constructing of a sense of belonging and alignment with the RACF (Jaye *et al.* 2015). However, Lee,

Simpson, and Froggatt (2013, 54) suggest that the ‘resigned acceptance’ about the transition to residential aged care they found among participants in their study may be a realistic response to these transitions. We interviewed residents who talked of increasing disability and decreased function, but did not gain access to residents who might have been willing to talk to us about preparing for death. Residents’ references to the facility as ‘home’ may indicate that they had reconnected socially and spatially, indicating a successful transition into residential aged care, however we are uncertain as to whether this successful transition resolves the temporal liminality associated with being in the space, place and time between independent living (the life before) and death (the endpoint of residential care).

RACF as social institutions occupy a liminal position within society. As a space, the RACF is an institution where older people are sequestered from the rest of the community – a holding place where they come to die. This is reinforced by the near one hundred percent mortality rate of its residents. No-one stays for long.¹² While staff and managers strive to make the institution as homely as possible, residents know that their tenure is temporary (Jaye *et al.* 2015). The liminal position of RACF is worth further exploration. Smith (1999) identified four categories of place; sacred – one which generated awe and excitement; profane – which is the opposite of this and associated with unease or revulsion; mundane – associated with everyday life and mediated between the sacred and the profane; and liminal – which provided an alternative point of mediation outside of the everyday rules of life. We have focused on the liminal in this article, but RACF exhibit elements of all these categories. In a small community, the RACF can occupy an important position as an employer and there are likely to be strong ties to the community because residents are local. The RACF can be a place of sanctuary for vulnerable older community members. As a repository of frequent death but also carework that involves intimate bodily intrusions and toileting, it is at the same time profane. RACF exhibit mundane characteristics in the daily traffic between the community and the institution as workers arrive for their shifts and leave for home, as foodstuffs and other goods and services are delivered, and as residents leave and return from outings.

As a symbol, the RACF represents, while troubling, normative societal values about ageing and older people in several ways. Older people in New Zealand *Pākehā* discourses lack value because they are economically unproductive, and also represent a growing economic burden to taxpayers (Grant Thornton NZ Ltd 2010). The poor pay and employment conditions of the aged care industry’s careworkers are considered to reflect this lack of social value (Human Rights Commission 2012). While there are instances where the care that residents

in RACF receive is unacceptable (*Marlborough Express* 2010a, b; *New Zealand Herald* 2009, 2010a, b), there are also reports of careworkers who are committed to the wellbeing of the vulnerable residents in their care (Human Rights Commission 2012; Henley and Jaye 2015).

It may be significant that we found scant evidence that residents formed deep friendships with each other. The primary relationships they described were with family and with staff, rather than with each other. Looking at the work by Roberto Esposito (2009) with regard to *communitas* (that is, developing a community of shared experience), it seems that during the transition phase, the residents are more *immunitas* (that is, the recipients of something that is done to them), rather than the active participants of a transition that leads to *communitas*. This confirms previous research that aged care residents often had feelings of ‘otherness’ in relation to their co-habitants because of perceived differences in cognitive function and memory (Lee, Simpson, and Froggatt 2013; Pirhonen, Tiilikainen, and Pietila 2017, 13). It may be that this also reflects residents’ attempts to retain some of the independence and privacy of their former life, and could also reflect that relationships formed with other residents are only temporary. Unlike other institutional collective liminal experiences such as those reported by Purves and Suto (2004) and Murphy *et al.* (1998), aged care residents are aware that they will never leave the institution. Over time, residents can develop a sense of belonging – previous research has shown that in the aftermath of the Canterbury earthquakes (Jaye, Hale, and Carswell 2015), staff in Otago RACF that received residents evacuated from Canterbury residential aged care facilities reported that the two groups (residents and evacuees) tended to stick to their own groups.

At this point, we would like to bring the discussion back to address the broader question of our research project. How is a successful transition from the liminality associated with admittance to an aged residential care facility an indicator of quality of care? We have identified what quality of care looks like to RACF staff, residents and family members previously (Jaye *et al.* 2016). Here, we suggest that the success or otherwise of the transition also indicates quality of care. Obviously, part of this success lies in personal choice, life experience and the psychology of the resident. However, much of the success lies in the skill of the staff in observing residents’ moods, assisting in connecting them with others and with activities in the facility, and ensuring that issues are dealt with by being available to talk to the residents. At the same time, supporting the families of residents, whether nearby or distant, by welcoming them, or by maintaining communication and being accessible to discuss issues, is also important in providing quality care. Quality in care is far more than physical assistance and

support. Both participating RACFs gave evidence of being strongly resident focused. We do not know how the transition to care is managed in facilities that might not be so resident-oriented in their care ethic.

While the relational aspects of care were encapsulated in the 2008 Ministry of Health audits (current at the time this project was conducted) for residential care facilities to provide ‘staff interaction and suitable/appropriate activities’, this did not directly address the issues associated with liminality in residents’ transitions to residential care. This transition appears to depend on the individual staff members concerned, on the managerial supervision and close interaction with the residents and their families. Certainly, the staff in both facilities ensured that the residents in their care felt safe, secure, and assisted them to negotiate the liminal spaces, places and temporality of transition into care so that residents found home in the RACF.

The principal limitations to this study were that only two RACF took part, and participating residents were selected by staff which no doubt resulted in our recruiting and interviewing people who were in relatively good health, articulate and without any cognitive or communicative impairments.

CONCLUSION

The transition into aged residential care is one of an individual’s final major life stage passages – frequently precipitated by a traumatic event and legitimated by failing to convince needs assessors of one’s ability to adequately perform activities of daily life. Given that the numbers of older people resident in RACF are expected to increase over the coming decades as the generation of baby-boomers age (Grant Thornton NZ Ltd 2010), closer attention to the ways in which older citizens navigate the transition into residential care is warranted. As Hofmeister (2002) noted, times of transition can provide opportunities for both turmoil and renewal. RACF staff are in the unique position of being able to act as navigators and guides for older people who enter aged residential care. The degree and rate at which a new resident comes to feel at home in the RACF institution depends in part on the ways that their passage is eased by the people they encounter there and the connections with others that they are able to make. Further research may improve these processes of transition for older people and their families, and guide those who work in the aged care sector.

ACKNOWLEDGEMENTS

The willingness of the residents, their family members, managers and staff in

sharing their views and experiences with us has been greatly appreciated. This research was funded by a Dunedin School of Medicine Deans' Bequest Fund grant.

NOTES

- 1 Dr McKechnie is a Medical Anthropologist and Health Sciences researcher with an interest in end of life care, and living with chronic conditions. Her current research is a contract with Unitec developing, implementing and evaluating a navigator role working with families in stroke and district nurse experiences providing palliative care in the community.
Email: roz.mckechnie@xtra.co.nz.
- 2 Associate Professor Jaye is a medical anthropologist whose research is highly eclectic, multi- and transdisciplinary. She has conducted research across the fields of medical anthropology and sociology, public health, medical education, and general practice. Her current research interests include communities of clinical practice and teamwork in healthcare settings, medical education, moral economy, and studies in aged care.
Email: chrystal.jaye@otago.ac.nz.
- 3 Dr Hale is an anthropologist and former social worker with older people whose research is focussed on different forms of care: informal and formal, home and community, and institutional care. Her current research interests include studies in migrant communities and informal care throughout history.
Email: beatricehalenz@gmail.com.
- 4 Associate Professor Tordoff is a pharmacist with experience of working with older people in hospital and community settings. Her research focuses on 'medicines use in older people' and on 'medicines policies' (i.e. on appropriate use of medicines, and access to medicines).
Email: june.tordoff@otago.ac.nz.
- 5 Associate Professor Robertson is an Occupational Therapy lecturer with an interest in ageing well and in client education. Her current research projects include immigrants' access to health care and models of community based initiatives.
Email: lindar@op.ac.nz.
- 6 Dr Simpson is a qualitative and public health researcher, recently retired. She has an interest in ageing and experience in evaluating community initiatives. Her recent work includes injury prevention, child health and the determinants of health.

- 7 Dr Butler is an anthropologist and occupational therapist. She has a focus in her work and research on disability and care, particularly about the complex issues that arise in the relationship between people with disability and those who care for them (either paid or unpaid).
Email: mbutler@op.ac.nz.
- 8 Since the completion of this project, failures of care in New Zealand residential aged care facilities have continued to attract media attention (see for example, Akoorie 2017; Johnston 2016; Radio New Zealand 2016/2018).
- 9 This document has been updated and superseded by the Ministry of Health's 2016 *Healthy Ageing Strategy*.
- 10 In New Zealand, nearly forty per cent of deaths in the over sixty-five age group occurred in RACF since 2000 (Broad *et al.* 2013).
- 11 New Zealanders of European descent.
- 12 According to a 2015 media press release, the average length of stay in RACF for all four levels of care (rest home, hospital, dementia, and psycho-geriatric) ranged from seventy-two to eighty-five weeks (Stock 2015). Connolly *et al.* (2014) reported that the highest mortality rates occur within six months of admittance to a RACF, particularly for those admitted to hospital level care following discharge from a public hospital.

REFERENCES

- Akoorie, Natalie. 2017. 'St Kilda Care Home Fails Elderly Resident, Ordered to Pay \$10,000'. *The New Zealand Herald*, 8 November 2017. Accessed 31 January 2018 from http://www.nzherald.co.nz/business/news/article.cfm?c_id=3&objectid=11941664
- Blundell, Kay. 2013. 'Woman Found Covered in Faeces at Retirement Home'. *The Dominion Post*, 30 July. Accessed 16 February 2016 from www.stuff.co.nz/dominion-post/news/8978486/Woman-found-covered-in-faeces-at-retirement-home
- Broad, Joanna, Merryn Gott, Kim Hongsoo, Michal Boyd, He Chen, and Martin Connolly. 2013. 'Where do People Die? An International Comparison of the Percentage of Deaths Occurring in Hospital and Residential Aged Care Settings in 45 Populations, Using Published and Available Statistics'. *Inter-*

national Journal of Public Health 58 (2): 257–267.

- Bülow, Pia. 2003. 'In Dialogue with Time: Identity and Illness in Narratives about Chronic Fatigue.' *Narrative Inquiry* 13 (1): 71–97.
- Connolly, Martin, Joanna Broad, Michal Boyd, Ngaire Kerse, and Merryn Gott. 2013. 'Residential Aged Care: The De Facto Hospice for New Zealand's Older People.' *Australasian Journal of Ageing* 33 (2): 114–120.
- Davidson, Natasha, Katie Elkin, and Dawn Carey. 2016. *Complaints to the Health and Disability Commissioner about Residential Aged Care Facilities: Analysis and Report 2010–2014*. Auckland: The Health and Disability Commissioner.
- Diamond, Tim. 1992. *Making Gray Gold: Narratives of Nursing Home Care*. Chicago: University of Chicago Press.
- Esposito, Roberto. 2009. *Communitas: The Origin and Destiny of Community*. Stanford: Stanford University Press.
- Frank, Jaquelyn. 2002. *The Paradox of Aging in Place in Assisted Living*. Westport, Connecticut: Bergin and Garvey.
- Goffman, Erving. 1961. 'The Characteristics of Total Institutions.' *Conference Proceedings of the Symposium on Preventive and Social Psychiatry 15–17 April 1957*, Washington D.C.: National Academies Press.
- Grant Thornton NZ Ltd. 2010. *Aged Residential Care Service Review*. Accessed 6 August 2017 from <http://www.grantthornton.co.nz/insights/aged-residential-care-service-review/>
- Gubrium, Jaber. 1997. *Living and Dying at Murray Manor*. Charlottesville: University of Virginia Press.
- Hale, Beatrice, Patrick Barrett, and Robin Gauld. 2010. *Age of Supported Independence*. Dordrecht: Springer.
- Henley, Blake, and Chrystal Jaye. 2015. 'Doing Aged Residential Care Better: The View From the Trenches.' *New Zealand Medical Student Journal* 21: 7–11.
- Hirst, Michael. 2002. 'Transitions to Informal Care in Great Britain During the 1990s.' *Journal of Epidemiology and Community Health* 56 (8): 579–87.

- Hofmeister, Sabine. 2002. 'Intermediate "Time-spaces": The Rediscovery of Transition in Spatial Planning and Environmental Planning'. *Time and Society* 11 (1):105–130.
- Hogue, David. 2006. 'Whose Rite Is It, Anyway? Liminality and the Work of the Christian Funeral'. *Liturgy* 21 (1):3–10.
- Human Rights Commission. 2012. *Caring Counts: Report of the Inquiry into the Aged Care Workforce*. Accessed 6 August 2017 from <https://www.hrc.co.nz/your-rights/business-and-work/tools-and-research/caring-counts>
- Hurlock, Debb, Constance Barlow, Anne Phelan, Florence Myrick, Russell Sawa, and Gayla Rogers. 2008. 'Falls the Shadow and the Light: Liminality and Natality in Social Work Field Education'. *Teaching in Higher Education* 13 (3): 291–301.
- Jackson, Jean. 2005. 'Stigma, Liminality, and Chronic Pain: Mind-Body Borderlands'. *American Ethnologist* 32 (3): 332–353.
- Janlöv, Ann Christin, Ingalill Rahm Hallberg, and Kerstin Petersson. 2006. 'Older Persons' Experience of Being Assessed For and Receiving Public Home Help: Do They Have Any Influence Over It?' *Health and Social Care in the Community* 14 (1):26–36.
- Jaye, Chrystal, Beatrice Hale, and Sue Carswell. 2015. 'Post-Earthquake Evacuation of Aged Care Residents from Canterbury, New Zealand: Lessons in Resilience'. *Sites: A Journal of Social Anthropology and Cultural Studies* 12 (2):133–153.
- Jaye, Chrystal, Beatrice Hale, Jean Simpson, June Tordoff, Linda Robertson, Mary Butler, Roz McKechnie, and Jessica Young. 2015. 'One of Us: Stories From Two New Zealand Rest Homes'. *Journal of Aging Studies* 35:135–143.
- Jaye Chrystal, June Tordoff, Mary Butler, Beatrice Hale, Roz McKechnie, Linda Robertson and Jean Simpson. 2016. 'Quality in Residential Care: Exploring Residents', Family Members', Managers' and Staff Perspectives'. *Quality in Ageing and Older Adults* 17 (4):253–262.
- Jeyaraj, Joseph. 2004. 'Liminality and Othering: The Issue of Rhetorical Authority in Technical Discourse'. *Journal of Business and Technical Communication* 18 (1): 9–38.

- Johnston, Martin. 2016. 'Woman Given Wrong Medication at Rest Home Dies'. *The New Zealand Herald*, 15 February 2016. Accessed 31 January 2018 from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11590014
- Kiata-Holland, Elizabeth. 2010. *'All In a Day's Work': The Lifeworld of Older People in New Zealand Rest Homes*. Unpublished PhD Thesis, General Practice and Primary Care, University of Auckland.
- Kiata, Liz, and Ngaire Kerse. 2004. 'Intercultural Residential Care in New Zealand'. *Qualitative Health Research* 14 (3): 313–327.
- Lagacé, Martine, Annick Tanguay, Marie-Lyse Lavallée, Joelle Laplante, and Sarah Robichaud. 2012. 'The Silent Impact of Ageist Communication in Long Term Facilities: Elders' Perspectives on Quality of Life and Coping Strategies'. *Journal of Aging Studies* 26 (3): 335–342.
- Lee, Victoria, Jane Simpson, and Katherine Froggatt. 2012. 'A Narrative Exploration of Older People's Transitions into Residential Care'. *Aging and Mental Health* 17 (1): 48–56.
- Marlborough Express*. 2010a. 'Abuse a Warning For All Rest Homes'. *The Marlborough Express*, 17 August. and url: <http://www.stuff.co.nz/marlborough-express/news/4031542/Abuse-a-warning-for-all-rest-homes>
- . 2010b. 'Jail for Indecency in Rest Home'. *The Marlborough Express*, 17 August. url: <http://www.stuff.co.nz/marlborough-express/news/4031516/Jail-for-indecency-in-rest-home>
- Meleis, Afaf Ibrahim, Linda Sawyer, Eun-Ok Im, DeAnne Hilfinger Messias, and Karen Schumacher. 2000. 'Experiencing Transitions: An Emerging Middle-Range Theory'. *Advances in Nursing Science* 23 (1): 12–28.
- Ministry of Health. 2002. *Health of Older People Strategy*. Wellington: New Zealand Ministry of Health.
- . 2002. *Health of Older People: A Statistical Reference*. Wellington. Accessed 10 August 2017 from https://www.health.govt.nz/system/files/documents/publications/stat_report_9.09.pdf
- . 2015. 'Residential Care: Questions and Answers'. Accessed 15 June 2015 from <http://www.health.govt.nz/our-work/life-stages/health-older-people/>

long-term-residential-care/residential-care-questionsand-answers

———. 2016. *Healthy Ageing Strategy*. Wellington. Accessed 31 January from <https://www.health.govt.nz/publication/healthy-ageing-strategy>

———. 2018. 'About Residential Care'. Accessed 27 February 2018 from <https://www.govt.nz/browse/health-system/residential-care/about-residential-care/>

Murphy, Robert, Jessica Scheer, Yolanda Murphy, and Richard Mack. 1988. 'Physical Disability and Social Liminality: A Study in the Rituals of Adversity'. *Social Science and Medicine* 26 (2): 235–242.

New Zealand Herald. 2009. 'Rest Home Neglect Common – Nurses'. *New Zealand Herald*. Accessed 8 October 2009 from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10601877

———. 2010. 'Nurse Struck Off for Punching Elderly Man'. *New Zealand Herald*, 11 May 2010. Accessed 20 May 2011 from http://www.nzherald.co.nz/retirement-villages/news/article.cfm?c_id=306&objectid=10644200

New Zealand Aged Care Association. 2011. *The Future of Aged Care: A Discussion Paper*. Wellington.

New Zealand Labour and Green Parties. 2010. *Report on Aged Care: What does the Future Hold for Older New Zealanders*. Accessed 9 August 2017 from https://home.greens.org.nz/sites/default/files/Aged_Care_Report_for_email.pdf

Olaison, Anna, and Elisabet Cedersund. 2006. 'Assessment for Home Care: Negotiating Solutions for Individual Needs'. *Journal of Aging Studies* 20 (4): 367–380.

Parr, Hester. 2003. 'Medical Geography: Care and Caring'. *Progress in Human Geography* 27 (2): 212–221.

Pirhonen, Jari, and Ilkka Pietila. 2015. 'Patient, Resident, or Person: Recognition and the Continuity of Self in Long-term Care for Older People'. *Journal of Aging Studies* 35 : 95–103.

Pirhonen, Jari, Elisa Tillikainen, and Ilkka Pietila. 2017. 'Ruptures of Affiliation: Social Isolation in Assisted Living for Older People'. *Ageing and Society* Early Online: 1–19.

- Purves, Barbara, and Melinda Suto. 2004. 'In Limbo: Creating Continuity of Identity in a Discharge Planning Unit'. *Canadian Journal of Occupational Therapy* 71 (3):173–81.
- Radio New Zealand. 2016. 'Caregiver Gave Wrong Person Medication'. *Radio New Zealand*. Accessed 31 January from <https://www.radionz.co.nz/news/national/302837/caregiver-gave-wrong-person-medication>
- Randall, William, and Gary Kenyon. 2004. 'Time, Story, and Wisdom: Emerging Themes in Narrative Gerontology'. *Canadian Journal on Aging* 23 (4):333–346.
- Rittman, Maude, Christopher Faircloth, Craig Boylstein, Jaber F. Gubrium, Christine Williams, Marieke Van Puymbroeck, and Charles Ellis. 2004. 'The Experience of Time in the Transition from Hospital to Home Following Stroke'. *Journal of Rehabilitation Research and Development* 41 (3a): 259–68.
- Shield, Renee. 1997. 'Liminality in an American Nursing Home: The Endless Transition'. In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 472–491. London: Bergin and Harvey.
- Smith, Philip. 1999. 'The Elementary Forms of Place and Their Transformations: A Durkheimian Model'. *Qualitative Sociology* 22 (1):13–36.
- Statistics New Zealand. 2015. 'Living Outside the Norm: An Analysis of People Living in Temporary and Communal Dwellings, 2013 Census'. Accessed 4 August 2017 from <http://m.stats.govt.nz/Census/2013-census/profile-and-summary-reports/outside-norm/residential-old.aspx>
- Stock, Rob. 2015. 'Rest Home Stay Can Cost Over \$80,000'. *Stuff*, 7 June 2015. Accessed 28 February from <https://www.stuff.co.nz/business/money/69112545/rest-home-stay-can-cost-over-80-000>
- Turner, Victor. 1969. *The Ritual Process*. London: Routledge and Kegan Paul.
- Turner, Victor. 1990. 'Liminality and Community'. In *Culture and Society: Contemporary Debates*, edited by Jeffrey Alexander and Steven Seidman, 147–154. Cambridge: Cambridge University Press.
- Van Gennep, Arnold. 1960. *The Rites of Passage*. London: Routledge and Kegan Paul.