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Recommended Citation
doi:10.21427/D7D44T
Available at: https://arrow.dit.ie/ijass/vol6/iss1/6
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Abstract
A sample of 40 older persons, (30 female; 10 male) half of whom resided in public and half of whom resided in private nursing homes across Cork city and county participated in the study. Participants were interviewed about their experience of entering and living in nursing home care. The qualitative data yielded from the interviews identified that the majority of the sample entered into care due to poor physical or mental health. The features of residential care reported that were liked were an enhanced sense of security, the company of others and being looked after. The features of residential care reported that were disliked were the lack of control over ones daily life and residential care being a very ‘public experience’ characterised by a lack of privacy.

Introduction
The care of older people is becoming a greater concern in contemporary Ireland due to a number of factors such as the aging demographic profile, greater attention paid to quality assurance in the care sector and the incidence of nursing homes being closed for reasons of poor or illegal practice. A Code of Practice for nursing homes exists, the Health (Nursing Homes) Act
1990, which sets out best standards of care and while the code is not legally binding, it sets standards for high quality care to which homes can work towards along with provisions for the protection of residents from abuse and undue influence. In addition, the National Council on Ageing and Older People (NCAOP) have produced guidelines on ‘Care and Case Management for Older People in Ireland’ (Delaney, Garavan, McGee & Tynan., 2001) for greater individualization and professional (and client) collaboration in care planning.

In Ireland in 1996 there were over 400,000 people over 65 (11.4% of the population) and by 2021 it is estimated that this number will rise to over 620,000 (15.5% of the population). At present just over 21% of older people are aged 80 years or over and this in turn is expected to rise to almost 25% by 2011 (Fahey, 1995).

Nursing Home Care
In Ireland approximately 25,000 older people are cared for in public and private nursing homes (Holland & O’Brien, 2003) and with the population projections outlined above this number is likely to rise. One of the objectives of the health strategy, ‘Shaping a Healthier Future’ (Dept. of Health, 1994) was ‘to provide a high quality of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home’ through ensuring adequate standards in nursing homes. Yet, in contrast to physical care, resources and staffing, little is known about resident quality of life and the care practices undertaken with residents in nursing homes or other long stay units.

The Health (Nursing Homes) Act 1990 introduced compulsory registration, standards for the design and management of nursing homes and a voluntary code of practice but is vague and lacking in clarity with respect to standards on practical care practices. Sections 5-8 in particular deal with resident well-being including provisions regarding occupation and recreation activities, freedom to exercise choice, privacy space for personal belongings and the provision of information concerning current affairs, local matters community resources and events. Section 5.A emphasises the maintenance of ‘suitable
and sufficient care to maintain the person's welfare and well-being, having regard to the nature and extent of the person's dependency’. How this could be maintained, in practical terms, is not spelt out.

The importance of standards in care practices for quality of life in nursing homes was identified in the 1988 policy for the older persons, ‘The Years Ahead’. Section 9.45 stated ‘The quality of their lives is dependent upon the nature and quality of the care provided by those who work in the institutions catering for the elderly. This is particularly the case having regard to the susceptibility of the elderly to institutionalisation in a care setting’.

In their review of the implementation of this policy, Ruddle, Donohue and Mulvihill (1997) stressed the need for a more holistic approach to the care of older persons service coordination and an inspectorate for the residential care of older people.

In 2000 the NCAOP published research involving a survey of approximately 30% of 580 long-term residential care facilities (including district and psychiatric hospitals) in Ireland. Of these, slightly over half indicated that they had quality initiatives. These ranged across a number of areas such as: therapies, recreation, care practices, individual assessment, staffing, policies and buildings or facilities. Staffing was reported to be the most important factor contributing to overall quality of care.

Following on from this research the NCAOP (2000) published a ‘Framework for Quality in Long-Term Residential Care for Older People in Ireland’ emphasising the need for uniform standards of care, quality assurance mechanisms, an independent inspectorate and an authoritative statement of policy on prevention, assessment, rehabilitation, standards of care and the maintenance of independence and dignity in continuing care.

According to the NCAOP, residential care ‘must be provided to such a standard to those older people who can no longer be maintained in dignity and independence at home that they experience both health and social gain from the service. Attention must focus unequivocally on the quality and
effectiveness of long-term care services, rather than on the provision of such services to a minimum standard’ (ibid: 21).

The NCAOP (2000) identified a number of factors which need to be addressed in the development of such quality standards. These included:

- the need to specify clear performance targets and indicators in standards;
- the stated policy objectives of health and social gain for all health services;
- the objective of promoting quality of life having regard to the dignity, independence and autonomy of the older people resident in long-term care and the importance of an Inspectorate that is independent and comprised of people with first-hand experience of providing high standards of care for older people.

The relative lack of information on the quality of care in the nursing home sector has been highlighted by Mangan (2003) who identified the need for questions to be answered such as: How much choice is being exercised by older persons in long stay care? Is there an over protective environment or paternalistic practices? What attempts are made to provide a stimulating environment, contact with the home place? The report recommended further research to be carried-out on quality of life in long stay.

An example of such research is that undertaken in 2003 by Age and Opportunity (2003) which explored residential care from a qualitative perspective. From interviews undertaken with 31 older people across 3 residential centres, they concluded that companionship and security were perceived by older people as positive features of residential care while the loss of functional capacity and also of control and choice were cited as the most negative.

In the child care arena residential care practices have already come under critical scrutiny due to heightened public consciousness on child abuse and because a climate of ‘quality assurance’ and high quality care is now seen as a priority across the public services. Inquiries such as that into the operation of ‘Madonna House’ have emphasised the need for research into residential care and recommended that “Comprehensive research programmes should
be developed and should include longitudinal and qualitative studies...to illuminate the... experience of care” (Report on the Inquiry into the Operation of Madonna House, 1996: 118).

**Institutionalisation**

Concerns with respect to nursing homes and the problems of institutionalisation have been raised previously (O’Connor & Thompstone, 1986; O’Connor & Walsh, 1986) and mistreatment in both family and residential care is now an issue of greater public awareness and becoming a social concern in Ireland (O’Loughlin, 1998; O’Loughlin & Duggan, 1998) and across other Countries (Bennett, Kingston & Penhale, 1997).

Institutionalisation “involves symptoms, including apathy, withdrawal, loss of motivation and helplessness- all said to result from depersonalisation caused by block treatment in groups, routinisation and role deprivation” (Jack, 1998: 11).

Infantilisation, depersonalisation and dehumanisation are reported as the most frequent complaints voiced by older people about their care staff and the insidious effects of institutionalisation can be seen in low expectations regarding privacy and other individual rights (Dept. of Health/Social Services Inspectorate, 1989).

By reinforcing block treatment of residents, whereby blanket rules are applied with little consideration given to the individual residents, nursing homes regimes may lead to insufficient regard being paid to individual differences and personal preferences. The inappropriate use of restraints, such as medication, locked doors, tightly tucked-in bedclothes and the use of furniture to restrict action have also been identified as practices which compromise dignity and human rights (Bennett et al., 1997; Dept. of Health/Social Services Inspectorate, 1989).

While many older people experience a contraction in the activities they engage in and social life, this contraction is heightened for those resident in nursing homes. Reduced community involvement and participation in
society at large, diminished opportunities to socialise, a narrowing of a person’s circle of friends and acquaintances and ill-health and disabilities all contribute to this.

Activities in residential care tend to be limited to television viewing, radio listening and reading with residents showing passivity and forebearance in their acceptance of such a restricted range of recreation (Southern Health Board, 1999).

Past research in Ireland has concluded that resident daily activities were ‘unduly influenced by the routine of the home itself’ and that the ‘ethos and context of their daily lives are orientated by institutional living’ (O’Connor & Walsh, 1986: 75).

While recognising the difficulties nursing homes face in their tasks, relatives reported that they felt enough was not being done to mentally stimulate residents as staff were preoccupied with their ‘work’ and did not have the time for meeting resident’s individual needs (ibid).

Tribunals in the U.K. have also noted that some nursing homes have little if any stimulation other than constant television, little opportunity for residents to go out into the community and staff who often distance themselves from residents, thereby reducing the quality of these interpersonal relationships (Registered Homes Tribunal Secretariat, 1987).

Contributing to such practices and other forms of resident (and staff) maltreatment include the staffing features of burnout, (exhaustion, insufficient training, case overload, excessive administrative demands, and an overburdened case load. Many organisational features are known to contribute to this risk including commercial pressures, insufficient job induction, a lack of inservice training, inadequate equipment aids or household resources, excess home occupancy, poor lines of management communication, ineffective leadership and supervision, an ‘insular and closed’ institutional climate and excessive staff autonomy (Bennett et al., 1997).
Staff factions, managers feeling 'under siege', high staff turnover, uncertainty over the aims and practices of the nursing home along with a low staff morale are other potent ingredients of a poor care work environment (Jack, 1998). Research has suggested that indicators of quality for nursing homes should include measures which examine the extent to which the environment is homely as opposed to institutional, fosters social interaction, provides opportunities for choice, offers opportunities to engage in personally meaningful activities and facilitates the participation and consultation of residents in care regimes (Wade, Sawyer & Bell, 1983).

Institutions work when individuals have a good chance to be themselves in an environment where living and organization are based on principles of sharing and economies of scale and which are not domestic or familial. Training and social legislation need to facilitate the development of institutions with the capacity to support and reconcile individual and collective interests (Kellaher, 1995; O’Shea, Donnison & Larragy, 1991).

On a positive note a variety of initiatives have been enacted across the Country to improve the quality of life older people in residential care. These have involved arts programmes, yoga, sensory gardens and links with schools and retirement groups.

The aim of the present study was to explore older peoples’ experiences of residential care.

**Method**

**Participants**

Public and private nursing homes across Cork City and County were approached by letter to ask if they were interested in participating in the study. Initially 20 private nursing homes agreed but 3 were later unable to commit. 10 public nursing homes initially agreed to participate but 3 were later unable to arrange interviews in the time period of the study. This left a sample of 17 private and 10 public nursing homes that participated in the study.
In recruiting older persons to participate in the interviews, senior nursing staff approached residents where there was no major concern regarding their physical health or mental capacity to inform them of the study and to determine if they were interested in participating or not. 2 residents were interviewed in each public nursing home and 1-2 residents were interviewed in each private nursing home. In selecting who to interviewed from those who had expressed interest, the researcher prioritised balance in gender and rural/urban representation and a diversity in age across the sample.

Of the 40 interviewees, 36 from Cork city and county, 1 was from Dublin, 2 were from England and 1 from Scotland. All had lived in the Cork area over the past 20 years. The average interviewee age was 75 years (range 55-96). Over three-quarters of the sample were widowed (25 female; 5 male) and a quarter were single (5 female; 5 male). The majority of the sample had been in nursing home care for 3-4 years (range 6 months-20 years). None of the sample were known to have dementia.

Procedure
A focus group with 6 older persons in one of the nursing homes was initially carried-out to enhance the interview developed from theory and past research studies. The issues raised in the focus group added to the interview developed. The interview lasted for a duration of approx. 20 minutes (range 10-60 mins.). All of the interviews were carried-out in the person’s room or in one of the communal rooms, dependent upon the interviewee’s wishes. All of the interviewees were informed that confidentiality would be respected and that they were free to withdraw from the interview at any time. All names have been changed.

Results/Discussion
Going into Care
Poor physical and/or mental health such as arthritis, multiple sclerosis, stroke and psychiatric complaints, were cited by the majority of the sample (n=33) for admission into care. Approaching half of these also mentioned that they did not want to be a burden to their families (n=15). A small number
mentioned social reasons such as death of a spouse, fear of intruders and a lack of home support services (n=7).

In the words of Mary aged 82, who has been a resident for 4 years ‘I always had problems. I found it hard to get a carer, my family are great but I would not have expected them to look after me. This was my last option. I hung on as long as possible’.

These findings correspond with those of Age and Opportunity (2003) which found that poor health, insecurity and fear of living alone, death of a ‘life companion’ and a lack of companionship were the main reasons older people reported entering residential care. A smaller number in their study reported an inability to cope, the breakdown of a family unit/inability of the family to cope, homelessness and ‘planning for the future while it was still possible’ as the main reasons.

Our findings were also similar to those of Allen, Hogg and Peace (1992) in the U.K. They found that there are five main reasons why older people go into residential care: experiencing a fall (and sometimes associated injury), following an acute illness, inability to look after themselves, excess pressure on their carer(s) and because of loneliness.

When asked what concerns, if any, they had about going into nursing home, all of the sample (n=40) expressed concern regarding their privacy. All (n=40) reported worrying about sharing a room as it meant relinquishing their privacy and other concerns they had experienced included: getting on with others (n=10), the safety of their personal possessions (n=5), dealing with someone dying (n=5) or who had Alzheimer’s (n=5) and the fact that it would not be their own home (n=5).

As noted by the Residential Forum (1996) ‘One of the things people fear most when considering a move into a home is that their personal habits will be exposed to other people and others’ to them.
An example is sharing a meal table, but more significantly sharing a bedroom... Screens or curtains may give some privacy but as they do not conceal noises and odours it is limited' (p13-14).

Half of the sample (n=20), all of whom were in private nursing homes, expressed concern about the financial cost of being in care. This ranged from 320-435 Euro per week and on top of this are the costs of 'extras' such as hairdressing, chiropody and physiotherapy. For 10 of the sample, leaving their own home was a concern because they worried about who would look after it until they got back. All of these 10 were in care long-term but were keeping their house as long as possible as it was their way of 'getting through' living in the home and of clinging on to their old life. As illustrated by Siobhan aged 70 and a resident for over 1 year, 'I worried about my garden and my possessions, who would look after it when I came here'.

Another 10 residents spoke of their concern regarding the 'reputation of nursing home care'. They were influenced by comments from friends and others and by the media regarding how people were sometimes not so well treated in nursing homes. As John aged 69 and 2 years a resident said 'You hear things and read things, so I was worried about coming here, but I asked my doctor so I was happier'.

Similarly, a significant number of older people sampled by Age and Opportunity (2003) also expressed initial uncertainty and unhappiness about going into residential care with a small number feeling 'let-down' by family and other carers. Over a third of their sample did however suggest that they were well prepared for their move into residential care.

Other research has identified location of the home was important for pragmatic reasons (nearness to relatives and past residence) as well as for maintaining a sense of self through continuity with a place or community (Reed et al., 1998).

**Living in Care**
All of the sample reported that it was hard to adjust to being in a nursing
home at first but the majority (n=35) reported that they had settled-in after about 6 months. In the words of Elizabeth aged 69 and 2 years a resident ‘At first I woke up and didn’t know where I was, I found it hard to share a room, but now I’m lucky I get on with most and can still move around’. 5 of the sample reported that they still found it hard to adjust to and had difficulties in relating to staff and fellow residents. All of these 5 have been residents for 2 to just over 3 years. As Sara, 80 years of age indicated, ‘Some days are good, some days are bad’.

All of those interviewed also reported that it was hard to get used to having dinner so early (at approx 16.30 pm) but all were happy with the choice of meals available to them. Research by O’Connor and Walsh (1986) involving interviews with Irish nursing home residents reported how residents found it difficult trying to settle into the routines of the home and how much they missed the emotional involvement of family life. ‘It’s the little things that they miss, like staying in bed in the morning. They also miss choosing their own meals or eating when they feel like eating’ (p25). The authors concluded that, nursing homes are more concerned with ‘the fitting (of residents) into the home rather than on the individual needs of the resident’ (p62).

Features of Residential Care That Were Liked

Security

A sense of security was reported by three-quarters of the sample (n=30) as one of the best or most positive feature of living in care. This is in agreement with Irish research which found that ‘one of the key benefits of living in long-term residential care was the sense of safety and security which it brought. Safety and security had three aspects. The first related to having doctors, nurses and other staff on hand in case of emergency...Security was also related to personal security...Less frequent...was the importance of the sense of the familiar, and of knowing where everything was and what to expect’ (Age and Opportunity, 2003: 36-37).

The value of security was also noted by Horkan and Wood (1986) who reported that ‘for women, in particular, the security and protection of the home is seen as being of major importance’ (p92). A sense of safety and
security is seen by the psychologist Abraham Maslow (1987) as one of our most fundamental needs, second only to physiological needs such as hunger and thirst.

**Social Company**
The company of others and having people to talk to was cited by half of the sample (n=20). Nearly three-quarters of the sample (n=29) reported making close friendships in the nursing home they were in and 10 of the sample reported that other residents gave them their greatest source of social support because they understood life in a nursing home. As Sheila aged 69 and 4 years a resident said ‘I find that the other residents know what its like to go from your own home to a nursing home, those working here or even my own family don’t understand’.

This is also in agreement with the research by Age and Opportunity (2003: 33) which found that ‘by far the most commonly cited factor contributing to quality of life for residents was the availability of companionship...a large number perceived that the move to residential care had significantly improved their quality of life on this dimension...Most residents, when they spoke, associated company with being in the presence of a ‘buzz’ and ‘life’.

Similarly research in the U.K. highlighted that ‘for many people group living offers a set of social relationships unavailable to them outside life in a home. Many older people in particular live isolated lives, afraid or unable to go out, until they join life in a home’ (Residential Forum, 1996: 16).

**Being Looked After**
Being looked after was stated by a quarter of the sample (n=10) as one of the best features of nursing home care. This may reflect a high importance attached to needs, particularly physical needs, being met and a sense of safety with less worry about potential problems and difficulties such as mobility difficulties or ill health. This concurs with past research by O’Connor and Walsh (1986) who concluded that ‘For many of the residents living in care, the best features are that day-to-day needs are being looked after...that there is no need to worry about things as they are paying others to look
after them' (p103). While the participants in our study did not indicate that they purposefully opted out of decision making in their daily lives, the aforementioned research study did find that 21, out of a sample of 97 residents, stated that they did not want more say in the daily running of the home.

Equally research in Ireland by Age and Opportunity (2003) concluded that being cared for in residential care added to older people’s sense of well-being and was usually contrasted to their situation before entering residential care, with many feeling that they had struggled with the everyday things of life. According to Age and Opportunity (2003: 37) ‘Being cared for included having other people take an active interest in your health as well as your laundry, personal care and appearance and meals’.

Research by Allen, Hogg and Peace (1992) in the U.K. also found that social company and being looked after (particularly having nice meals cooked up for them) were what older people liked most about being in residential care. Not surprisingly, the majority of the Allen et al. (1992) study as well as our study had lived alone before going into residential care.

Features of Residential Care That Were Disliked
Our findings regarding the main aspects of residential care disliked by residents differ considerably from those reported in the Allen et al (1992) study. They found the main sources of dislike were other residents and physical features of the home. A lack of privacy was only a complaint of a minority of their sample and the authors concluded that ‘given the circumstances in some homes, it was surprising to us that it was not mentioned more often’ (p.199).

Lack of Privacy
All of those interviewed (n=40) responded that lack of privacy one of the worst features of nursing home care. This included not being able to lock doors, not having your own space and worrying over others getting at personal possessions. All indicated that they had to get used to not having their own space as it was not their own home so changes had to be expected.
Past research in residential care has emphasised how personal identity may be linked to privacy and physical space though ‘being able to have your belongings around you’ (Age and Opportunity, 2003: 34).

Research by Counsel and Care (1991) in the U.K. has also highlighted the lack of privacy standards in residential homes for older persons. They identified four factors that significantly affected privacy standards: rules and regulations of the home, the pressures of communal living, building design and staff attitudes, particularly that of the head of the home. The report identified how the presence or absence of the practice of knocking on doors was often very indicative of staff attitudes towards privacy and that ‘the more frail and dependent a resident becomes, the more they lose control over their privacy’ (p5).

In the U.K., the Residential Forum (1996) highlighted how a high number of staff caring for someone with physical care needs also compromises privacy and thus its advisable through good rota management to enable the number of staff involved with any given resident to be kept to a minimum so that s/he can expect to be cared for by a small number of staff.

Monotony
All of those interviewed (n=40) reported feeling that the days were monotonous, ‘everyday being the same’. Most (n=30) felt that the daily routines never changed and over half spoke about not having enough to do or not having the choice to do something different. Betty (aged 76 and 2 years a resident) wish ‘I would love to do more’ was a sentiment shared by at least half of the sample.

Our research concurs with the ‘loss of control and choice’ which Age and Opportunity (2003) reported as one of the key negative domains of the quality of life of older Irish people in residential care. A conclusion from their research was that ‘residents wanted choice over simple things like the newspapers that they read, the time they got up and went to bed and ate and the type of food and drink that they had. They also particularly wanted to be able to choose the television programmes that they got to watch’ (p38).
However it's worth noting that a number of the homes, 4 of the 27 visited in our study, had quite varied activity programmes contributing to great diversity, choice and change in daily life experience. Poetry readings, pet therapy, bingo, hymns, art therapy, craft, exercise, a snozeleen room, yoga and reminiscence therapy represent the range of activities that were made available. In the gleeful words of Margaret, a 77 year old, resident for over 4 years in one of these homes 'you never have a minute to rest there is so much to do'. Other interviewees spoke of how they were encouraged to help in the garden, with the fire and to help fellow residents. 3 of the homes visited had pets (cat or dog) which were reported, by both staff and residents, to be a great source of comfort for residents.

This is in keeping with Gallagher’s (2005, p.301) observation that ‘Expectations in relation to what a dependant older person might expect in a residential unit have changed from an emphasis on physical care, to meeting psycho-social, spiritual and emotional needs. There are many innovative examples of good practice involving the arts in care settings; participation by service users themselves in the programmes provided in care centres; and more interagency cooperation in creating a better environment for older people’.

While routines are often associated, in a negative sense, with institutionalisation, structure in itself should not be seen as unavoidably negative. Rather ‘it is the way in which staff work within these routines which is important. The key determinants are those of involvement, influence and flexibility. Structure and routine should be a benefit to the service users and determined by them’ (Residential Forum, 1996: 31).

In relation to this, research by Age and Opportunity (2003) identified how routines may also be a source of comfort in residential care by helping make people feel safe and taken care of. Specialised training in ‘animation of the older person’ which is to be found in many European Countries, may be one solution towards addressing such monotony in residential care. This training is usually undertaken by social care graduates or ‘social pedagogues’ and focuses on the use of reminiscence, creative and recreational activities in the care of older people. Gallagher and Kennedy (2003: 34) have previously
noted how ‘While there are at present no dedicated career posts (in Ireland) for social care graduates in services for older people, this is not so in the rest of Europe where the role of ‘animateur’ is well established and filled by social care graduates’.

Methodological Issues
A major drawback in the research is the sampling process. In order to comply with ethical requirements, the managers of each of the nursing homes informed the researcher which residents could be approached to participate in the study. As a consequence any older person who was ill, who might have been harmed or distressed by the study or who had expressed no interest in the study to the manager was not approached.

The sample thus lacked random selection and representation of older people that are very ill or who have dementia, groups which constitute a substantial proportion of residents in nursing homes.

Conclusion
This study provides a snapshot of how residential care is experienced by older persons. The findings reinforce the importance of a more holistic approach to long term care of older persons as advocated by the National Council on Ageing and Older People (1997). As noted by Moane (1993: 201) there is a need for ‘more innovative caring programmes which combine the positive features of care in the home, such as intimacy, privacy, autonomy and care by a close relative with those of residential care, such as professional assistance and the alleviation of the burden of care’.

The eight domains of social gain within long-term residential care (companionship, personal identity and privacy, group identity and being part of a community, involvement in meaningful activity, contact with family/friends, being cared for, safety/security and religion) identified by Age and Opportunity (2003) may be a very useful starting point for further research in this area.
Health care is not only encompasses the prevention and treatment of illness and disability but also the promotion of the well-being and welfare of the whole person. Therapeutic nursing care i.e. ‘care that makes a positive difference to patients’ (Waterworth, 1995, p13) involves a multi-professional, person-centred approach recognising the contribution others play to a person's care and working with them for the person's own benefit. Older people are not a homogenous group but rather include persons with a wide range of abilities and a diversity of interests whose individuality needs to be respected.

References


**Acknowledgements**

The authors wish to thank all those that participated in this study and to the Royal Irish Academy and Thomas Crosbie Holdings Ltd for funding.