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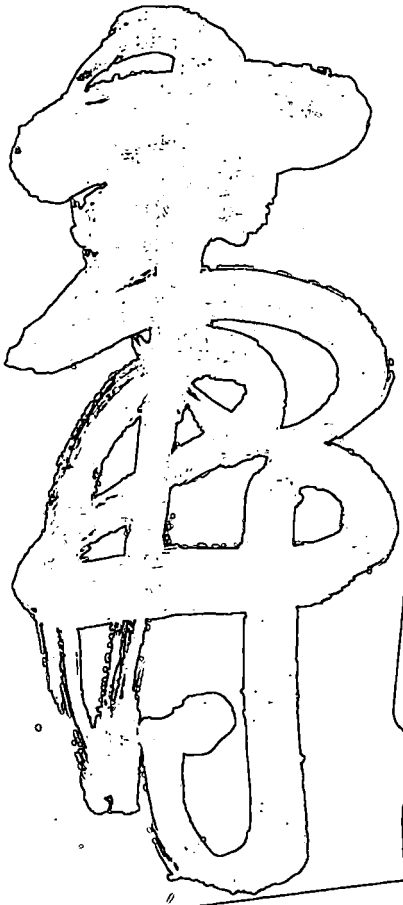

"IT'S OUR HOME": THE QUALITY OF LIFE IN PRIVATE AND VOLUNTARY NURSING HOMES

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"IT'S OUR HOME": THE QUALITY OF LIFE IN PRIVATE AND VOLUNTARY NURSING HOMES

"IT'S OUR HOME":
THE QUALITY OF LIFE IN PRIVATE AND VOLUNTARY NURSING HOMES

By
Joyce O'Connor and Marie Walsh.

NATIONAL COUNCIL FOR THE AGED, 1986
REPORT NO. 14

This Report has been prepared by Professor Joyce O'Connor, Director, Social Research Centre, N.I.H.E., Limerick and Ms. Marie Walsh, formerly Research Assistant at the Social Research Centre

for

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FOREWORD

"It's Our Home" is a companion volume to *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector*, which is being published simultaneously by the National Council for the Aged. Whilst the latter focuses on quantitative data relating to homes and their residents, the present study concentrates exclusively on the quality of life enjoyed by those who find themselves for one reason or another living in nursing homes.

"It's Our Home" is also the third in a series of studies published by the Council which concentrates on the quality of life of old people living in different settings. In common with two other publications, which relate how elderly people experience life in a rural and in a suburban area respectively, this study relies on old people's own accounts to relate as faithfully as possible how they experience their life situation.

The Council is particularly pleased to be able to present this report because the significant growth in the number of nursing homes established in the last decade indicates their importance as a life setting — often an end-of-life setting — for many old people. It provides information about nursing home residents, their attitudes about planning for the eventuality of going into homes and why they did so, aspects of daily life (both of the able-bodied and the more incapacitated residents), their social contact patterns and their levels of satisfaction with living 'in care'. The views of nursing home staff and of relatives complement those of residents, to give a comprehensive picture of the quality of life in private and voluntary nursing homes.

The purpose of such information is to increase understanding of nursing home life. This will, the Council hopes, be of benefit to the general public, to those involved in the running of nursing homes and to those whose responsibility is to ensure that appropriate standards are maintained in all nursing homes.

Whilst the Council believes that the levels of material and service

provision in nursing homes has a direct bearing on the quality of life of residents, it does not accept that they, of themselves, guarantee a good quality of life for such people. Once again, this report underlines the heterogeneity of all elderly people. As such, the Council hopes that it will promote both a better understanding of nursing home residents and ever improving standards of life for residents which will answer their individual needs.

The Council would like to thank the authors, Professor Joyce O'Connor and Ms. Marie Walsh, for preparing this report on its behalf. It congratulates them and the whole team at the Social Research Centre, N.I.H.E., Limerick for their achievement in providing such a clear picture of the quality of life in voluntary and private nursing homes. This is based on detailed and exhaustive interviews with nursing home residents, their relatives and staff in nursing homes in the Eastern Health Board area. Without the co-operation of these people, the report would not have been possible. The Council is therefore indebted to them for their invaluable assistance and goodwill.

It wishes to thank also the members of the Consultative Committee established by the Council to provide guidance and advice in preparing the report. The members of this Committee are listed in the authors' acknowledgements. Finally the Council wishes to thank its own staff, Mr. Bob Carroll, Secretary, Mr. Michael Browne, Research Officer, and Ms. Jennifer Leech for their considerable contributions to the production and publication of the report.

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September 1986

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Mr. Michael Browne	Chairperson, Consultative Working Group and Research Officer, National Council for the Aged.
Mr. Lorcan Byrne	Member, National Council for the Aged and Friends of the Elderly.
Dr. Davis Coakley	Consultant Physician in Geriatric Medicine, St. James's Hospital, Dublin 8.
Ms. Margaret Horne	Member, National Council for the Aged and Head Social Worker, Adelaide Hospital, Dublin 8.
Mr. Brian Harvey	Member, National Council for the Aged and Information Officer, Simon Community National Office.
Ms. Maeve Keane	Member, National Council for the Aged and Matron, St. Mary's Hospital, Dublin 20.
Mr. Charlie Killeen	Senior Executive Officer, Hospital Department, Eastern Health Board, James's Street, Dublin 8.
Dr. Pat Quinn	Director of Community Care, Eastern Health Board.

Ms. Sheila Simmons	Member, National Council for the Aged.
Dr. Cyril Warde	Director of Community Care, Eastern Health Board.

We are particularly grateful to Dr. Dick Stokes, formerly Director of Community Care, Limerick, and to Mr. Kieran Hickey, Eastern Health Board, for their practical guidance in the planning and organisation of the study. Their support and advice deserve special mention. Dr. Joe Robins and his colleagues in the Department of Health, the Programme Managers and Directors of Community Care in the study area greatly facilitated the study. Special thanks to Mr. Donal O'Shea and Mr. Michael McLoone, North Western Health Board for their detailed outline of one of their programmes of care for the elderly in Buncrana. While not attempting to name each individual, we would like to express our appreciation to all concerned. The fieldwork was executed with the highest degree of professionalism and commitment by members of the Social Research Centre's Survey Unit. The interviewing team consisted of: Siobhan Carey, Barbara Crowley, Gemma Rowley, Kevin Thompstone and Marie Walsh. They put few limits on their working hours and their work laid the foundations of the study. To them goes the credit for the high quality of the data received.

The contribution made by other Social Research Centre staff Members is also recognised, among which the help of Emer Smyth, Mary Donohue and Mary O'Donoghue deserves special mention. They carried out the content analysis and provided the material from which the qualitative data were organised in a systematic way.

Karen MacCarthy worked prodigiously and with unfailing spirit on several transcripts of this study. Her skill and expertise contributed in a major way to the production of this report. Ms. Lindsay Mitchell and Dr. Kieran McKeown read through several drafts and made very constructive editorial comments. Ann Lynch and Heather Sheane proof-read initial drafts of this report, and their help was much appreciated.

The study's greatest debt is to the residents, relatives and staff who kindly gave of their time and of themselves. Their contribution and kindness is gratefully acknowledged. The generous co-operation of the proprietors/persons in charge and the staff of the nursing homes visited is also acknowledged.

None of the above mentioned is responsible for the final manuscript. Any errors or omissions are the sole responsibility of the authors.

CHAPTER 1

INTRODUCTION: BACKGROUND AND FOCUS

Introduction

This study is about the quality of life in private and voluntary nursing homes in the Republic of Ireland. It is based on information gained from a sample of elderly people who have taken the step of moving into a nursing home. In this study elderly residents and their relatives describe their own experiences. The staff working in the homes outline their experience of working with the elderly. This report will allow policy makers, service providers, educationalists and researchers to further examine the quality of life in nursing homes. An equally important outcome, however, is that the descriptions of life in nursing homes can be passed on from those people who have actually experienced this life-style to those who may be considering the decision to go into care now, or in the future.

Recent trends in research, which are directed towards a better understanding of the ageing process, have shifted from quantitative to qualitative approaches. Some commentators have suggested that people's adaptation to later life can most effectively be studied through an examination of the life-history of an individual. A variety of life-styles and adaptations related to life experiences, marital status and gender make it impossible to speak of a typical elderly man or woman or a typical form of adaptation. The eight profiles presented in Chapter 2 clearly illustrate these points. This study looks at what the nursing home offers, with a description of some of the physical features and arrangements for care, its facilities, services, staffing and admission and discharge procedures. A profile of the residents in care is presented. The description of staffing arrangements and buildings provides a context in which to evaluate care.

The focus of this study is on the quality of life of elderly people in nursing homes. What are the attitudes of staff to residents? How did residents come into care? What and how were the decisions made? What kind of

institutional regime exists? What is the reality of living, on a daily basis, in care? Do residents have social contacts in the home and how do they maintain links with the community? What are residents' needs, worries and fears? The study also explores the experience of residents, particularly how they have planned for later life and retirement. Residential life and the quality of life experienced, as told by the elderly themselves, are described. Policy issues relating to the care of the elderly are discussed in this context.

There is growing concern amongst policy makers and service providers about the provision of care and the rights of elderly people who are in institutions, in particular in nursing homes. The National Council for the Aged has recently published a general report: *Institutional Care of the Elderly in Ireland.*[1] The present study is the second stage of a research programme designed to help policy formation in the area of nursing home care of the elderly in Ireland. The first stage, which outlined the context in which care is provided, is the subject of the report, *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector*, a National Council for the Aged publication also prepared by the Social Research Centre. The central concern of this report, *"It's Our Home"*, is to outline the quality of life experienced by residents in private and voluntary nursing homes.

Previous Research: Issues Raised

The critique of residential care, particularly in the United Kingdom and the United States of America, is long-standing. The work of Peter Townsend, in the late 1950s, can be seen as providing a benchmark and setting the focus of research in this area. Recently, research has begun to focus more sharply on the quality of life issue. It has highlighted the capacity of residents-in-care to respond to the fostering of self-determination and to benefit from a supportive environment. Attention has also focused on the broader issues of the provision and integration of private care into the range and mix of sources of help offered to the elderly. The response to the these concerns has been to call for a major review and regulation of nursing homes. There has been no representative study which explores the dimensions of nursing home care with the purpose of informing the legislative and regulative process. This study, together with the report *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector* fills this gap by providing baseline information on which a new code of practice might be based.

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[1] National Council for the Aged, *Institutional Care of the Elderly in Ireland,* Dublin: National Council for the Aged, 1985.

The Research Programme

The Research Programme looks at two separate but interrelated and complementary aspects of the care of the elderly in private and voluntary nursing homes. Two stages of investigation were involved. In the first stage a quantitative approach was adopted and a Census questionnaire was carried out involving all the private and voluntary homes known in the Republic of Ireland. The results of this are reported in *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector.* In the second stage a representative sample of 24 homes was selected and a sample of residents, their relatives and staff was chosen for a study of the quality of life among residents. This detailed study used a combination of quantitative and qualitative methods. The fieldwork commenced in March 1985 and by May 1985 it was completed.

National studies are generally based on structured interviews and they present findings in the form of statistical results. It is rare for statistical analysis to bring out the rich and complex realities lying behind the facts and figures. This is where the value of smaller studies based on qualitative research is maximised. The case-study material and the qualitative analysis allows us to go behind the detailed statistics and can give us some understanding of the lives of residents in care. The study was conducted in a series of stages. Firstly, there was the background research which involved both documentary and in-depth, semi-structured interviews; next came the pilot phase of the study, and finally the main study was undertken after detailed analysis of these pre-tests. A brief outline of each of the stages is now presented.

Pre-test and Pilot Stage

The preliminary reserach consisted of a series of informal, in-depth interviews and discussions with nursing home proprietors, staff, relatives, residents and service providers. A detailed content analysis of the data was then undertaken in order to structure the in-depth interviews with residents. In the case of staff and relatives, the pre-tests helped structure the questionnaire. These interviews assisted the exploration of the conceptual area of the study and helped focus and define the research design. Similar stages of development were followed for the study, *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector*: the resident's interview, the staff questionnaire and the nursing home census were undertaken in three locations around the country. The pilot study was regarded as an integral part of the research design and many changes were made to the interview schedules and questionnaires. During the various pre-tests and pilot phase, consultations and discussions were held with various individuals and groups including the Consultative Working Group

set up for this study by the National Council for the Aged. These discussions proved to be of major benefit to the study.

Main Study

The data for this study were obtained from a multi-stage random sample of 24 nursing homes. Fieldwork was completed between mid-March and May 1985, with a total of 20 homes visited and 97 residents, 22 staff, 18 relatives interviewed. Four out of the 24 homes selected did not participate. Two proprietors refused to allow Social Research Centre fieldwork staff to interview residents, on the grounds that they felt that the homes they ran were too 'up-market' to allow intrusion into the lives and privacy of the residents. One nursing home proprietor agreed to let the study take place on the understanding that at each interview with a resident, a staff member or the doctor attached to the home, would be present. This was a condition which we felt we could not fulfill and so this nursing home was not included in the sample. The fourth home was one that had a very high percentage of confused residents and it proved impossible to interview them.

The interview with the resident was usually carried out in private and recorded on tape, and all residents were assured of confidentiality. In a few cases, staff members came in during the interview. In one nursing home residents were advised by staff not to be interviewed on tape, and in this case, the interviewer took notes during the four interviews and then immediately after each interview taped the answers in each of the areas covered during the interview. Interviews with staff and relatives were carried out in private. The quality of the completed interviews was very high and the proposed study was generally well received.

Fieldwork Training and Organisational Arrangements

Considerable time and effort was devoted to interviewer selection, as the empathy and sensitivity of the interviewer to the nature of the study was of paramount importance. A number of criteria guided the selection of interviewers including interviewing ability and experience, empathy with the study population, attitudes towards the elderly, organisational ability, capacity to work as a team member and interest in, and enthusiasm for, the job. The fieldwork team included five interviewers who underwent a training programme. The main focus of this programme was to enable interviewers to become familiar with the interview schedule, to achieve a full understanding of the project and to impart a common approach. The programme covered the following areas:

- Familiarity with design of study
- Detailed briefing on, and knowledge of, research instruments

- Simulated interviewing
- Interviews with elderly residents, their relatives and staff
- Discussion group after "trial" interviews.

The Research Instruments[1]

Census: Proprietors/Persons in Charge

Essentially the investigation involved a Census questionnaire being sent to voluntary and private nursing homes. The following areas were covered in the Census:

- Nursing Homes: The Physical Environment
- Profile of Residents in Care
- Facilities and Services: The Living Environment
- Staffing Provision
- System of Admission and Discharge.

This self-administered questionnaire was structured and pre-coded, with a fixed sequence of topics to be followed by the proprietor or person in charge of each home. Interviewers called to each home to collect the Census questionnaire and checked that all questions were adequately answered. In some cases the Census was sent back by post to the Social Research Centre.

In-depth Interview

Residents were given an interview which used a structured format of questions, organised to resemble a conversation with a purpose. The interviews were recorded on tape. The main focus of this interview was to let the elderly speak for themselves. The interview covered the following topics:

- Going into care
- Daily dimensions of residents' lives
- Social contact patterns
- Life satisfaction, needs, worries and fears
- Planning for later life and retirement.

A pre-coded questionnaire was also used to get factual information from the residents and this covered areas like socio-economic characteristics and

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[1] For a full discussion of the methodology see *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector.*

health. An index of life-satisfaction was used but not analysed as it confirmed our experience that the elderly responded much better to a more qualitative approach because it enabled them to define their situation for themselves.

Structured Interview: Staff
Staff members were interviewed by the use of structured, but open-ended, questions. The areas covered were:

- Background information, socio-economic and employment characteristics
- Awareness of the needs of the elderly
- Stereotyping of residents in the nursing home environment
- The ethos of the home
- Coping with residents
- Personal experience of the elderly
- Career expectations.

Structured Interview: Relatives
The relatives' questionnaire was also structured but open-ended. It covered the following areas:

- Relationship of relative to resident in care
- Feelings of relative on placement of resident in care
- Level of communication with resident
- Effect of residential care placement on the quality of communications between the resident and family members
- Relationship between resident and staff
- Perceived effect of residential care on the quality of relatives' lives
- Socio-economic background.

Analysis of the data
All the interviews were assessed thoroughly by listening to them on tape prior to getting transcripts of the tape. A detailed content analysis, organised around the main themes of the study, was then undertaken. This content analysis was very painstaking and time-consuming. However, it was felt that such care and detail of analysis enabled the researchers to let the elderly speak for themselves, and to identify issues that are central to any discussion on the quality of life in residential care.

Consultative Working Group – National Council for the Aged
Throughout the course of the study the authors were able to consult with a

small consultative group, set up in February of 1985, to promote the progress of the study and to ensure that it addressed key issues. The main focus of this group was policy-related.

Organisation of the Report:
This report is organised into ten chapters. Chapter 1 describes the background and focus of the study. Chapter 2 presents eight portraits which help to illustrate the diversity of the lives of elderly people in care. A description of the residential care and a profile of the residents is the main focus of Chapter 3. Working in residential care is the focus of Chapter 4. Residents' descriptions of going into care are given in Chapter 5. In Chapter 6 the experience of living in care and its daily dimensions are detailed. Chapter 7 explores the range and extent of elderly people's social contact both inside and outside the home. Their level of satisfaction together with their concerns are the focus of Chapter 8. Chapter 9 outlines residents' views and experience of planning for later life and retirement. The final chapter, Chapter 10, reviews the main findings of the study and raises a number of key issues relating to the findings. A bibliography accompanies the main text, listing all those books found useful in the preparation and writing of the study. The report contains four appendices. The first appendix contains tables relating to the residential care setting and the residents' profile. Appendix 2 contains the questionnaire designs. The sample selection within nursing homes is given in Appendix 3. Appendix 4 outlines programmes of care for the elderly in the North Western Health Board.

CHAPTER 2

HOME LIFE: EIGHT PORTRAITS

Eight portraits of elderly residents in care serve to illustrate the lives of the elderly, their experiences, attitudes and the quality of their lives on a daily basis. These portraits highlight the fact that the elderly are not a homogeneous group, that people differ in their life experiences, so that for some, life in care is a prison and for others, an opportunity for a new life, a development of unrealised potential. Life events, social, economic and medical, helped shape their lives; residential care is their last refuge.

Esther

Esther's married life and her past experiences are of particular significance, as they help give a context to anyone looking at how she has adapted to life in the nursing home. Esther had a very hard life and her marriage proved to be exceptionally difficult.

After her family were reared her husband's health deteriorated:

> "My husband was very sick, mentally ill, he was violent and I nursed him till he died. I got terribly run down ... I had a very hard life".

Esther's life was further complicated by her family problems which left her emotionally spent and unable to cope with her youngest daughter's decision to move out of home. Esther is not the type of person who could live alone. She was unable to cope with the 'emptiness' of her home and her life:

> "It was the loneliness I found the hardest. I felt isolated at home particularly during the day. I weighed just seven stone and looked about ten years older than I do now".

Her doctor told her that if she didn't pull herself together and try and reorganise her life she would die. Esther saw the nursing home as her last

hope and once she moved into the home she felt herself beginning to recover.

After a very restrictive married life, which denied her any sense of freedom and caused her great mental and physical stress, the nursing home proved to be a totally new and rehabilitating change. Her new-found freedom allowed her to come and go as she pleased, to make decisions for herself and gave her confidence in herself and a sense of assertiveness which she had lost:

> "I had no confidence in myself before I came here. I hadn't the courage to go out; now I feel I have far more courage than I ever had. If I want to go some place I will go there. Before I wouldn't say boo to a ghost but I have got very bold since I came here".

Esther finds plenty of activity to fill her time in the home including doing messages for others. "It never feels monotonous, not anything like I found it at home, I never feel bored".

The only complaint she can make about the home is the lack of company of her own age. She also feels that an occupational therapist would be a great asset to the home "to get people interested, to raise them a bit".

The impression Esther gives is of a strong, resilient woman who has managed to survive years of family tensions. In the nursing home she has found hope and a new way of life and she is eagerly determined to enjoy herself, while helping anyone who comes in contact with her along the way. As she says herself "before I came here I was praying to die, now I love life, I have really lived since I came here".

Paul

Paul is eighty-five years old and has been living in a nursing home for more than three years. He can no longer leave his room which, unfortunately, is on the third floor of the building. Like many nursing homes, there is no lift and he can no longer manage to climb the stairs.

Paul has had very little contact with other residents in this home during the past year because all the residents on his floor are confined to their rooms.

Although Paul doesn't say so directly, one senses that he misses the warmth of family life. He speaks with great affection and admiration for his son. Paul's wife died suddenly many years ago, and even today one sees that he still feels the loss of his partner.

Although this was a severe shock to Paul, he is not a man who succumbs to self-pity or despair. He describes himself as a stoic individual, who doesn't worry unnecessarily. Today he accepts his lot in life with a good grace, and makes the most of his situation now. Paul takes life as it comes

now; he lives one day at a time.

Paul's greatest worry in the past few years is that he should die suddenly, alone. For this reason, he gave up his own home and decided to move to a nursing home. For Paul, this move gave him an added sense of security. Since he moved to the nursing home, however, he has come to realise that even there, he has no guarantee that he will die in the presence of others. This realisation came to him when he heard of other residents dying alone and unattended. He says:

> "There has been a case or two here where a man died suddenly and he wasn't found by the night nurse for two or three hours".

Paul gets on well with the staff members. He appreciates the difficult nature of their job, part of which involves bringing meals from the basement to residents on every floor of the house. This has been a particularly difficult task for a nurse on night duty who may have to cope alone, or with the aid of one other person, with breakfasts for thirty-five people. The situation has changed somewhat now, with two night nurses on duty.

He also praises the matron:

> "The matron comes in nearly every day to see how I am doing. She stays a little while and talks. She is exceptionally kind and good and very considerate, there is no mistake about that, and that is something which, I can tell you, is not in every nursing home".

It is precisely this human touch that makes life tolerable for Paul, who now spends the greater part of his days and nights alone.

Paul has to occupy himself largely by reading the daily papers and library books supplied by his son. He now finds it very difficult to read, and only reads with the aid of a magnifying glass. Paul's interest in, and knowledge of, current affairs is obvious from his conversation. He was aware of forthcoming legislation on nursing homes, and referred to the fact that they occasionally have visits from the Health Board personnel — "who come to the door and look in and ask you how you are".

Paul chose this home because he knew he would be looked after there until his death, and he therefore accepts, without any trace of self-pity, the limitations imposed on him by his failing health and by the physical structure of the nursing home.

Paul can be described as a man at peace with himself. He has led a full and busy life and even today he manages to occupy his time. He would love to go outside again but knows now that this is no longer possible for him; so he accepts that he will never be able to go out of doors again.

Mary

Mary's outlook on life contrasts sharply with that of Paul's. Unlike Paul, she is ill-equipped to cope with the situation in which she now finds herself. Mary too resides in a third floor room of a nursing home. Like Paul, she is also confined to her room, but cannot move at all without assistance. Whereas Paul has a room of his own, Mary shares a room with two other residents, but this fact does nothing to improve her situation. Both of Mary's room mates are confused, and are unable to carry on a conversation. Mary longs for a room of her own, or at least a room with a non-confused companion on a lower floor, but she says such a room would be too costly. Mary has few visitors either from inside or outside the home. On occasions, when Mary has visitors, normal conversation is made impossible due to the constant interruptions of her confused room mates.

Mary is further handicapped by the fact that she is partially blind. This prevents her from reading and watching television or playing cards. Not surprisingly, Mary is a very lonely woman. During her earlier years, she always had lots of friends and companions. She misses that company and friendship now. Mary never married, and she has one brother who comes to see her occasionally. She lived with her brother and his wife for some time before she was moved to the nursing home. Her sister-in-law is a more frequent visitor, but the relationship between her and Mary is not good. Mary describes her as being "hard" and insensitive to her needs. Mary had no say, whatsoever, about going into the home. She had been ill in hospital and her sister-in-law had her moved to the nursing home. She says "they just brought me here, I could do nothing about it".

John and Noel

John and Noel are two elderly men, who probably never met one another, but whose pattern of life has many similarities to that of other elderly people.

John and Noel could best be described as confused. Noel, as well as being confused, has had a leg amputated, and he feels that this is the reason why he came to the nursing home. Noel stays in his room all day with the door open. Like many other elderly people, he does not like to feel shut-in in a small room. Noel has not developed any special friendship with other residents; he spends his day alternating between sitting in his chair or lying in bed. Noel says he can manage with difficulty with the help of his walking-aid to move between his bed and chair.

John is not physically handicapped like Noel. He can walk around the home and says he is free to go out to town if he wishes. He says — correctly — that it's a ten to fifteen minute's walk to the town centre. John admits quite freely that he spends most of his day sleeping — he corrects himself to say

"not really sleeping, but it seems like that".

John is staying in a home which might not be able to cater for him much longer. This home is a retirement home, and the residents must be able to look after themselves and their personal hygiene. This is becoming a problem for John who is sometimes incontinent. The matron in this home is very good to John, keeping a special eye on him and making sure that he is ready for breakfast in time in the morning and checking on him last thing at night. Although John appears to be sleeping most of the day, he knows a good deal about the daily running of the home and mentions some of the activities of the other residents during the course of conversation.

Neither John nor Noel find their daily life monotonous, both are content to live in a home, and neither show any indication of unhappiness. Both let it be known, in their own way, that they are aware that they are not regarded as being the same as other adults. John remarks that they always leave a light on in his room at night and says "I wonder why".

Noel insisted on shaking hands several times with the interviewer, asking if the interviewer noticed anything. He pointed out eventually that his handshake was as firm as anyone else's, obviously an indication to him of his normality.

Both John and Noel are slow to advise other elderly people about moving to a nursing home. Neither feel that they could give anyone definite advice for or against the move. Noel says you must do what you want to do. John's advice is to be careful in what you do:

> "Before you consider giving up your home, make sure you know what you are doing. This is something that shouldn't be done too quickly, you should consider the matter carefully and consider your alternatives".

Helen

Helen has lived in a nursing home for the past four years. She made the decision to come to a nursing home shortly after her husband's death. Helen was seventy-five at that time. Her husband's death was a great shock to her. He was many years her junior, and they were married when she was in her mid-fifties. Theirs was an extremely happy marriage, and when Helen's husband died, she suffered from severe depression — so much so, that she had to be hospitalised. As Helen got better, she realised that she could no longer live alone. Although she was physically fit and active, she felt that she was too old to shop and fend for herself, and because she lives on a small fixed income, she couldn't afford to hire any help. Helen has no near-relatives with whom she could stay, so she felt that the only feasible alternative open to her was to go to live in a nursing home.

Looking at her decision in retrospect, Helen feels in some ways that she made the wrong decision. Had her financial situation been better, she would not live in a nursing home. Ideally, if she had her choice, she would like to live in a home where she could meet people and chat, but she says "even if I had the money, I'm probably too old for that now — but I'd have a stab at it".

More so than any other factor, Helen finds that the nursing home she lives in doesn't provide her with adequate company. Most of the residents in this home are confused, a fact which was not pointed out to Helen when she made enquiries about the home. Helen expected to find ill people living in the home, but not mostly 'confused' people. She says:

> "People with all their faculties shouldn't be taken into a place where people are senile. I would expect people to say — 'she wouldn't fit in here at all, she's perfectly sane, she would want to be with people like herself, she wouldn't be happy here'. But nobody cares about you when you are old, nobody gives a damn if you're happy or not, you're only fit for the bin".

Apart from this, Helen finds that she has little in common with the other residents. She acknowledges that her background and life experience differ widely from those of the other residents.

Helen tried to settle into the routine of the nursing home and to become acquainted with the few residents who are not senile. The fact that there is just one room where the residents congregate makes this task very difficult. Because most of the residents are confused, ordinary conversation becomes impossible. The sight of all the residents in varying degrees of 'senility', sitting on chairs lining the walls of the lounge, filled Helen with horror on the first occasion on which she ventured into the lounge, so much so that she felt like running from the room. At this moment, Helen realised that she had chosen the wrong nursing home for her, but couldn't summon up the energy or the finance necessary to investigate and choose a home more suited to her needs. Neither did Helen expect to live so long. At the time that she entered the nursing home, she thought that she would probably die within twelve months but this was not to be, and she has now been a resident for over four years. Helen thinks that it's too late for her to change now, but she is bitter about 'being led up the garden path' by the proprietors who, seemingly, went out of their way to encourage her to enter their nursing home.

Life would be more bearable for Helen, who at the moment is recovering from an operation, if she could get a medical card. Helen is quite deaf and she also needs to have her glasses changed. Because Helen lives on a very small fixed income, the bulk of which goes to pay for her upkeep in the

nursing home, and leaves her with approximately five pounds per week for her personal needs, she cannot afford to pay for her extra medical expenses. Helen has some old friends who come to see her occasionally, but since she became ill and confined to her room, her main link with the outside world is a male resident who is amongst the very few, in this home, who venture out alone. She describes this resident as being very good to her; he comes in occasionally to sit and talk a while, and also shops for her when the need arises. The irony of the situation is that had Helen been acquainted with this man in her earlier years, she would not have considered him socially compatible. Now old age, loneliness and isolation have drawn them together. Helen hates to be old. She thinks that there is no place for old people in our society. As far as she is concerned, once you have to live in a nursing home, your life is over. She says:

> "You're boss of nothing, you have to fit in with everything. You only go into a nursing home to die. All your independence is gone".

Helen goes as far as to suggest that you should be "put to sleep" at seventy, because in her eyes old people are a nuisance for themselves and other people. She says:

> "When you get old — you're old. You can't make plans, you're better not here at all. When you come to seventy, nobody wants you —everybody likes to be wanted, and you're not wanted when you are seventy. Nobody understands what it's like to be old, until you are old".

Tom and Betty

Tom and Betty are a retired couple, who made the decision to go to live in a home. Both are in their late seventies, and are in good health. The home they chose to retire to is a retirement home, which caters for elderly people who are still active.

The main reason for this couple to move to the retirement home was to maintain their independence, which they were unable to do in their own home. When Tom retired he found that he didn't qualify for a contributory old age pension. All his efforts to get a reduced contributory or non-contributory pension failed, so Tom continued to work until he was about seventy, when the firm he was working for, at that time, went bankrupt, and he was given his notice.

When Tom and Betty came to live in the home, they were extremely fit and active people; this is still the case for Tom who is seventy-eight years old. His wife, who is a year older, finds that she now tires very easily. Both have adapted to their new life style in their own ways. Tom did not let retirement or his new environment depress him or deter him from doing the

sort of things he has always done. So how does he spend his day?

"Well first of all I go out and collect the newspapers for those that have them ordered; after that I'd sit down and read the newspaper. If I had anything up town to do, I'd go out. I am a general handyman, I do repair works for this entire building. A lot of the residents ask me, if they break their furniture, break their radios, break the electric light, break this and the other, (that's the usual) would you ever fix it for me; so there's not a room in this house that I haven't done repair work in of some kind, and then I cut all the grass throughout the season in the gardens front and back, I run messages for the matron and one hundred and one jobs, I am just a jack of all trades".

Betty is a far more retiring person. She spends her day sitting in their room reading mostly, but sometimes knitting. She rarely goes to the lounge because, she explained, it is difficult to read with so many interruptions. Betty occasionally goes out to meet her daughter and have a chat over a cup of coffee. She is however less inclined to go out than before.

Betty usually goes to bed immediately after her evening meal. She reads until about midnight every night before she settles down for the night. Tom occasionally watches television in the lounge in the evening. He usually retires at about 10.30 p.m. He has put a bolt on their door, which contravenes the Health Board's rules. Tom is aware that he is breaking the rules, but he put the bolt on the door to prevent interruptions and disturbances during the night. He says:

"I had to put that on because of patients getting up at night time rambling, going around, sometimes I had to get out of bed in the middle of the night and drag them along the passage way and put them back to their beds, with their clothes half naked on them. One woman from across over there, came down here, and came in here in the middle of the night and tried to get into bed with me; thinking she was in her own room".

Tom and Betty have five children, two sons and three daughters. They have a son and daughter living in Scotland, both of whom are married. They also have an unmarried son and two daughters living in another part of Ireland. During the interview, Betty speaks very little except when her family are mentioned. Both of them miss their own home, because they can no longer have their family to stay with them. They cannot have a member of their family in for a meal, and they miss the informality of those family occasions. 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.

Both Tom and Betty agree that the matron is a very nice person who tries her best to please all the residents and to remember their various likes and dislikes.

Life does not always run smoothly in the retirement home. During the course of the conversation one can detect undercurrents which suggest that living in an institutionalised home is not easy, even for a couple who have each other's emotional support.

Betty sometimes feels unwanted, isolated from her family. Ideally she would love to be in the midst of her family, knowing that she was loved and cared for. The move to the home has upset her more than her husband; he, in a sense, can continue the pattern of his daily activities, working as he did throughout his life, and retiring to his room which is their 'home' at night. She, however, no longer has enough to do to occupy herself, and one gets the impression that the people with whom she would like to be occupied are her family.

Betty can see some advantages for herself in living in a home. She no longer has to shop or cook, and because prices have risen so much in the past few years, shopping would now be a great source of worry to her.

Tom is unlike many other elderly people, who make very few plans. Budgeting and planning for holidays are the plans he mentions. Holidays have to be planned carefully to suit their families' plans. Tom says:

"You organise all that to suit them and plan in advance".

To Tom and Betty, and particularly to Betty, this will never be home. Occasionally they have discussed getting a flat, or moving to another home, with chalet-type residences. They had one in mind and had their name down for this, but think that it is unlikely that they would be offered a vacancy. Tom is opposed to getting a flat, because, he feels that they would not have security of tenure. "Anything could happen" he says "owners could die, the house could be sold, there may be noisy children, we might not be able to get a suitable replacement flat". During the years since they first moved into the home, they have had some misgivings, but overall they don't regret it, especially now, says Betty, because she feels her health is deteriorating. Although both of them are aware of the fact that residents who need a great deal of care cannot be catered for in the home in which they are now staying, neither of them mention this possibility in relation to themselves.

CHAPTER 3

THE RESIDENTIAL CARE SETTING AND PROFILE OF RESIDENTS IN CARE

This chapter examines the context of care. It explores the dimensions of the physical environment and arrangements for care, facilities, services, staffing and admission and discharge procedures. The final section presents a profile of residents in care. To facilitate the reader, tables contained in Appendix 1 are referred to in the text.

Nursing Homes: The Physical Environment[1]

The analysis of the physical characteristics of the homes indicates that few are in poor physical condition. While gardens are attached to most homes, not all of these were deemed to be accessible to residents with limited mobility. Private homes tend to be smaller than voluntary homes in terms of bed numbers. There are exceptions to this in that a small number of voluntary homes have high bed to resident ratios. Minimum temperature levels are outlined in Department of Health regulations and while most homes do provide central heating, there is evidence that temperatures are not monitored in around one-fifth of homes. Voluntary homes are not required to comply with the 1985 Regulations[2] drawn up by the Minister for Health under the *Health (Homes for Incapacitated Persons) Act 1964.* The findings of this study indicate that very serious consideration should be given to the inclusion of both private and voluntary nursing homes in any new or amending legislation.

Of the 20 homes, only 9 conduct fire drills. This is a cause for concern and immediate action. The safety precautions taken show that over three-quarters of homes have fire escapes. Those that have none consider that the

[1] See Table A.3.1 – Table A.3.14

[2] *Homes for Incapacitated Persons Regulations, 1985.*

number of exit routes from the home for residents is adequate and, in their opinion, a fire escape is unnecessary. Fire extinguishers are present in all homes.

Medical alert or emergency call systems are provided in most homes and located, for the majority, in residents' bedrooms. The results clearly indicate that more attention should be given to locating alert systems in other areas which are frequently used by the residents.

Over two-thirds of the homes do not provide a sluice room. Given that the provision of at least one room, of specified minimum size, is the standard clearly recommended by the Department of Health Regulations, this indicates another area that requires immediate attention.

Facilities and Services: The Living Environment[1]

Most of the homes were not purpose built as nursing homes. All of them have beds on more than one floor and only a third of these have elevators. The importance of this finding must also be seen in context. Most residents are in homes on a long-term basis and, while not affecting all residents immediately, it could become more problematic where mobility decreases with age.

The following findings highlight the ethos of residential care which, overall, can be seen to emphasise continuing dependence and not the maintenance and development of independence. Furthermore, lack of facilities in voluntary and private homes is sufficiently serious to break Department of Health Regulations.

The findings show that, apart from walking aids and wheelchairs, other prosthetic devices are not available. Handrails, when provided, are mainly located in corridors but are rarely installed, for example, in dining rooms or sitting rooms. Ramps are provided as an alternative to steps by less than half of all homes, as are special eating utensils. Lifts, automatic doors and other devices, such as stripes on floors, which facilitate mobility and independence, are rarely provided. Greater use of aids could help in the promotion of independence amongst residents with reduced capacity for self-care.

A sitting room is provided for use by residents in almost all homes. However, a quarter of these are combined with the dining room. A reception area where residents can meet and entertain various visitors is also provided in almost all homes. The situation for residents in multiple rooms, however, is much worse, as they may not have the choice of entertaining their visitors in private. Privacy for residents in multiple rooms can be further affected by the absence of screens around beds.

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[1] See Table A.3.15 to Table A.3.20

The level of personal and recreational facilities provided for residents is limited. The most commonly provided personal services are hairdressing and chiropody; physiotherapy and occupational therapy are less common. Television and newspapers are the backbone of the recreational facilities provided.

The Ethos of the Home[1]

Private homes are more likely to see their main concern as the provision of nursing care, while voluntary homes are more orientated to the provision of non-nursing care.

Involvement with the residents in the running of the home is the exception rather than the rule in the 20 homes studied. Only a third of the homes involve residents, usually in the washing and drying of dishes and laying of tables.

Staffing Provision[2]

Most homes (14) are run by a registered general nurse although 6 are not. Registered general nurses are the largest group of employees in private and voluntary homes. The high number of nursing aides employed is worth noting. The ratio of full-time equivalent nurses to residents is higher in private than in voluntary homes.

As one would expect, the homes make provision for maintaining contact with residents during the night. These provisions include night staffing, staff staying in the same building as residents and staff linked to on-call paging systems. The adequacy of some of these provisions would need to be monitored.

The Department of Health recommends that a general practitioner should be available to residents of every home. Approximately half of the homes have their own doctor. When homes are visited by doctors, weekly visits are the norm in private homes, while in voluntary homes doctors visit as and when they are needed. The adequacy and provision of qualified staff is an issue that needs to be further explored. Specific staff ratios to residents should be given, enforced and monitored.

Systems of Admission and Discharge[3]

Approximately two-thirds of homes have conditions which they specify before residents are admitted to care. The main condition, particularly in

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[1] See Table A.3.21 to Table A.3.24

[2] See Table A.3.25 to Table A.3.31

[3] See Table A.3.32 to Table A.3.35

voluntary homes, is that the resident is ambulant. Waiting lists are common, the findings indicating that voluntary homes are more likely to have a waiting list. According to the proprietors or persons in charge, application for entry is rarely made by the residents themselves. While they are involved in the application process, this is usually done with the help of relatives, friends or service providers.

Short-term care residents are more likely to leave nursing homes to live with relatives or friends. A little less than half of the homes with long-term residents have no special conditions for discharge of residents. The main reasons given for leaving were the need for nursing care, psychiatric care, disruptive behaviour and financial reasons. Discharge from residential care is unusual for long-term residents, further underlining the importance of the creation of an environment that seeks to develop, maintain and maximise the full potential of each resident.

The results outlined above give evidence of a care system that is custodial in orientation, having a philosophy of care that promotes dependence. In many ways the picture of services and facilities available reinforces the stereotype of the elderly as being unoccupied and separate from the rest of society. By providing care that, in many cases, does not respect the privacy and potential of each individual for self-determination, dependence is created.

Profile of Residents

Contrary to the popular stereotype, not all residents are totally dependent in terms of their capacity for self-care. However, there are significant numbers of residents who are dependant, and these are more likely to be in private homes.

The profile of residents in the private and voluntary homes under study indicates that they are more likely to be female (4 to 1 in private nursing homes and 3 to 1 in voluntary nursing homes). Ninety per cent are either widowed or single, with 10 per cent married. For over two-thirds of those who are married, their children are likely to live within ten miles of the nursing home. A third have brothers and sisters who live nearby.

Almost all the residents were over sixty years old, with a very large proportion being over seventy-five years. Most of those interviewed were Roman Catholic. The majority had spent less than three years in the nursing home, and had been living at home previously. Most of the residents had obtained a Leaving Certificate, but less than one-third had any other qualifications or training. The most common occupation was the routine non-manual category; no-one described themselves as having been unemployed. When those interviewed were asked about their own state of health, over two-thirds described their health as being either good, very

good or excellent. Over 95 per cent expressed satisfaction with health care provided in the home. Over half of the residents said they went out of doors at least once a week, a third went out for a walk every day. However, staying out overnight was not a common occurrence. Over 40 per cent of the residents did not have a medical card, and over 55 per cent were not members of Voluntary Health Insurance. Almost 80 per cent had a state pension and almost 30 per cent had an employee pension. In nearly 70 per cent of cases, deductions were made from these pensions towards upkeep in the homes and over half of the residents received no part of their pensions. Almost 70 per cent had other sources of income, most describing this as coming from "savings and investments". Three-quarters of residents said they were unable to save while in the home, one quarter managed to save a hundred pounds.

The next chapter looks at the staff who work in nursing homes.

CHAPTER 4

WORKING IN A NURSING HOME: STAFF'S PERCEPTION AND ORIENTATION

The staff in a nursing home have, in common with any caring institution, a primary role in the creation of the home's ethos and environment. The role of staff is central to the running of the home, as well as to the provision of care. This chapter looks at the staff who work in nursing homes, how they view their work, their daily contact with residents, their views of the needs of the elderly and their career perspective and orientation.[1]

How Staff Perceive the Elderly

When asked how they felt about working with the elderly, the responses indicated that staff were very positive in their feelings. The responses include words such as 'like', 'love', 'enjoy' or 'happy to work with' the elderly. In only two cases was there a negative element in the responses but, in both cases, there were positive elements also, for example:

> "I always liked it, get satisfaction, enjoy talking to them — can be frustrating at times"

> "I become more aware of them as individuals, rather than lumping them together. It also reminded me that I could end up in a place like this myself. It set me thinking about the future".

As a general pattern, it emerged that those who felt they had not changed their views on the elderly since coming to work in the home believed that this was because they were already familiar with, and had an understanding

[1] Twenty-two staff were interviewed: 11 nurses, 7 supervisory staff and 4 nursing aides.

of, old people. Many of those who thought they had changed felt they had learned more about the elderly. Their experience had given them a better understanding of old people so that they now tended to see them as individuals rather than as a group.

Contribution of the Elderly to Society

Staff members felt that the elderly have a major contribution to make to society, "they have a whole life experience, words of wisdom at times; they shouldn't be cast aside". The emphasis of some staff was that the elderly could teach young people and children about life and could also contribute to family life, while others mentioned that the elderly could tell us about things we would not otherwise hear about. Only one staff member thought that the elderly had no contribution to make to society.

Awareness of the Needs of the Elderly

Staff are aware of a wide variety of needs among the elderly. These needs can be classified under three basic headings:

- Physical needs[1]
- Psychological needs[2]
- Social needs[3]

There are differences between taking care of the elderly and taking care of other age groups. In the area of physical needs, staff mention factors such as the feebleness of the elderly demanding a slower pace on the part of the staff:

> "Pace is slow, need to slow down for fear of bumping, to be calm, they get very confused and fussed".

Greater general care is seen as being needed, and a special type of nursing is required for confused and helpless residents. Older people's skin needs more care, particularly in the case of incontinent and or bedfast residents. Regarding the social and psychological needs of the elderly, staff mention

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[1] Including supervision, nursing care, security, adapting one's pace to their's, comfortable surroundings, heat, good meals.

[2] Including total acceptance, affection, humour, reassurance, diplomacy and patience, love, sympathy, independence and a programme of constant stimulation.

[3] Including the need for companionship, letters from family, visitors, a good listener, a home from home, maintaining a way of life which preserves dignity and privacy.

that one needs to be especially kind. The elderly need to be humoured, they need more sympathy and patience and they need someone to talk to and someone to listen to what they say. Compared to younger people, they are seen to be less resilient emotionally and are entitled to more respect because of their age. There is also the different working environment: some staff mentioned that taking care of the elderly in a home was like working in a home environment — the elderly's home. This created more of a bond between the resident and carer, which had some of the characteristics of a family relationship. Only one staff member differed in that she thought there should be no difference in taking care of the elderly and taking care of other age groups:

> "Happy medium needed here — treat the elderly and the rest the same. There is no difference".

Type of Care: Custodial or Rehabilitative?

Staff feel that elderly people should be allowed to do as much as they can for themselves. The elderly should be allowed to remain as independent as possible and encouraged in their efforts, but help should be forthcoming if the resident genuinely needs it:

> "Our old people have to be helped. We get them to help themselves, but their hygiene could deteriorate very quickly".

> "It depends on the physical ability present. They should be constantly encouraged to help themselves — that's most important".

> "Of course, they get all the assistance they need, but aren't helped unnecessarily. Keep them independent as long as possible.".

Staff indicated that the stage at which the staff member would intervene depends on a number of factors:

- The independence or autonomy of the resident
- Hygiene considerations
- Dignity of the resident
- Physical condition of the resident
- Mental attitude of the resident
- Effect of excess help on the mobility of the resident.

When staff were asked about residents being involved in small tasks, the responses indicated a policy of allowing those who want to, to do certain tasks for themselves. In some cases, the staff say the residents are unable to do any tasks, and sometimes only a small number in a home would do laundry or ironing or other tasks for themselves. When looking at these

responses, one needs to remember that some homes tend to accept only a certain type of resident. For example, some homes cater almost exclusively for those who are mentally or physically disabled, while others take residents who are mobile and have all their faculties. Therefore, the variety of tasks, and the number of residents who do certain tasks for themselves, will depend on the type of resident accepted in any particular home, the policy of the home and the staff. Generally, it seems that staff allow residents to do certain tasks if they themselves wish to but, in few cases, encourage them to do so. Tasks mentioned were as follows: laundry, ironing, dusting own rooms, tidying or 'keeping' own rooms, dressing own bed, laying tables, washing dishes, helping other residents, gardening. Sometimes, residents are considered too slow to get involved in the home as well. While staff would not stop them doing anything, they would not ask them to do tasks:

> "They keep their rooms, dusting, making beds, etc. Of course some will do this, others won't. But if they want to, we can't stop them".

This explanation is interesting in that it helps to explain the type of task mentioned: apart from gardening, laying tables, washing dishes, possibly helping other residents and ironing, all the other activities are carried out in the resident's room without much need for supervision by the staff. It is possible that staff will encourage residents to do only certain kinds of tasks. They prefer not to have them involved in other tasks where they may be a danger to themselves and others, or simply because they slow down the work being undertaken. Overall, it would seem that residents are not encouraged to participate in running their home.

Time Available for Residents

When asked if they felt they had enough time to give to the residents, it was clear that staff considered this to be time left over when the "work" is done. Taking care of residents' physical needs is not generally considered as 'giving time' to them. 'Giving time' is interpreted as talking to them, mothering them, visiting them individually and listening to them. This can usually only be undertaken when 'more pressing' tasks have been finished. If the workload is big at any given time, then talking to residents or advising them has to take second place. The following two responses illustrate this point:

> "Yes, we have enough time to give to residents except in the morning when we are very busy".

> "I would like to give them more time but this is impossible with the shortage of staff".

In the area of spending time with residents, all staff agreed that time spent helping the elderly to remain as independent as possible was well worth while since maintaining independence amongst the elderly, for as long as possible, is of vital importance, and every effort should be made to encourage them to remain autonomous.

In relation to this, staff were asked if they thought it was a good idea to spend money on aids and devices for the purpose of maintaining independence. All the staff agreed on this, some qualifying their answers somewhat:

"If they're ones that will suit them".

"Certainly, it's much better for them to get around without the staff".

"Any aid that will make them more independent is terribly important".

"Yes, even on loan — but they must be shown how to use them".

Coping with a 'Difficult' Resident

Staff were asked how they would cope in the following situations:

- with a resident who refuses to eat
- with a resident who wants to go home
- with a resident who is depressed
- with a resident who refuses to speak

Coping with a Resident who Refuses to Eat

The method of coping seems to be to coax the resident to eat, and if he/she still refuses, offer to vary the food or offer drinks as a substitute. Staff suggested various methods of coping with this problem, many suggesting more than one or alternative courses of action. Table 4.1 gives a list of strategies used by staff. One staff member says:

"We don't have that problem, residents like this would have a psychiatric problem. We rarely have psychiatric cases and, when we do, they are not serious. This situation does not arise".

Table 4.1. *List of strategies used by staff when a resident refuses to eat.*

- Substitute liquids, protein drinks or glucose drinks
- Get medical advice
- Coax or encourage resident
- Don't force them
- Investigate reasons
- Keep patience
- Give tonic to increase appetite
- Try something different/vary food
- Be firm
- Leave them alone in the hope that they will eat when hungry
- Stay with them
- If long-term residents, eat a meal with them
- Give small amounts of nourishing food
- Find out food likes and dislikes
- Change to a different room/make fuss over them
- Feed them oneself
- If refusing vehemently, might be put on tranquillisers
- Would have to make some senile patients eat
- Tell them you had some yourself and it was good.

Coping with a Resident who Wants to go Home

Discontentment among residents is seen as one of the most difficult situations facing a staff member. Essentially, they bear the brunt of the resident's discontent in a situation which is not of their making. Some homes deal with this problem by not accepting on a long-term basis, any resident who does not wish to stay. For this reason, in some homes, residents are accepted initially on a trial basis, and if this does not work to the satisfaction of both parties, then the resident is not accepted on a permanent basis. Some staff say that the residents are free to leave if the family are willing to take them. This is the nub of the problem as far as the staff are concerned. They must find a way of dealing with the resident who wants to go home, when their relatives are unable or unwilling to have him or her at home.

Quotes in Table 4.2 will illustrate staff responses to this situation:

Table 4.2. *List of strategies used by staff when a resident wants to go home.*

- "We won't stop them, anyone who wants to go can go."
- "Never hold them here, tell them if they are not happy they can go home. You can't please a hundred per cent of the people all the time."
- "Have a staff conference about the resident."
- "Talk to resident's G.P."
- "We have to deal with each case individually, they settle down after a while, takes time to settle. Reassure them they don't have to stay. Sometimes they think they have been dumped."
- "It takes a while for them to get settled. Most of them don't want to come really. So we try to get them to settle down. Talk and explain it's for their own good."
- "Usually senile. Talk to them and advise them. Sometimes say 'there is a bus strike on'."
- "Usually, very confused people. Say 'hold on we'll see'. They often forget about it then."
- "Say, I'll ring your daughter, but she's out."

The overall picture which emerges from the responses is as follows:

- Staff will talk to the relatives, other staff members or their General Practitioner.
- Staff will not hold the resident against his or her will.
- Staff will convince the resident that the home is the best place, by means of reassurance, helping them to settle, humouring them, discussing the situation.
- Staff will put off giving a direct response, hoping the resident will forget about it.
- They may also attempt to deceive the resident by pretending something is being done about the situation.

This last category of response can only be described as being thoughtless, and most surely cause considerable anguish and uncertainty to the residents involved.

Coping with a Resident who is Depressed
In their answers to this question, many of the staff suggested more than one way of coping with a depressed patient. Some suggest initial strategies which are usually followed by seeking medical advice if they don't work: Seven of the 12 staff who would seek medical advice would seem to do so at an early stage. Some of the responses are as follows:

"Doctor usually prescribes anti-depressant, encourage them to mix and go out."

"We'd get the doctor and they would probably be sedated. We'd also talk to them."

"Discuss with Consultant Psychiatrist. Refer to treatment if necessary."

Coping with a Resident who Refuses to Speak
The staff we spoke to saw this as being linked with a state of depression, and thought that in this case they would probably get a doctor. One member also said she would include in this category residents who answer only in monosyllables. These responses illustrate how staff would cope with this situation:

"Keep talking to them regardless, as if they were answering. Try and find the reason."

"Encouragement. Sometimes happens when they blame relatives."

"We'd keep talking to them, try to build up their confidence."

"Leave them alone."

It is worth noting that nearly a third of the staff interviewed could not suggest any method of coping with a resident who would not speak. No staff member interviewed suggested involving the family of the resident in the problem.

Description of an Ideal Resident
Staff were then asked to outline a description of their view of an "ideal resident". These views give a good indication of their orientation to, and perceptions of, the elderly. Most of the staff answered this question from the point of view of the ideal resident being one who will 'fit in' in the home. Only five staff indicated that they did not think in terms of ideals, and one of these qualified her answer as follows:

"I don't know if there is an ideal resident — but if the resident is able

to manage everything, if he/she knows the routine and can organise his/her own routine over that of the house — also one who is very helpful."

The other staff members say:

"We're here to look after them, there isn't an ideal."

"They're all different, I don't think in terms of ideals, we are here to help whoever comes to stay in this home. There are no ideals."

"Everyone is individualistic — there is no such thing as an ideal resident."

"They're all the same to me."

Table 4.3 outlines the personality traits and characteristics which were mentioned by the staff who saw an 'ideal' resident as one who fits in.

Table 4.3. *Profile of an 'ideal resident'.*

- Undemanding
- Chatty
- Not troublesome
- Thoughtful
- One we don't know is in the house
- One who can look after him/herself, independent
- Fits in
- Co-operative
- Healthy
- Serene
- A good outlook on life and accepts age
- Likeable person, outgoing and cheerful
- A good mixer
- Actively interested in the home
- Easy going and friendly
- Physically and mentally capable of participating and enjoying various programmes.

In one instance a staff member said that all residents were 'ideal', they all 'fit in'. This home takes the residents for a trial period and if this does not work to everyone's satisfaction then the resident is not accepted on a long-term basis. Although independence was mentioned frequently by the staff, one person pointed out that contentment was more important:

> "What matters is that the resident is content, that they are happy, making progress, doing something, you could have a totally independent resident who is an agitator."

Other staff saw an ideal resident as one who had interests which he/she pursued, and who had his/her faculties. This was sometimes linked with being mobile and independent. The following responses are typical of these:

> "Comes in mobile, able to look after themselves, independent orientated, able to go out."

> "Someone who is fairly mobile, independent and has some interests, i.e., reading, TV, knitting."

It seems that the staff who saw the resident's contentment as being most important, and considered the pursuit of interests and having the faculties and health to do so, were looking at this question of the 'ideal' resident from the point of view of what was good for the resident, rather than what was manageable for the home.

Recreational Facilities Available

From the staff answers, it appears that very little is being done in nursing homes to provide recreational activities. It must be noted that the type of activity and facility provided will depend, in part, on the cost, and also on the response from the residents. One staff member said that the residents in the home in which she worked were not interested in occupational therapy. It appears that many residents are not physically well enough, and do not have the mental concentration for sustained activities. It cannot be stressed too often however, that when we speak of the elderly we are not talking about a homogeneous group. We are speaking about individuals, each of whom has his/her own likes and dislikes. Some may like organised activity — some may not, and their wishes must be taken into consideration. It must also be remembered that these people have often grown up in times when the individual rarely put his/her own feelings and priorities first. Future generations of elderly people may be more demanding. As one staff member commented:

> "This generation of elderly had hard lives, their expectations are low

— today's generation would not live in this type of environment, they have too much — what will they be like in fifty years time?"

The 'Ideal' Nursing Home

The answers to this question reflect the staff's views on the structure of the building, staffing levels, activities available, facilities, type of resident catered for, meals, atmosphere, location, size, quality of staff reflected in the type of care provided, and a recognition of the individuality of residents. The most important factor is that there should be a homely atmosphere, where residents can relax. Many of the responses to this question include several features which should be incorporated into an ideal nursing home. Table 4.4 gives a sample of the kinds of replies that were received.

Table 4.4. *Staff's Perception of the 'Ideal' Nursing Home.*

"The meals should be varied and of a very high standard. The residents should be treated as individuals and there should be first class bathing facilities. The bedrooms should be bright and cheerful looking."

"Custom built, single storey, all on one level."

"A home from home — must be homely. Give them food, heat and be nice to them. Not glamour [they] need a reasonably sized room as well, not the tiny place they put them into in some homes."

"It should be a caring environment — people should be allowed to relax and know that they have nothing to worry about and there is always someone there to talk to."

"Well-run, good nursing care, hygiene."

Career Development

The vast majority of staff interviewed (18) indicated that there is no policy on staff development in the homes in which they work. However, some staff members thought that the practical experience gained through working with the elderly and from discussing cases, provided a means of staff development. One person said that in-service programmes were organised for them.

When asked specifically about their career development, 20 of the 22 staff answered the question in terms of their career in five years time but not all answered from the point of view of career development alone: some staff

included an element of personal development in their answers. Overall, the answers imply that staff put little emphasis on career planning. Fifteen staff indicated that they would remain in the same job, although one qualified her answer by saying "unless it was nearer home".

The people in the supervisory group are more attached to their job than those in the staff group. All eight who responded to this question, indicate that they would not change to another job, whereas six of the staff group would change their job, or consider doing so, if the opportunity arose.

Summary

Overall, the profile of staff which emerges is one of a hard-working, warm, caring group of people who are interested in the care and well being of the elderly. As one might expect, the staff themselves are not an homogeneous group. One common element however, is that they do have an awareness of the needs of the elderly. Staff, in general, hold that it is important to view the elderly as individuals, rather than a group. They see the importance of enabling elderly residents to become independent. However, they appear apprehensive about getting them involved in activities where risks are involved.

Strategies used for coping with the elderly on a day-to-day basis vary widely. It appears that the structure of the homes, and the constraints of time and staffing, place considerable emphasis on physical care. Physical needs are given priority, and giving time to the residents is something that happens in an unplanned and haphazard way. Many of the staff indicated that often the physical health of a resident improves greatly when the resident has regular meals and good nursing care. The ethos of the homes is oriented to the management of care. Most staff enjoy working with the elderly whom they see as having a contribution to make to their communities, family, friends and nursing home. However, on other occasions they are often referred to as "being like children". In many ways staff seem to think one way about the elderly and, on a day-to-day care basis, act quite differently. In practice the most convenient and 'realistic' solution applies when dealing with residents. While it is not the norm, the suggestion that problems can be sorted out by the use of drugs, or by treating residents as if they did not know what was going on needs to be viewed with some concern. The orientation of staff is to care within a "homely" context with the individual being the focus for care rather than the group. The reality of care on a day-to-day basis, however, falls short of these aspirations. Most work in situations where staff development is minimal and the career development of staff is not addressed by management or by staff themselves. Most of the staff saw their current job as one which would remain. Future plans were vague as far as career planning and development were concerned.

CHAPTER 5

GOING INTO CARE

Community care of elderly people has been the explicit aim of governments and all political parties over the last three decades. While the precise meaning and application of the concept has varied considerably, it has been taken to mean the maintenance of independence in the community for as long as possible. Research in the United Kingdom and the United States of America has shown that a significant proportion of residents in residential care are physically and mentally capable of living more independently in the community. For a large number of elderly people, admission to a home rests on social factors such as the lack of alternative forms of care, rather than simple physical or mental disability.

In this chapter we examine the reasons why residents go into care together with the views of their relatives and the staff of some of the homes in which they live. The process of choosing residential care prior to moving into a nursing home is also considered. Who makes the decision to come into care is explored. Finally, we look at how residents adjust to life in the nursing home.

Going to Live in Residential Care

The elderly gave many different reasons for their entry into residential care. In some cases more than one reason was mentioned and sometimes a very obvious reason, for example a stroke or some serious physical disability, was not mentioned at all. This may be because the resident does not consider the physical disability to be serious enough to warrant residential care. It may also reflect the attitude that the elderly resident may feel that he/she could have continued to live in the community if more care had been available.

Not all the residents were forthcoming with their viewpoints when the question of entry into residential care was discussed. This could indicate

that all the residents were not happy with the way the decision was reached, and certainly, in a few cases, the interviewers felt that the resident was "putting on a a brave face":

> "I was living in a granny flat, my daughter made all the arrangements for me to come here."

> "My daughter encouraged me to come here, it is nearer to her home than the other home I was in, and she knew I was unhappy there ... I agreed with my daughter that I would not intrude on her".

However, others were more forthcoming in their condemnation of family:

> "I had no say whatsoever about getting into the home. They just brought me here. I could do nothing about it".

> "After my operation I had severe pain and I was often under the influence of very strong drugs — namely morphine. During this period my behaviour and conversation was quite erratic and often nonsensical. It was then my children decided to get me into a home. They picked this home because of my religious beliefs. I didn't see the home, I never had any ideas about going into a home, particularly not this home with all the residents deteriorating downstairs. Then there is the size of the room and the horrible little backyard — it's scandalous. I could go outside if I was on the ground floor but you have to share down there. Here I must wait for them to bring me out".

In all, 27 elderly people suggested that another party influenced their decision or actually made the decision for them.

Reasons for Entry into Residential Care

Health

Poor physical or mental health is rarely given as sufficient reason for entry to a nursing home. Few residents isolate poor health as the main reason for their coming to a home, even in cases where their health is obviously such that they would need full-time care to live at home. This is very striking in view of the fact that in the eyes of the public at large, taking care of physically or mentally disabled elderly is a primary function of nursing homes. This is not to say that the elderly do not see the benefit of nursing or supervisory care: it simply is not a major feature in the reasons given for entry. Only 3 residents made the decision because of their state of health. In one instance, where the resident had suffered a stroke, the decision to reside in a home was made so that she would not be a burden on others:

"I wanted to come to a home where you are cared for — I would hate to be a burden on anyone".

In another case, the resident decided to come to the home because of his fear of dying alone at home:

"That's precisely what it amounts to, you feel the sense of security which you have lost at home. I love my home but when you get two heart attacks like I got, it completely changes your outlook so it does."

Where two people are living together, the declining mental or physical health of one can force the decision:

"I was living with my sister. She was deaf and inclined to wander so I thought we needed to move to a home".

The elderly do not always wait until the situation is at a crisis or near crisis point. Sometimes the decision to go into a home is made before things become too difficult:

"We moved here for health and safety measures — the house and garden were much too big — I spent all my time working. We picked this home so we could have an apartment together".

Homelessness

Not having a home of their own was found to create problems for a minority of residents in this study. These residents found themselves without anywhere to live, and this resulted in their decision to come to live in a home. Two people who lived in guesthouses found that, after a period of hospitalisation, they were unable to return to their former addresses. In one instance, where the person's health was very poor, the proprietors refused to allow him back and, in the other case, the rent was raised while the resident was in hospital and he could not afford to pay the higher rates. From the elderly persons's perspective, there may be little time to choose a home which is suitable for his/her own requirements. Because of age and ill health many elderly people no longer have the energy to find alternative accommodation, whether it is in another nursing home, or some other type of accommodation.

Not owning his own home was the primary reason for one resident making plans to move into a nursing home, and was the indirect cause of a similar move by another resident. For others, who live with friends or family, this problem can arise with the death of the house owner, and the elderly person may find him/herself unwanted in the house. In this study, an elderly woman who had previously lived with a friend, who had been the

owner of the house, found that she couldn't get on with the new owner, and so decided to move to a nursing home. Not having security of tenure in their home is an additional problem with which many elderly people have to cope.

Two residents state that they came to the home because they had no one to take care of them in their own homes:

> "I was in hospital before I came here. My son could not care for me on his own, so he made all the arrangements for this place. I didn't really want tocome — I felt pretty upset but there are so many strange things happening today."

The sentiments expressed by this last resident may well represent the unspoken feelings of many elderly people who would remain in the community with family and friends if the necessary care was available.

Death of a Companion

The death of a husband, wife, friend, brother or sister usually marks a crisis point in an individual's life. Fourteen elderly people indicated that the death of a loved one influenced their decision to go into residential care. This is not surprising in view of the fact that many elderly people cannot cope with their daily lives without the support of others. The death of a close companion leaves a gap in the support network which cannot readily be filled, and the surviving elderly person must face up to a major change in his/her life.

In the responses, the deaths of a husband, friend, sister, wife and housekeeper are mentioned as part of the events leading to the decision to enter a home. The death of a close companion is rarely mentioned in isolation, but is more usually mentioned in relation to ensuing illness, loneliness, and nervousness because of being alone on the part of the survivor. A pattern emerges whereby the elderly person is often very shocked by the death of a companion and, in some instances, becomes ill, sometimes requiring hospitalisation:

> "My husband died suddenly, and the shock made me very ill, I became very nervous staying in my own home at night and my brother had to leave his own home to stay with me."

> "My husband died last October and shortly after that I became ill with pneumonia and had to go to hospital. I felt I couldn't manage at home on my own."

For some residents, the decision to move to a home is delayed and some interim measure is adopted:

"I was in a guesthouse for about two years after my husband died. Then I was ten years in a home but I had to move from there as they decided to change it into a guesthouse."

"I lived with two friends after my husband died and then I moved in here. I had my name down for another home but it would have meant waiting for too long so I settled for this place, which is always convenient as my brother lives up the road in another home."

The decision to live in a nursing home prior to the death of their companion had already been considered by a small number of residents. This resulted in a move to a home somewhat sooner than had been planned.

In other instances, the death of a companion coincided with the hospitalisation of the elderly person and forced them to consider their future plans:

"I was in a hospital and my housekeeper died so I knew I would have to find a place like this."

The respondent's family are not always in agreement with the decision to move to a home:

"Myself and my husband had already decided to move into a home and had given in our name to another home, but then quite by accident after my husband's death, I saw this little apartment here and decided this was where I would like to be. My sister advised me strongly to take this place. I have two sons who live abroad and one in Dublin: my sons abroad were furious when they heard that I was going into 'an old folk's home' but they have accepted it now.

Afraid to Live Alone

Only 4 of the residents said that they made the decision to move to the home because they were afraid to live alone. All had come to the home within the past three years and all were female. One of these had her house burgled for the second time while she was in hospital. It was then that she decided that she could no longer live alone.

Planning in Advance

A small number of residents decided to move to a nursing home, at a stage in their lives when there was no immediate need for care. These residents could have continued to live in the community for a longer period if they had so wished. Basically, this group of residents encompasses people who wish to make plans in advance of old age and those who plan to remain independent of family and friends. For these elderly people, the decision to go into residential care is, in fact, a choice which is made at a time when the

person is still active, and allows that person to plan in advance for a time when he or she is less able:

> "When I finished work I felt the whole trauma of retirement upsetting. I was very glad to move into the home. I always visualised that I would come to a nice home like this."

> "I was living alone in this semi-detached entirely dependent on my wonderful next-door neighbour — I began to realise that I was an enormous responsibility for her so I decided to move into a home."

Two residents indicate that they made the decision to move to a home because family life was becoming too much for them. In one instance the person was living with her son, his wife and young children:

> "I decided myself to come here, the children became too much, babies were coming. I came in here to see what it was like and the minute I walked in, I liked it. Then Sister ... appeared and it crowned it — she was so warm and homely."

Convalescence

Nursing homes sometimes cater for both short-term and long-term residents, and 9 of the residents in the sample were short-term residents. The usual reason for entry to short-term residential care is to convalesce, often after a period of hospitalisation. These residents go into the home for a short period (usually two weeks), to benefit from nursing care and attention which is not available to them in their own homes. Some elderly people go into residential care on a short-term basis for reasons other than convalescence. For example, some stay during holiday periods when the family of the elderly person is absent from home and others come because they need a break from living alone. In one case, the resident came to the home while her house was being renovated. These residents eventually become long-term residents — more usually those with chronic ill health or disabilities:

> "If I were older, I would come to live here permanently".

For those who come to the nursing home from hospital for a short-term stay, arrangements are usually made through medical personnel or a social worker. In the situation where the resident has nowhere else to go, the move to a home allows some breathing space while alternative arrangements are made. This sometimes creates problems for those homes which accept short-term residents for a specified period only. The following quotation from a staff member illustrates this point:

"There are not enough geriatric beds. People are living longer today. The old tradition of granny at home died out. They can't take up hospital beds, so where do they go to when they can't take care of themselves? This is the big problem. We will only take them for two weeks. We will only take them if they have somewhere else to go afterwards. But it does happen that we get people who don't have a relative to go to. So we have to spend a lot of time organising somewhere for them to go. We can't throw them out on the street."

"I came to stay here for two weeks and I thought it was grand. I really like the home and I would recommend it to all my friends."

Not all residents are as happy as this with their decision, and some occasionally have second thoughts. Others wish to return home and seem unaware that their stay has, in effect, become long-term. They retain the illusion that they will return home at a later date. One wonders if this is an example of residents' own unwillingness to accept the reality of their lives.

Other Reasons

Amongst the remaining residents, 8 were confused or vague about the reasons why they came to live in residential care: some respondents could no longer remember clearly why they came to the home, or who had made the decision. In some instances, the residents had been severely incapacitated at the time of entry, resulting from a stroke or other serious illness. In others, the confusion was due to poor memory and approaching senility. In two cases, the residents were reluctant to give details apart from stating that the decision was their own, and in one of these instances the interviewer felt that the resident really had no other alternative. Generally, those who were confused accepted the fact that they were in the home, without questioning the reasons why they had come there in the first place.

Choosing a Home

The choice of a home is often limited for the elderly by a number of factors. Some elderly people appear to have a say in their choice of home, others are limited in that places are not readily available in the home of their choice. Many homes have a waiting list which is not always strictly adhered to on a 'first come, first served' basis. Nursing homes use other criteria for selection, such as need. If the elderly person is in poor health at the time of entry, he/she may not be in a position to make a choice or to insist on certain conditions. Financial considerations may also be a constraint on the choice of home, but this was seldom mentioned by the residents in this context. The elderly appear to be more worried about the cost of the home later, after they have already become residents.

Some residents say that they came to the home on the advice of others. Sons and daughters are often a source of advice or direction, or, in the absence of these, nephews and nieces assume the role of surrogate son or daughter. Brothers, sisters, friends, religious, doctors, other medical personnel and social workers are also a source of advice or direction. In some instances, the distinction between advice or actual decision-making is not clear cut:

"I was in hospital with chest trouble when I was seventy-eight, and the doctor there advised me to sell my house, go for convalesence and then go into a nursing home because I wouldn't have managed on my own."

"It was my doctor's decision, I was no longer able to take care of myself."

Where arrangements were made by others, i.e., family, friends, hospital staff and social workers, the residents give very little information as to why a particular home was chosen. Usually if a reason is given, it is that the home was chosen to be near a relative or because it was recommended by others. Responses which state that the arrangements were made by others are generally vague, and one gets the impression that the elderly person had little say in the choice of home:

"My son and daughter made the arrangements for me."

"The nurse in the hospital and my daughter made all the arrangements."

For residents who were involved in the choice of home, personal contact seems to have been the single most important factor. Eight respondents had stayed in the home previously, 3 had known other residents there and 9 were acquainted themselves, or through a family member, with members of the staff.

While some residents gave very little information on their choice of home, others gave none at all and, in some cases, several reasons were given:

"My sister and I had visited a friend here and we also stayed here for a few days before, and it seemed quite adequate. This home is also quite near where we used to live and it's close to some of our relatives."

"The sister in charge of this home is a life long personal friend, so that influenced me in deciding to come here. It was also vitally important to me that I could bring some of my own possessions with me."

The religious ethos of the home was a decisive factor for 7 residents. These are all members of minority religious groups who wished to live in a familiar religious environment.

For residents who moved to a home which was near relatives or friends, being in their own neighbourhood was very important:

> "I chose this home because it's near my old home and I feel 'at home' here in this neighbourhood."

> "I wanted to remain in this neighbourhood near my old friends."

In one instance, a resident picked a home because she was unknown there:

> "I chose this home as nobody knows me here, my daughter is a nun and she has a lot of contacts. I wouldn't like to be somewhere they knew me. I like to be independent."

Other reasons which were considered important for the choice of home were its location, that is its convenience, its situation and the type of accommodation. Three residents chose the home because apartments were available which allowed them a maximum amount of privacy, while at the same time benefiting from the care and supervision available. Likewise, 3 other residents were influenced in their choice because they wished to have a private room:

> "We picked this home because we could have our own flat."

> "I made all the arrangements myself. My doctor recommended this home to me. She felt that I would have a spacious room of my own and this also helped my decision."

The good reputation of the home influenced the decision of some residents. Four of them say that this was important to them, and 2 mentioned that they had heard about the name. For 15 residents, a recommendation or the reputation of the home was considered important.

Nursing care was important for 2 residents:

> "I wanted to come to a home where you are cared for, I would hate to be a burden on anyone."

Being able to bring some of one's possessions and the fees featured in two responses. For 3 elderly residents, the choice was a random one, for others it was the only place available. Four residents mentioned that they were on the waiting list for other homes, but decided to take a place where they are residing presently, rather than wait indefinitely. Two residents moved from another nursing home because they did not like it. One woman said that the home was chosen for her by her grandchildren because "it was the only

place they heard laughter."

Visiting the Home before Deciding to Live There

About one-third of the elderly interviewed said that they were familiar, to some degree, with the nursing home before they made the decision to go to live there. Some residents went to visit the home before they made their choice, others had been familiar with the name and reputation over a number of years. Some had stayed there previously, sometimes more than once, for convalesence purposes, before they made their final decision to reside in the home.

Not all residents responded to this question, so it is difficult to estimate accurately how many of them had not visited before entering the home. Out of the remaining 52 residents, only 16 state categorically that they had not visited the home.

Pre-knowledge of the Decision to Move to a Home

Not all elderly people are aware that the decision is being made for them to go into residential care, and being aware of the decision does not mean that they are consulted about a home of their choice:

> "I was in hospital, my daughter and the nurse arranged for me to come in here."

> "My nephew arranged for me to move in here when I was in hospital."

One resident says, (speaking of herself and her sister):

> "We did not mind moving into the home, but we really didn't have any say in the decision."

All residents are not always aware that they are being taken to a home:

> "We just came here in the car, I didn't know that I was going into a home."

Who Makes the Decision to Go into a Home?

Elderly residents are not always sure of who the decision-maker is:

> "The lady I worked for took very ill, she used to fall out of the bed, it was getting too much for me. Then the Health Authority put me in here."

> "I was put in here by the County Council or Health Board I suppose."

The responses from these residents give some insight into the reasons why others place, or advise, elderly people to go into care. Indications are that

relatives and other concerned personnel are made aware of the vulnerability of the elderly person which, in practice, will often mean the care of that person until his/her death. Sometimes, but less likely, relatives and others, armed with foresight, suggest to the elderly person that he or she should make plans for their future care. Thus one active lady of ninety-four, who has been in residential care for three years, says:

> "I had a beautiful flat of my own, the people who owned the house only used the house at weekends. My doctor was worried about me and advised me to consider a home seriously. I knew I would eventually go into a home."

Likewise another elderly resident says:

> "My daughter and son advised me to find a suitable home to move into while I was still active. They helped me make all the arrangements. I picked this home as I wanted to remain in my own neighbourhood and near my old friends."

Sometimes the relationship between the elderly person and his/her family is not harmonious, and the decision is made when the relative is no longer able to cope:

> "My daughter won't take me home, she decided. She said to me, 'mammy you're not looking after yourself, you're getting neglected, the flat is neglected, you aren't cooking. I am running down here four or five times every day sometimes up to twelve o'clock at night and I am trying to look after my own family, and I just can't do that. I'm not a trained nurse — you'd want a trained nurse for that kind of thing ...'"

The more usual pattern seems to be that relatives and others have a say in the decision-making, and that the decision is made in response to an urgent situation which needs an urgent remedy, and, more often than not, that remedy is the placement of the elderly person in residential care.

The decision to go into residential care may be accepted with quiet resignation, as something which is inevitable and must be tolerated. This is not surprising in view of the fact that many people, particularly those of the older generation, grew up in a world where the 'rights' and wishes of the individual were not paramount. They are unlikely to express those demands, particularly in the later years of their lives.

Elderly residents in homes understand the burden that their care would place on their families and friends and would prefer to maintain their independence by going into a nursing home. Others feel that they have been 'let down' by their families, who in turn feel that it is not practical to look after them at home. Thus, one hears comments occasionally — sometimes

even by those who feel that they have had a say in the decision-making — such as:

"My generation was used to looking after their parents in their old age. I hadn't expected this."

"The day of granny in the corner is gone."

"It would be better if they (the elderly) lived normally — no nursing homes."

Nineteen residents indicate that the decision was definitely made for them by another party. Forty-nine residents indicate that they made the decision because of their circumstances at the time. This includes 9 short-term residents. Eleven people made the move to residential care, without any pressing need to do so at that time. Eighteen residents are vague about who actually made the decision but, in approximately half of these cases, it is likely that the decision was made by another party.

Excluding the short-term residents, approximately half of the interviewees made the decision to come to the home because they could no longer cope in their daily lives. This may have been due to ill-health, inadequate support structures, old age, loneliness, fear or homelessness. Many of these elderly people could have continued to live in the community if better support networks existed, and better facilities for the care of the elderly. Some would need full-time care and attention, a fact which is sometimes overlooked by the elderly themselves. A large number of the elderly had a say in the decision to move to residential care. For many, this decision was made because of their circumstances at the time of entry, and often encouraged by family, friends and medical personnel.

Decision to go into Care

Only in the minority of cases was the decision made to go to a nursing home without some significant event having taken place in the life of the resident. Examples given are as a result of a heart attack, stroke, death of a partner or companion, chronic ill-health or simply the inability to continue to live alone any longer. Table 5.1. gives relatives' perceptions of why residents go into care. All but one of the relatives interviewed thought that the right decision was made, although a number qualified their answers. For example, one thought that her parents had made the right decision, but made that decision too early; another said that the decision was right, but only if her mother wanted to remain in this country, and a third relative thought that it was the right decision, at present, for her husband. The fact that the relatives see the decision as being the right decision must be seen in the context of their own position vis a vis the resident. Some of the relatives

accepted the decision because it was the wish of their parent, others because they could not provide alternative arrangements. A number of relatives who did provide alternative arrangements found that they could not cope with the extra burden placed on them. The acceptance of the decision made by the relative or the making of the decision for the resident, has to be seen in this context. What would providing alternative arrangements do to the relative and his/her families' lifestyles? The point is made that the resident is not the only one that must be considered, they must also consider the needs of the significant others in their lives. As one respondent put it:

"I couldn't short-change my husband and family."

When considering the question of guilt, this too must be seen in the light of the preceding paragraphs. Few of the relatives interviewed admitted feelings of guilt; for some, the question never seems to arise. These relatives do what they think best, or allow the resident to do what he/she thinks best, and accept the decision as the best possible one under the circumstances. Because all of those interviewed maintain close contact with the resident, it is likely that they feel that, under the circumstances, there is no more that they can do, so the question of guilt does not arise. The most frequently mentioned reason is that residents can no longer cope, and families are unwilling, or unable, to provide the type of support and care which will enable the resident to live in the community. This is mentioned in 14 responses. Generally, the picture which emerges from these responses is of an elderly person who, through ill-health, feebleness, fear, or simply old age, is no longer able to cope with day-to-day living, and who is not provided with the necessary amount of support by family to enable them to continue to live in the community or with their family. Nursing homes are the last resort for these people.

Table 5.1. *Relatives' perceptions of why residents go into care*

- Residents generally can't cope anymore
- Insecurity on the part of the resident
- Lack of companionship
- Nowhere else to go
- Families can't/don't want to cope
- Fear of intruders in their home
- Need for nursing or complete care
- Convalescence
- Break down of the extended family system
- Independence from their families

A feeling of insecurity which comes from living alone, and a fear of attack or intruders, also features in many of the answers. This feeling of insecurity, seems to have two elements:

— Fear of being alone, possibly due to ill-health, old age, being unable to cope.

— An actual fear of attack.

One relative says that fear of attack is the number one reason for entry into nursing homes over the last two years. An actual fear of attack is specified by 4 of the relatives. Many other relatives mention the need for nursing care and companionship as decisive factors in the decision to come to live in a nursing home.

Decision to go into Care: Views of Staff

Here, feelings of insecurity among the elderly was given as a reason for their coming to live in a nursing home. Not being able to cope and having no one to care for them was also mentioned. Loneliness, the need for companionship, lack of communication with other age groups, the need for nursing care and supervision and, in one case, the need to go into care before the resident becomes too infirm, were mentioned by other staff members.

> "If it's a personal decision, it's often fear of living alone. Burdens of home management are too much for them. In some cases it's because no one wants to look after them."

> "Families can no longer cope — or if they have no family, they are no longer able to cope with the outside world."

> "[They need] security — someone at hand twenty-four hours a day, because of sickness and illness, long-term illness, senility. Nursing homes have a more homely atmosphere. Also the fear of attack and not being able to cope."

Settling In: Adjusting to Home-Life

This section looks at how residents settled in to home life. It relates residents' experiences and staff's orientation to new residents. Moving from one's home, sometimes away from one's family, friends and neighbourhood, is a traumatic experience for many elderly people. Many residents are ill-prepared for the move and have poorly defined expectations about their future life. Even those who have made the decision themselves can find the experience upsetting. This is not surprising in view of the fact that for many, the habits and routine of a lifetime have to be

discarded and new ways adopted. It is also a time when the elderly person must accept a limitation to their independence and a realisation that they are no longer self-reliant. Ill-health and the death of a close companion may intensify the feelings of loneliness and isolation for some, while others may find the change a welcome break from their old life which has become disrupted and has lost its continuity.

Initial Reactions to Life in the Home

Initial reactions vary amongst the residents whom we interviewed. Some had already had experience of nursing homes and found that they could settle quickly into the new routine:

> "I didn't like leaving the other home but I was quite confident that I would settle here. I will stay here now."

Others had given some thought to what their new life would be like and did not find it much different from what they had expected:

> "I didn't mind coming here, life is much the same as I imagined it to be. We had visited here and we heard about other places, so we had a fair idea of what it would be like, so it wasn't a complete surprise."

For other residents the move to the home was filled with trauma, which was intensified by the fact that they were making a break with their old life. For these residents, an awareness of what they were losing occupied their thoughts more than the changes which lay in store:

> "At first the move was very traumatic — leaving my home after forty-four years was a very emotional time for me."

> "It was very strange at first after all the years in my own house. I wasn't in good form. I couldn't sleep or eat for a while, but I settled."

> "It's heartbreaking to leave your own place and move into a home."

For some, acceptance and resignation came after a time, and the advantages of being in residential care came to be appreciated:

> "I was very shattered at first, I didn't want to give up my home and independence to move into an old folks home. I didn't even want to think about it. I found it very hard to adjust but as time goes by you appreciate the place and forget what you had last."

> "I felt dreadful about leaving my own place to come here. In the beginning, I found it hard to accept being put in a place like this, but now I think you just have to accept it."

Some elderly people deeply resent coming to a home and this resentment prevents them from making any attempt to settle. In addition, if infirmities are present, these can prevent elderly residents from mixing with others which, in turn, heightens their sense of loneliness and isolation. This is particularly true for bedfast residents who occupy upstairs rooms.

Residents who have been placed in a home against their will are also likely to resent the move. The anxiety displayed by one elderly woman, who had been placed in a home by her daughter, illustrates this point. She had been in residential care for one month and had not settled in at all. Her extreme anxiety was very evident and she believed that she was heading towards a nervous breakdown:

> "I feel that I didn't get a good night's rest, my bones are sore from lying around, I will stiffen up if I don't go out, if I don't walk around. I have myself in an awful state."

This woman felt powerless to cope with her situation, she wanted to return to her own flat and this provoked a constant argument with her daughter. She quotes her daughter as saying:

> "You know very well you can't go home. We are paying for the flat, [her mother's former residence], the money won't last out much longer, we are paying the rent and we have to live too, I'll be broke and we'll have nothing."

Very extreme reactions to being placed in a home were not found to be typical of the residents. Possibly, residents who initially react angrily do settle down to some extent, as time goes by, and some will attempt 'to save face' by accepting the decision as their own, rather than admitting that they have been placed in a home by their family.

Not all residents are upset at the prospect of a move to a home. Sometimes ill health and the knowledge that they cannot continue on in their old life softens the blow:

> "I felt happy enough about moving. I couldn't look after that lady [employer] any longer."

> "I am very independent, I would rather be in a home than a burden on my family. Life is much better than I expected in here. I really didn't think I would settle in as fast as I did."

> "I liked the change in environment when I moved here."

> "I settled in straight away — it's really luxurious you know."

For others, the move to a home gave a new dimension to their lives, but

this too is sometimes tinged with a degree of sadness:

> "I can't believe how well I am, considering the state I was in before I moved in here. I have never been so happy. I don't think I could ever go back home. I fell on my feet here. I help this old nun out — it gives me an interest in life."

> "In the beginning it was very exciting, I had lived with a young family — then the quietness and the peace, I was very glad to get away from the kids. Young people do not want people at my age — it seems to be so with all the old people I spoke to. I felt lonely at the time about coming to live here, lonely for the children, but I had to make the break — things could not have improved. The children were noisy, they loved to play, they turned the TV up loud."

For short-term residents, the move to a home is less traumatic. In many cases, the time spent in a nursing home is an extension of a hospital stay, and these residents expect to return to their homes after convalescence. However, residents who found that their convalescence period had become extended or whose future seemed uncertain tended to display a degree of anxiety and sometimes expressed a wish to return home as soon as possible. It must be stated that short-term residents whose stay is prolonged should be informed about the reasons for this, otherwise they must live with the anxiety of not knowing where they are expected to reside for their remaining years, and consequently are not in a position to plan for themselves.

Adjustments

Adjusting to life in residential care can take a considerable amount of time and effort on the part of some residents, while others find that they settle in quickly and with very little effort. The fact that some residents are very conscious of the fact that adjustments have to be made with their change in lifestyle does not seem to be related to whether or not it was the resident's own choice to come to live in a home. Those who have come to a home out of their own choice are as likely to be aware of the difficulties which may lie ahead, if not more so, than those residents who come because of ill-health or generally being unable to cope:

> "You break away from a certain amount of your local old connections and come to live with a lot of strangers — although you might know some of them. You have to adjust to the loss of company you know and trying to make friends with all the residents here and weighing up the different characters. It's a difficult thing to do at that stage of your life."

Residents have to cope with adjusting to the 'loss of their old life', and coping with the unfamiliarity of their new life:

"When you have your own home, things are different, but you have to make the little effort to make the best of it."

"The hardest thing is to give up the freedom of your own home — the sense of being in control over your own life."

"I cried a lot until I got used to the place. When you are at home you are your own boss but I could no longer look after myself."

Many residents were pleasantly surprised because they found the home very much to their liking and consequently had little or no adjustments to make:

"I didn't like the idea of coming into a home. I had heard about other places where residents were always fighting with each other. This nursing home is better than I imagined — there is a nice crowd of people here."

"I settled well and didn't have adjustments to make."

"This home is nicer than I imagined. I thought it would be more regimental."

"I didn't really have any adjustments to make to life here. I'm very happy here, it's a lively place — just like an hotel".

Residents tend to make a distinction between 'settling in' and adjusting to their new life. Residents find that initially they have to go through a settling-in period, during which they may find the environment very strange and experience a longing for their old life. Adjustments are not considered until the resident decides to settle, and sets about creating a new life in the home. Consequently, some residents find the settling-in period to be minimal, and that they have few, if any, adjustments to make.

Helping Residents Settle in: Staff's Views

Interviews with staff indicate that they had similar methods of welcoming new residents. A typical approach would be to introduce the resident to staff members and to other residents, tell them the routine, show the resident around the premises, show the resident his/her room, and generally help them settle in. Many of the staff mention several ways of helping the residents get settled, some emphasising certain points more strongly than others. For example, some staff members put more emphasis on helping the resident become integrated with the other residents:

"Show them their room and the house. Introduce them to other patients. Help them unpack. Arrange personal belongings. Help them get acquainted and talk to other residents; the room must be to their own liking, with their own possessions. Introduce them to the staff. Let them settle in".

"Chat to them and integrate them into the life. Encourage old residents to welcome new members."

Other staff suggest making a 'fuss' of new residents. Two staff said they would make a fuss of new residents, others suggest being very friendly or being very nice to the resident. In one home, each sister welcomes the new resident to the home, and the chaplain mentions them at their first mass in the home. Others do not agree that any fuss should be made about the new resident:

"They fall in — make no fuss. Show them around and introduce them to everyone, but eventually they fit in themselves."

Others place emphasis on getting to know the new resident, his/her likes and dislikes, and they encourage the new resident to talk about themselves and their life. Mention was made of getting the resident involved in the activities or pastimes in which they are interested.

Although some of the staff mention talking to new residents, being friendly with them, only in two cases did staff mention that they make an effort to get to know about the person's past life, or about the person's food likes and dislikes. It would seem that greater emphasis is placed on getting the new resident settled into the new environment. Emphasis tends to be on fitting into the nursing home rather than on the individual needs of the resident.

Summary

Residents go into care for a variety of reasons. There is rarely a single reason for elderly people to take up residence in a home. For most, a number of factors arise, usually over a number of years. The final decision to enter a home is often related to an incident in the life of an elderly person which makes it too difficult for him/her to continue to live in the community. The evidence, suggests, that for many of the elderly, their ability to maintain their lifestyle is gradually eroded over the years. Generally, the picture to emerge is that residents go into care for a variety of reasons such as health, homelessness, lack of security of tenure, death of a companion, convalescence, or a planned decision over a number of years. Poor health is rarely given as the main reason for going into care even among those whose state of health is obviously such that they would need full-time care if they were to live at home. Popular images of the elderly are

often not shared by the elderly themselves. For example, only a small minority (4 out of 97) came into nursing care because they were afraid to live alone. Relatives' views of why the residents go into care gives a picture of an elderly person who through ill health, feebleness, fear or simply old age is no longer able to cope with day-to-day living, who is not provided with the necessary amount of support by family which would enable them to live in the community or family. Nursing homes are seen as the last refuge for these people. Staff perceive that fear of being alone or need for security is the main reason why elderly people go into care. Not being able to cope or having no one to care for them is also mentioned. It is worth noting that the elderly themselves see their decision to go into care in slightly different terms.

Choosing a Home

Choosing a home is often limited for the elderly by a number of factors. Some appear to have a say in the choice of home focusing around the type of care provided, nearness to friends or relatives, religious ethos or good reputations. Others never expected to live in care and were not party to the decision to go into care. Approximately one third of the elderly interviewed were familiar with the nursing home before they made the decision to go to live there. Others had, in effect, no choice as they were taken to the home without prior consultation.

Adjusting to life in the nursing home can be a very traumatic experience for many elderly people. Many of the residents we talked to were ill-prepared for the move. Settling into home life is a difficult transition period. It is a time when limitations to a person's independence and self reliance are challenged. For some it is a place to end their days; for others, a release from a life that was problematic and confined. For most however, the initial reactions to home life were mixed. Residents who had made the decision themselves were more readily able to adapt, while those who were placed in a home against their will were, naturally, more likely to resent the move. However, not all residents were upset at the prospect of a move to a nursing home. Ill-health and the knowledge that they could not continue on in their old life enables them to come to terms with their new life. Whatever the situation a resident finds him/herself in, it is a period when staff and management of nursing homes need to be aware of the difficulties and needs of people who are making major changes in their life-styles. Staff appear to place too much emphasis on residents fitting into the running of the home. Special attention should be given to the individual and his/her needs at this period of decision and transition. Short-term residents whose stay in the nursing home is prolonged should be informed of the reasons for this decision. Future planning of their own lives is taken away from them if residents are not consulted about this basic decision.

CHAPTER 6

DAILY DIMENSIONS OF CARE

What is it like to live in a nursing home on a daily basis? Is there a routine that shapes the lives of elderly residents who live there? Are residents' lives limited and narrow as is popularly thought? This chapter considers these questions by exploring the daily life of residents in nursing homes. To begin, residents describe their daily patterns of activity.

Residents' Average Day

Descriptions of daily activities vary widely. Generally, residents who are fit and well are better able to superimpose their routine on that of the home, compared to residents who are incapacitated. Elderly people in homes are incapacitated in various degrees: some are bedfast, while others are roomfast and can only leave their own room with the help of others. Some residents are not allowed or are not able to leave the home on their own, while others feel well enough to go into the garden occasionally. Some are fit and well enough to go outside the home for walks, visiting, shopping, a cup of coffee and chat. This group is most likely to be able to create their own routine around that of the home.

In looking at the residents' daily routine, the importance of not categorising residents into a homogeneous group is further reinforced. In our analysis we examine the daily dimensions of residents' lives by looking at the following groups:

- Residents who are active
- Residents who are incapacitated.

Daily Dimensions of the Lives of Active Residents

The daily routine in nursing homes divides up the day into manageable portions of time throughout which residents spread their activities and

pastimes. Active female residents are similar to male residents, in that they tend to develop a routine of their own which intermingles with that of the home.

The day starts early with breakfast being served from seven o'clock onwards. For the majority of residents in private homes, breakfast is served in bed —while residents in voluntary homes are more likely to breakfast together in the dining area. Possibly, this reflects the physical capabilities of residents in these homes, in the sense that private homes cater for a majority of the physically disabled. As one resident said:

> "Of course it's much handier for the staff to serve us breakfast in bed — it saves a lot of time and bother in the long run."

As most homes cater for both male and female residents, the routine imposed by the home is similar for males and females. Few of the male residents interviewed chose to avail of the opportunity to lie on in bed in the mornings. All have risen by nine o'clock and the earliest time mentioned is seven o'clock. The most popular times for rising are between half past seven and half past eight. Mealtimes are set early or later, according to the hour at which breakfast is served. Women residents sometimes complain about the times for meals:

> "We have breakfast at seven or earlier, a ridiculous hour. Lunch is then at twelve and tea at four, which are far too early in my opinion."

Overall, only a few complain about mealtimes, most just accepting the routine of the home without questioning. While a few active women residents like to rise early, most women avail of the opportunity to 'lie in' until nine or ten o'clock, with many getting up to go to religious services at that time.

Religious Practice

For the majority of active women residents, religious observation is an important part of their daily lives, and many avail of every opportunity to attend religious services. As a group, the matter attendance at services for men appears to be less of an essential part of their daily routine than it is for women, who more readily integrate attendance at service into their daily routine. This is not to say that male residents are less religious than female residents, but simply that attending religious services does not appear to feature as much in their daily routine as it does for women.

In many homes, religious services are held daily, twice weekly, or weekly for Catholics. These services are attended by the majority of active female residents. Some residents attend daily Mass outside the home. Members of other churches and religions do not always have the facilities or services in

the home in which they are resident, and, thus, are usually unable to attend church services as frequently as members of the Roman Catholic Church. They are compensated to some extent by a more organised effort amongst their fellow church members who, in some areas, organise a car pool to take the elderly residents to weekly services. Ministers in the minority religions are very attentive to the religious needs of their flock, and regularly make personal visits to the elderly members who live in nursing homes. It is a rare occurance for elderly Catholic residents in homes to receive a visit from a priest, other than those which are directly related to giving the Sacraments. Catholic clergy do not appear to make informal visits to residents in nursing homes.

Spending the Day

Women residents pass the day in a variety of ways, many of which are similar to male residents: going for walks, chatting in the lounge, reading and watching television. A few play cards, knit, crochet and write letters. Some residents remain very active and lead very busy lives:

> "I have a full life; I go to Charismatic meetings and physical education classes. I would love to do Yoga and become more disciplined in myself."

> "I have a full timetable — there is always something I must go to."

Others disengage themselves from former activities and lead a less active life:

> "I haven't many pastimes now since I've got older. Just reading and knitting now. I used to enjoy swimming — I was very fond of this —always swimming when I got the chance."

> "I don't look for things to do anymore, now I just sit back and relax. I'm afraid I'm getting lazy here with all the good treatment and care."

A few of the people interviewed were living in self-contained flats. These residents took care of their flats and provided their own meals, with the exception of lunch, which was eaten with the other residents in the central dining area. Living in a self-contained flat provides the best of both worlds for these residents. They still maintain the privacy of their own home, their independence, their sense of usefulness, coupled with the security of knowing that help is at hand in case of emergency.

> "I have the privacy of the flat and having visitors. The door is always open."

> "We are in charge of our own activities here in the apartment — there

should be more of these apartments — it gives you a great sense of privacy and it means that there is not a total break from running your own home and life to the life style of the nursing home."

"I get great pleasure out of keeping my own garden and flat. When you are in one of the apartments there are no restrictions really. It's like being in your own home, you have total freedom. Then there is the great security of the place and the care and attention we get from the nuns."

Other residents do not have the care and responsibilities that are those of the flat dwellers, although many make the effort to 'keep' their rooms and look after their personal laundry. A few become involved in the daily running of the home, and regularly help with laying tables, doing the dishes, helping with the linen, helping in the library, answering the telephone and doorbell. Others partake in seasonal activities such as gardening and fruit picking. Generally, residents tend not to become involved in activities such as these, partly because they feel that they are retired, many no longer feel capable of working and some adopt the attitude that they are paying well for the services and care available in the home, and this provides them with the opportunity to relax and enjoy their later years. Involvement in activities such as helping with the dishes or linen, takes place in a minority of homes. Many homes do not encourage the day to day involvement of residents in activities such as these, partly because of the slower pace of the elderly and also the risk of accidents.

Many of the elderly women and men interviewed said that they liked to go for walks when the weather is good. Women show some preference for walking in pairs rather than alone and occasionally used the opportunity to have a cup of coffee and chat while out. Many of the active residents appear to avoid the lounge and dayroom areas and prefer to 'keep' to themselves as much as possible. Because of this, some residents tend to stay in their own rooms a good deal, and do not mix too freely with other residents, perhaps forming one or two strong friendships within the home:

"Most people remain in their own rooms rather than using the recreation areas. The residents have everything they need in their own rooms, radios, TVs etc."

"I spend the rest of the day in my own room — very few people go to the recreational areas — they have everything they need in their own rooms. It's like a little home."

Not all residents have a lounge/dayroom available to them, and this was the case in at least one of the homes in which residents were interviewed.

The point has been made earlier that active residents do not always wish to avail of lounge or dayroom facilities. This is sometimes the case when a large percentage of the residents in a home are confused thus preventing ordinary conversation and pastimes in the lounge. Other residents don't wish to be drawn into gossiping circles and into the 'petty bickering' which sometimes takes place.

Pastimes and Activities

The pastimes most commonly mentioned by the residents are watching television, radio, reading and handcrafts for women such as knitting, sewing or crochet. Others mention card playing — sometimes going to play cards with friends — bingo, music — one resident plays the piano — and gardening. Watching television is mentioned by the majority of residents, quite a few of whom have their own set. Like the male residents, women also follow a very wide variety of televised sport, and many are keenly interested. The most popular events are international rugby and soccer, championship gaelic games and racing:

> "I love watching horse racing, hockey and rugby on the television — they're very exciting."

> "I love rugby, I nearly go into the scrum. My sons play rugby, we are a real rugby family. I watch an odd race on TV, my husband was a real race-goer."

> "I watch snooker and any of the big matches and races on TV."

Because all residents are not interested in sport, the noise level makes it impossible to follow the event and similarly because of the diversity of tastes, agreement is not always reached as to which programme should be viewed at any given time:

> "I would like to watch more sport and horse racing, but then it depends on what the others are watching and I don't want to cause any fuss."

> "I am not a great TV fan, I choose my programmes, but the programmes I'd like might not be the ones the other residents want, so if someone else wants another programme you just sit quiet and let them enjoy the programme."

Listening to the radio is also a popular pastime, and Gay Byrne is very popular amongst the radio listeners.

Card playing is mentioned occasionally by the residents. A few play regularly with friends outside the home, some play with friends and

relatives when they come to visit, others play with friends inside the home. Nothing the residents say suggests that impromptu games take place amongst various residents in the lounge or dayroom.

More women than men appear to carry on with pastimes which they have established over the years: in the case of women these pastimes are handcrafts such as knitting, sewing and crochet. This isn't surprising in view of the fact that these pastimes are ones which can as easily be carried out in a nursing home as in the residents' own home. However, not all women residents retain their interest in these activities. This decline in involvement may be due to ageing infirmities, lack of interest or, in one instance, a resident says, "I can't get any materials here". Another resident says "we used to do crafts which was great but that's finished with now".

Reading

For the residents who mention reading, newspapers are the most popular reading matter. Many of those who regularly read the paper buy their own, others depend on relatives to supply them with papers. The cost of papers is mentioned by residents who sometimes discontinue their practice of getting a daily paper because of this and have to be content with the occasional paper or Sunday papers instead. For those whose sight or concentration is poor, looking through magazines is preferred to other 'reading' activities. A few like to read particular types of books: romances, historical novels and religious books and pamphlets are mentioned.

Talking To and Meeting People

Meeting and talking to friends either inside or outside the home is a favourite pastime of many residents. A few mention that they avoid or would like to avoid having to talk to people on occasions. For some, making the effort to converse is too much, due to a wish for more privacy, or perhaps lack of interest or depression. This may be a particular problem for the less mobile residents who are sometimes taken to lounges or dayrooms and remain there for the greater part of the day. This point is made by one resident who wishes that she could be alone more often. For her, sitting in the lounge means that she must be prepared to be sociable and be ready to talk to others even when she is tired. Female residents often help other residents who are less mobile or more in need of care than themselves. On occasions, those who are well enough to go out sometimes do messages for disabled residents, others make a point of visiting and chatting with those who are confined to bed or their room. In two instances, sisters came to live in homes together, and in both cases, one woman spends a good deal of her time looking after her sister's needs:

"I spend a lot of time looking after my sister because she is inclined to wander into other people's rooms."

"I don't like to leave my sister alone except when she has to go to the doctor or hospital."

Looking after those who are less able gives residents a sense of purpose. One resident says "it gives me something to do". Making the effort to help a less active resident is not confined solely to the able-bodied. One respondent who is confined to a wheelchair regularly helps another elderly resident who is deaf and blind.

Taking a Nap

In the majority of homes, residents are free to take a nap at anytime they wish:

"You can take a nap or stay in bed all afternoon if one wishes so — complete freedom in your own room. All of January, I was in and out of my bed."

Many residents avail of this opportunity to nap during the afternoon and have a nap in their own room or sit and rest in the lounge. Others prefer to retire earlier at night and residents generally report that they go to bed earlier in the home than they would do in their own homes. Some read in bed, listen to the radio or watch television. Others retire because "there's nothing very much to do".

Organised Activities

Few residents mention activities organised by outside bodies. Outside bodies that are mentioned in this context are the Health Board and St. Vincent de Paul who organise trips outside the home for residents or take residents to bingo sessions.

The Daily Dimensions of the Lives of the Incapacitated Elderly

In this study, 19 residents were interviewed who were physically incapacitated to the extent that they were housebound. None of this group would be physically capable of leaving the home without the aid of others. Many were disabled to the extent that they could no longer leave their rooms without help and 10 of these are incapacitated to the extent that they need help with most of their daily activities. Some, although severely incapacitated, maintain as much independence as possible and manage to move unaided from bed to a chair, but for a few this is no longer possible. Out of the 19 residents who are housebound, 6 of these are residents in voluntary homes and the remaining 13 are residents in private homes.

The day begins early for many of the incapacitated residents. Some wake as early as five o'clock, some rarely sleep at all, just lying there waiting for the day to begin. All the elderly in this category who were interviewed have their breakfast in bed. Breakfast is served very early, one resident gets his breakfast at half past five, the last time mentioned was between eight and nine o'clock. Some incapacitated residents find that they can still manage to wash and dress unaided, but many need the help of the nursing staff. One struggles to maintain his independence through dressing himself, although this daily effort 'nearly kills me'.

Spending the Morning

Many of the residents spend the day alone in their rooms. Those who are mobile sometimes manage to call to see their neighbours on the same floor, but are unable to go downstairs; in only a few instances did the residents report being helped downstairs by the staff and spending some or all of the day in the lounge or dayroom. Residents sometimes hesitate to ask the staff to take them to the lounge — one woman says:

> "I go out very seldom as I have to be carried down the stairs, which is too much trouble to put the people to."

Others dread the thought of being carried:

> "I dread being brought up in the wheelchair — up and down the steps — I'm afraid they'll let me fall."

Those less able who remain in their room are usually put sitting in a chair for at least some of the day. "I just sit and sit and sit." Apart from the monotony attached to 'just sitting' some residents complain of the discomfort they experience:

> "I hate sitting in that chair, my legs are all gathered up and I can't stretch them, I'd prefer a chair that I could lie back in."

Many elderly residents suffer from hearing and sight impairment, and these complaints are particularly annoying for incapacitated residents, especially to those who have lost the full use of their hands. Reading, listening to radio and watching TV are among the few pastimes left to disabled residents and, for those whose vision or hearing is diminished, the only remaining pastime is talking.

Because many of the incapacitated residents who were interviewed are 'isolated' in second and third floor rooms, they are dependent on others to call to see them. In some cases, other residents of the homes have befriended their disabled companions, but this is not always the case. For example, the disabled resident does not always wish for the company of other residents

and sometimes the stairs provides the barrier to communication with other residents. Similarly, the mental condition of other residents may prevent a meaningful conversation:

> "What would make things more pleasant around here for a man in my position is if you had more mobile patients here, that's something you can't get over, you can't change that."

One resident complains that her visitors rarely stay long because her two confused room mates constantly interfere in their conversation.

Lunch is served early, usually at about midday, with a morning cup of tea at approximately ten o'clock. In some homes incapacitated residents eat alone in their rooms and this fact was remarked on by one resident who moved from one home to another:

> "I thought it was nice that we all eat together in the dining room, not all alone in one's own room on one's own little table like in ..."

However, for many incapacitated residents eating alone or with one's room mates is a fact of life in nursing homes, and many elderly people do not have the company of others, even at meal times.

Tea is usually served between four o'clock and five o'clock, "which is much too early in my opinion" according to one resident. Residents usually get a cup of tea or some other beverage at approximately eight o'clock. Residents can sometimes choose their own bedtime, but those who are most incapacitated are less likely to have a choice. In one extreme case, residents are put to bed at half past four in the afternoon. Residents sometimes choose themselves to go to bed early, but one feels that the routine of the homes is superimposed on their own wishes.

Pastimes

Most nursing homes provide very few or no facilities or activities beyond the provision of a television set in the lounge or dayroom.

Because many incapacitated residents do not have access to the lounge, they cannot benefit from this. Residents who have access to the lounge/dayroom often find that it's impossible to view television in this setting. Various problems can arise:

- Hearing problems
- Disagreements over programmes
- Noise and chattering.

Consequently, those who are interested in television, and who can afford to do so, usually provide their own set which they can view in the privacy of their own rooms. For similar reasons, many residents have their own radios.

Reading is a pastime which is enjoyed by some of the incapacitated residents. Others find that because of their sight or other disabilities, they find it difficult to read. Holding a book or newspaper presents major difficulties for some stroke victims or arthritis sufferers. Poor concentration is also found to be a problem, and if residents read, they tend to favour magazines more than other reading material. Very few incapacitated residents engage in any craft activity such as knitting or crochet. For some this is a physical impossibility, but others no longer have the interest. Residents rarely 'push themselves' to carry out an activity which has become difficult because of mental or physical disability. Lack of encouragement by others may also contribute to residents' declining interest in these activities. Only one resident (from a voluntary home) stated that the residents were encouraged to maintain their interests and activities:

> "They are delighted with you if you show any sign of enterprise — even writing a letter."

Very few other activities are mentioned by incapacitated residents. One man does some sketching in his room, but finds that he is limited by lack of space. Another man writes articles which are published occasionally but he finds that his poor sight is becoming more of a problem.

Two disabled residents do a daily crossword. Two others spend a good deal of time in prayer. Many feel free to take a nap during the day, and only one resident said that this practice was frowned on in the home in which she resided:

> "You cannot take a nap in the afternoon in case you will not sleep at night, and one is not supposed to go to one's room in the afternoon in case one might fall getting into the lift."

In spite of their disabilities and the lack of organised activities and company in certain cases, some residents say they are happy and content with their lives in the homes. They feel that life is more or less as good as it can be for them, and they feel thankful for the security and care that is provided in the home. As one resident put it:

> "You could be in much worse places."

It's not surprising to find that 8 of the incapacitated residents interviewed express discontent with their lifestyles in view of the restrictions placed on them by ill health, building structure, and lack of organised activities. The following comments by these residents illustrate their level of discontentment:

"It's dreary here — the day is about seventy-five hours long."

"They don't seem to do anything here, they sit around down there. I don't think they have much concentration. There is a committee here — they are the decision makers, but they need a psychiatrist. They have no understanding of the needs of people like me. They just understand the needs of those they push around. Yes, I find it very monotonous here. I don't like a bit of the food here ... I feel I am an individual but they [the staff] think I am not. The whole problem here is that people become institutionalised. The first place it starts is the service and the food. My room is terrible — you can't swing a cat in there. When I have people to visit, I have to ask them to sit on the bed. There is also no toilet on this floor. I told the committee members that when I die they can make a toilet out of my room. They don't like me."

"I have nothing to pass the time. I don't see well anymore. I can't see or anything now. I used to play cards when I was younger and tell fortunes — but I don't do that now — there are no cards here."

"Sometimes I feel so fed up with my life, I think it would be an ease if I were to die."

Summary

Overall, this chapter illustrates that the lives of elderly residents in nursing homes are open and free for some, while limited, confined and frustrating for others. There are a variety of life-styles experienced for those who have remained active. Descriptions of daily activities were unduly influenced by the routine of the home itself and also by the physical and mental well-being of the residents. Some residents are fit and well enough to go outside the home for walks or a cup of coffee and a chat. This group is able to create its own routine alongside that of the home. However, even for this group its daily activities are confined and have to be seen in the context of living in an institution with rules and regulations. More importantly, however, the ethos and context of their daily lives are orientated by institutional living. The day starts early, meal times and bed times are often organised to suit organisational time tables rather than an individual's body clock. The profile of the daily lives of incapacitated residents paints a picture of isolation, of a very limited and confined existence. Here the physical environment is important, as well as the ethos of the home. Conversation and social contact with other residents and visitors is of paramount importance to them and they are completely dependent on the nature of the home for social interaction and on other residents to make contact. There is a strong support network among some of the residents, but it is fragile and dependent on the health and well-being of the residents who help. While

some of these residents express a degree of contentment, others quite clearly are frustrated and isolated. The nursing homes superimpose their routine and orientation on these residents. In some instances, the ethos is custodial with no apparent effort to foster and nurture independence or the potential of the individual resident. These residents' responses are suggestive of passivity, their expectations are low. One must ask, if the more active residents will also eventually experience isolation as well as institutionalised barriers to communication and social contact?

CHAPTER 7

SOCIAL CONTACT PATTERNS

Studies on the elderly highlight social contact as one of the most central issues in their lives. Many elderly people experience a contraction in their activities in their later years. This is particularly true for the elderly in residential care. Undoubtedly, level of mobility, access to transport, ill health, disabilities which prevent writing letters and the death of existing relations and friends gradually narrows the resident's circle of friends and acquaintances. The opportunities to socialise are limited. Does this prevent the continuation and the formation of new friendships? This chapter explores the social contact patterns of residents. Relatives' experiences in visiting residents are also outlined.

Family Contact Patterns

When considering the issue of family contact, there are two issues involved: first, the frequency of contact and, second, the quality of the relationship.[1] Frequency of contact is an indication of a good relationship. In only two instances did residents imply that the quality of the relationship is not what they would wish even though visits are quite frequent.

Family contact, for most residents, occurs on a fairly regular basis. Residents are usually visited on a weekly basis, some being visited daily.

[1] In this analysis of patterns of contact between residents and their families, and in particular, that of visits to residents by relatives, the method used to establish the frequency of contact was to use the most frequent visitor as an indicator of the regularity of family contact. This may be misleading in the sense that a resident may have one frequent visitor and few or no other visits from family members. On the other hand, the frequent visitor may act as a 'go between' for the resident and other family members who cannot visit frequently, and therefore may pass on items of family news and interest.

Those who visit are more likely to be their children or close family relatives. These relatives live within a ten mile radius of the nursing home:

"My grand daughters are very good to me. They call at least twice a week. Christmas and Easter I holiday with them and I visit quite frequently."

Some residents receive only occasional visits from their family or close relatives. Often it emerges that this is because they live far away or are living abroad. The frequency of contact with a family member is appreciated by residents and the analysis indicates that the quality of the relationship is good:

"My second son is great, he visits at least twice or three times a week."

"My daughter and grand daughter visit once a week. My daughter is kept very busy at work."

"I see the family every week. My son lives close by, I see him the most."

"I see one of my nephews at least once a week, the others visit when they can. I also go out to visit them. They also come in for me for family gatherings even though they have a lot to do. If I wanted to go out anywhere they would collect me."

"My brother calls the most — I often go out with him. My son and his family call and I visit them regularly — I spent Christmas there."

In three replies, there is an element of loneliness and resentment:

"I don't see very much of my family — my daughter comes down from ... every now and then. I have two sisters living near here whom I see a bit."

In other replies, the resentment was more pronounced. Some were very upset and outspoken in their resentment at being 'put' into a home, and the family relationship was under considerable strain.

In the case of single residents without children, visits or meetings with other relatives may be infrequent, but the quality of the relationship is sometimes good and contact can be maintained through letters and telephone calls:

"My nephew and niece in England are the close relations ... My niece writes and 'phones very frequently. They came over from England to visit last year. I spent a week's holiday with them in ..."

"My only family is my sister [who lives in the home] and some cousins.

One cousin visited, but none of the others come."

Five female residents gave no indication as to the extent of contact with their families. On two occasions, the interview was ended abruptly by members of the nursing staff, and in two other instances, the resident refused to answer "any more questions" on social contact patterns.

Those female residents who received few visits from family members tended to be single or widowed without children. These women have few, if any, close relatives alive.

Short-Term Residents

Six of the active female residents interviewed were short-term residents. Five of these are widows, 4 of whom have children. In one instance the resident's children are unable to visit because of distance and ill health. The 3 residents with children have very regular visits, 2 of them being visited daily. The remaining 2 residents, 1 single woman and a widow without children, see some family members frequently when they are at home, but in one case, the resident's family do not know that she is in the home:

> "None of my family know that I'm here ... I visit one of my brothers every week when I'm at home. But I have three other brothers and a sister whom I never see."

Because there are only 6 short-term residents in the group of female residents, it is not possible to compare this group accurately with long-term residents. However, the evidence would indicate that family contact patterns amongst the elderly living in residential care and the elderly living at home are similar, suggesting that a move to residential care does not necessarily damage the relationship.

For elderly residents who are not ambulant, the question of going outside the home is totally dependent on the goodwill of others. They are taken out occasionally for the day or for special occasions to the home of a son or daughter. Occasionally, residents in wheelchairs are taken out around the grounds of the nursing home or out for a walk by relatives. With the exception of one resident, none of the infirm residents who are single mentioned being taken out for a day. Only one resident who was not ambulant said that she visited her relatives on a regular basis:

> "I spend every Sunday with my daughter — all the rest of the family call whenever they can. I spend Holy Days, social occasions and family gatherings with my family. Last year my son took me to ... for nearly two and a half weeks. It was marvellous. He also drove me to ... to visit my relations."

Elderly residents who are incapacitated often feel that they are no longer able to go out:

"I don't go out any more — I'm so weary and helpless."

"He [respondent's son] used to come and bring me home for a meal. I always went there at Christmas, but I didn't go there last Christmas. I would not be able [to go out] under any circumstances, if I was, I would love to go out."

Others think that it would cause too much trouble:

"I never go out now — I have no interest in going out — I'm only a burden to other people. I can't move a step without the aid."

"She [resident's daughter] sometimes takes me to her house for the day, but this is awkward because of the wheelchair."

Visits to Relatives by the Elderly Themselves

Social contact is a two way process. Residents' visits outside the home vary considerably. Some residents (20) visit their relatives very regularly and go on holiday with them and these residents also show in their answers that they are not depending on visits alone for family contact. Active residents often visit outside, spending days or weekends with family members. This allows the family more privacy and probably allows for greater relaxation in more familiar surroundings:

"All my sons call regularly — they sometimes call for me and I go out to visit them — my son looks after me, he helps me with problems and takes care of the financial side of things."

"I go out every weekend to visit some member of the family and they visit regularly."

In other cases visits seem to be less frequent — but would include occasions such as holidays, family gatherings and Christmas or Easter:

"I go out to my daughter at Easter, Christmas and the summer — but I haven't been able to go out much lately because of a heart condition."

"Not so much for weekends lately, as I have so many old things to take, I don't bother. I could if I wanted but I don't."

"I go out on Sundays to the family, I'm totally dependent on them for getting out."

Active residents who don't visit their children are unable to do so

because the families are living abroad. Contact is maintained with sons and daughters, and, occasionally, the residents in question visit abroad for holidays. Frequently, women in this group visit nieces, nephews and other relations, often staying with them for holidays in the summer and at Christmas.

"My daughter and I write every second week. I go to visit my brother and his wife quite often and stay there for Christmas."

"My only daughter is living in ... I visit my nieces and nephews at Christmas and for holidays."

There were five active residents who did not visit outside the home and extreme old age appears to be the reason in most cases but bad weather is also a limiting factor.

Relatives who do not have children of their own tend to visit nephews or nieces, sisters, brothers, cousins and distant relatives:

"I spend all my holidays with my nephew and his wife."

"I make the point of visiting my sister in hospital quite regularly."

"My cousin visits and takes me out sometimes."

It is difficult to establish the frequency of visits outside the nursing home by individual residents who have no children. The pattern appears to be one of irregular visits outside to relatives, and these visits are instigated by the relative who takes the resident out for a day or a short holiday. A few residents mention going on holiday independently of relatives.

Social contact with family or relatives needs to be put in context. Lifetime relationships and difficulties and problems that have occurred over a number of years are often carried into old age without resolution. Where family ties are good and strong they are likely to remain good wherever the elderly person may be located.

Contact with Neighbours and Friends

Neighbours and friends often come to visit or residents go out to visit them:

"I have two or three friends outside the home. I visit them some afternoons. If I didn't go to meet them, they would come to see me."

In the course of the interviews, it was found that elderly people do not always make a clear distinction between neighbours and friends. The terms friends and neighbours are synonymous for some people who consider

neighbours to be friends and do not seem to have developed friendships outside their immediate area. Possibly this phenomenon is related to social class factors or the individual's life experience in general. For women, in particular, it is possible that some have grown up, perhaps worked, married and raised a family without ever leaving their area of origin. If this were the case, then an individual's friends would be picked from surrounding neighbours. This is less likely to be the case as mobility for particular groups or classes in society increases and, overall, it is likely to decline with succeeding generations.

From the total number of active female residents, 46 maintain some contact with friends and neighbours outside the home. This social contact is maintained through visits by either party, telephone calls or through letters. Barriers to direct social contact can arise through geographical distance from old friends:

> "I have lived in ... so a lot of my friends are there. I write — they write".

Even small distances can create barriers which are almost insurmountable for the aged, unless door-to-door transport is available and organised by a third party.

Many elderly people find themselves unable to cope with the organisational aspect of providing transport to visit old friends and neighbours, even where relatively small distances are concerned, and similar problems must arise for their friends and neighbours who are in the same age group. There is also some evidence to suggest that some elderly people dislike leaving their own environment to travel outside. One resident stated that she would no longer travel in a car, even when she knew and trusted the driver because she was afraid of being involved in a car crash. Other residents indicated that, as they were getting older, they found that they were losing confidence in their own ability to travel alone. This also applies to walking short distances to the shops or church. Old age, a lack of confidence in one's own ability and increasing immobility all contribute to the reluctance of the elderly to travel, especially if the journey has to be made alone.

Poor sight and hearing also create barriers to communicating with friends and neighbours by letter or telephone. However, some residents do use the telephone extensively, or write frequently to friends and neighbours. These methods of communication substitute in part for direct social contact.

Approximately half of the active female ambulant residents who state that they have visits appear to have regular visits from friends and neighbours, the remaining half having less frequent or occasional face-to-face contact with old friends.

The responses indicate that the majority of active female residents do not visit old friends or neighbours. Although one resident visits friends very regularly:

"I go out nearly every weekend to visit my friend and stay from Saturday evening to Monday morning. We had great times together during the summer."

Sometimes residents go out with friends when they call:

"My best friends live outside the home, they visit regularly and I go out with them."

It has been pointed out earlier that the factors which prevent elderly residents from visiting old friends and neighbours are likely to apply also to their potential visitors. This fact is recognised by some residents:

"It's hard for my remaining friends to visit me. During the summer now, I must make a point of visiting some people".

"My best friend comes a long way across the city to see me."

Death has also taken its toll of friends and neighbours. This is mentioned by several residents:

"Old friends and neighbours used to visit, but a lot of them are now dead".

"One special friend used to visit me regularly, but I've had no visits now since her husband died."

Similarly, illness and declining health also diminish the number of visitors:

"My best friend outside the home has just moved into another nursing home — we don't keep in contact — it seems she has become a little senile."

A few residents say they do not want any visitors or would prefer, for one reason or another, that visitors did not come. For example, one resident felt that, because of real or imaginary class barriers, her visitors would not fit in:

"Some people will come and I don't want them here — one of them is a home help. I don't want them here — this is a very select place — not like some of the other places."

One resident says lack of privacy prevents visitors from coming often:

"Friends don't come very often. There's no place to talk to visitors —no privacy."

The previous lifestyle and friendship patterns of the individual resident must also be considered in this context. Residents who have formerly devoted themselves to husband and family might never have availed of any opportunity to develop close friendships outside the family circle. One elderly woman makes this point in her response:

> "I don't think I ever had any best friends as my husband and I were so wrapped up in each other, we didn't have much time for other people."

The point must also be made in relation to friendship patterns that, for many elderly people, family ties may remain strong enough even in old age to minimise the need for friendship ties outside the family circle. Not all residents gave details of the frequency of visits from old friends and neighbours. From those who responded directly to the question, 9 residents say that they don't have any visits from friends or neighbours, and 29 state that they do have visits. The frequency of visits mentioned varies a good deal from twice weekly, weekly, fortnightly, monthly to occasionally. Approximately half the active female residents who state that they have visits appear to have regular visits from friends and neighbours, the remaining half have less frequent or occasional face-to-face contact with old friends.

The individuals who do not have any visits from old friends and neighbours appear not to have formed close friendship ties with others, generally because of their lifestyle, but with one exception, which fits the stereotype of the forgotten elderly person in residential care.

> "My neighbours used to visit me for a while when I came here first but they don't come anymore."

Two of this group are alcoholics, one of whom says he had very little contact with his neighbours, and the other who had been living rough for some time before he entered the home. This resident is a short-term resident who will probably return to living in a hostel after being discharged from the nursing home. He will almost certainly go into residential care in the future.

One of the active residents is a married man living in residential care with his wife. He is particularly active for his age and occupies his time carrying out repairs, gardening and various other tasks around the home. He shares his spare time with his wife, and they keep very much to themselves within the home and have little contact with anyone outside the family circle:

> "We haven't given terrible confidence to anybody inside. We have lived most likely more to ourselves and apart from them. But still

nevertheless friendly always, but strict confidence, no, no we just don't confide in them that way."

One resident who does not maintain contact with old friends and neighbours prefers to make a clean break with his old life, apart from his immediate family. He actively discouraged his friends and former workmates from coming to see him:

> "I don't get visits from old friends or colleagues now at my own request because I cannot remember what they have said — so it's a waste of time."

Since coming to live in care, a small number of residents made new friends and acquaintances outside the home. These residents have established ties in the community rather than the nursing home in which they live.

Social contact among residents themselves is also very important. Visits between residents are particularly important for the incapacitated elderly in care as they are often dependent on others to make contact.

Correspondence and Telephone Communication

Most of the residents have some communication by letter and telephone with relatives; a few, however, have no close living relatives and have not kept up contact with more distant relatives. Communications very rarely deteriorate between residents and their close relatives to the extent that they no longer have any contact. The fact that all residents do not communicate by letter or telephone does not mean that they have poor contact with family members. The opposite is often true; where face-to-face interaction is frequent, family members often do not write or telephone because there appears to be little need to do so. Letter-writing and telephone calls are more often used to communicate when face-to-face interaction is not possible due to relatives living abroad or as a means of keeping in touch between visits. Some female residents tend to use the telephone as a means of communication in itself, whereas male residents tend to use the telephone as a means of arranging contact in person.

Correspondence or communication by letter or telephone is sometimes 'one way'. Residents are not always in a position to write letters or make telephone calls because of disabilities, ill health or lack of mobility. Very occasionally, letters are written for them by others. Telephone calls can be taken by infirm residents in their own rooms in homes which have such facilities but such an occurrence was only recorded in one home.

Many residents with sons and daughters abroad mention that the latter ring on special ocasions. This event is a source of pride for the resident,

especially if the distance is great, and the resident's relative does not count the cost.

The general pattern appears to be that those who correspond with, or telephone friends and neighbours, keep up a regular contact, with a few exceptions for whom the contact is more sporadic. Letter writing is slightly more popular than telephone calls. In a couple of cases, the main effort to maintain the contact appears to come from friends outside the home:

> "They [neighbours] write and send cards occasionally but I don't write them."

> "I rarely write or receive letters."

Visiting Patterns: Relatives' View

Family, friends or neighbours interviewed for this section were those whom the resident would contact in case of emergency. The frequency, level of satisfaction, duration and pattern of visits varied quite widely. This variation in visiting patterns was conditioned by several factors, the most important being the location of the home, the resident's health and disposition and the conditions under which the resident entered the home initially. The most immediate visitor or contact was usually either a son or daughter and their family. Where residents had living relatives, they were visited at least weekly, and more commonly, two to three times a week. Quite a substantial number of residents had daily visits from the relative, whether their son or daughter, their brother or sister. Many families organised their visits so that the resident had a daily visit from some individual family member. Relatives say they usually visited alone once a week in the main visit, and again during the week as a family, husband and wife alone, or other spouse with the children. Children in their teens usually visited alone to spread out visits over the week, as mentioned already.

Regardless of whether it was the male or female relative in care, female family members, that is wife, sister, daughter, daughter-in-law, aunt and granddaughter, said they visited more frequently and for longer periods. Some sons were very attentive in visiting their parents, usually dropping in on the way home from work or at an arranged time. The extent and frequency of relatives' visits is an important issue to residents.

When residents had no remaining family or no family in the immediate vicinity, the particular contact friend visited quite regularly, either once or twice weekly on a regular pattern. Other friends would also call. Relatives, family or friends who are living abroad/overseas usually visit quite regularly when they are at home on holidays. Otherwise, friends and neighbours are the only visitors.

Relatives' Level of Satisfaction with Visits

Most of the relatives think that the residents are satisfied with their visits: they 'brighten up' when visited, 'look forward' to the visit and the opportunity 'to chat about the family and old times'. In that respect, the visits are beneficial to them. The majority of relatives do enjoy the visits, but the level of satisfaction seems to depend on the demeanour, alertness or attitude of the residents and the conditions under which they initially entered the nursing home. Where the resident is alert, cheerful and contented in the new setting, and capable of participating in a lucid conversation, whether about family happenings or past memories, relatives get a greater level of satisfaction and are happier about the visit and about leaving the resident:

> "She looks forward to the visits and she likes talking to me as I enjoy listening to her talking about the past and about American politics. She's very well up."

Where there is a certain amount of guilt or misgiving regarding the resident's entry into residential care, visits are often traumatic and fraught with underlying tensions. In quite a substantial number of cases the extent and frequency of visits and the relative's attitude to visiting is conditioned by guilt feelings.

Guilt Feelings

In general, where there were guilt feelings because relatives felt that they were shirking their responsibilities by putting the resident 'away', they were being selfish, letting the resident down, or felt remorseful when they saw 'the terrible sad look of the people in there', they found the visits less satisfactory. The visits were, in these circumstances, described as 'tense, difficult, upsetting'. Relataives found they really had to 'force' themselves to make the visit.

A few relatives who did have guilt feelings considered the visits as a means to make amends. Several of the relatives felt the need to continuously explain and justify the reasons why the resident entered the nursing home initially. They often could not come to terms with the fact that their spouse or parent was now a nursing home resident. This was a constant source of misgiving and anxiety for them. One particular relative described herself as 'heartbroken' when her parents made the decision to move to a nursing home. But, in this situation, the relative suffers more from an acute sense of loss now the family home is gone and she cannot cope with the idea of going to visit her parents in the nursing home just as a 'visitor'.

Relatives, who themselves had no guilt feelings about their relation being

in the nursing home, did agree that some people would be inclined to feel remorse. But they looked at the situation from a more practical perspective, recognising that elderly people can be 'very difficult' and 'trying' and can place tremendous strains on family members who have other commitments. As long as the relative is doing the best for the resident, given the circumstances, then there is no need for such feelings.

Relatives' Relationships with Staff in the Nursing Home

Relatives encountered no difficulties dealing with the staff, describing them as 'caring, dedicated, kind and helpful'. At no point did they offer any criticism of the staff, nor did they mention any problems. Generally they described the relationship as being very good:

> "Have an excellent relationship with staff, we're on very good terms".

Financial Contribution

In the vast majority of cases relatives or family members did not contribute to the residents' upkeep in the home. The residents usually managed on their own pensions:

> "She's independent, she has a pension, she's quite well off really, no, there's no reason to contribute to his/her upkeep".

Except for certain items or little luxuries which the relative would provide or occasional sums of money, residents are quite self-sufficient. A few relatives did mention that with steadily rising fees this situation might not continue, and that they might have to contribute to the resident's upkeep if he/she is to remain in the home.

Perception and Satisfaction with Standards of Care

In general, both resident and relative were quite satisfied with the standard of care available in the homes:

> "They're very supportive, very kind, they seem to care for the residents' needs quite well."

Most homes seemed to cater fairly adequately for the residents' physical needs but relatives did agree that one could never be sure of the standards in the homes and that the cost or fee gives no indication of how their needs will be catered for, or the standards in the home. A few relatives expressed anger, revulsion and shock at the conditions in some of the homes:

> "Some of it is dire, I wouldn't let a dog live in some places."

One relative, who had 'visited dozens of homes', was appalled at the 'dreadful' standards in the homes.

The provision of services was seen as adequate in most cases but could easily be improved 'with a little thought'. Services were regarded as sufficient from a short-term perspective but their 'long-term adequacy' was questioned. Facilities could also be improved, particularly toilet facilities, which were in a few cases considered 'very poor'.

Relatives, on average, felt that enough was not being done to stimulate residents mentally, but they nearly always qualified this statement by pointing out the difficulty of this task. Homes are normally short-staffed, so that caring for the physical needs of the residents demands all their time and attention. It was also felt that 'they are old people, what can you do with them, there's so little response'. It was felt that residents are often just left there. Many of the relatives identified the need for occupational therapy to alleviate this problem and to 'get people going, get them involved'. It was agreed that the onus should not fall solely on the nursing homes but that more outside involvement is needed, from voluntary and church groups and particularly from the family themselves. The need to listen to the residents was identified as an important factor in mental stimulation.

It was felt that basic social needs were catered for to a certain extent but there was also a feeling of inadequacy or powerlessness:

"What can they do? They introduce them to each other."

Apart from bringing them to bingo, providing a T.V. or music and allowing them the freedom to come and go as they please, relatives couldn't totally identify other needs. Again it was felt that the staff were occupied by their 'work' and didn't have the time to cater for the elderly on a personal basis. More outside interest in the residents is needed.

Relatives identified improvements which they considered would make life more agreeable for the residents. These suggestions were made on the basis of their own experience in the homes. The general points included the following:

- A need for more staff in the homes to allow for more involvement on a personal level with the residents, especially where the residents are incapacitated.
- Residents should be allowed as much freedom and independence as is possible within the homes, they should be encouraged and be able to carry out their lives along very similar lines and patterns to their own homes.
- Social contacts and links outside the homes should be maintained by the provision of a place for residents to entertain their friends, make a cup of tea, etc.

- Many of the homes were custom built along lines that did not take into consideration the needs of infirm or incapacitated patients.

Change in Relationship since Entry

Generally there appears to have been no change in relatives' relationships with the residents since entry to the home. As relatives see it, there is still an independent, 'free' and relaxed relationship between the relatives and the resident and they come together with the same ease and companionship as previously. Where the resident's medical condition has deteriorated a lot, there is an element of dependency introduced into the relationship, but this does not seem to overtly affect their overall relationship. The move to the home has considerably narrowed the perspective of some residents and relatives find they do not have that much in common with them any more: "there isn't that same amount to talk about now. Their world is very much smaller".

Summary

Overall, the residents in care present quite a varied picture in terms of level of social contact with their children, close family relatives, neighbours and friends. In terms of both the frequency and quality of the contacts, residents looked forward to and appreciated their relationships with close family and friends and the fact that residents had moved to a nursing home did not appear to damage relationships. In general, contact with family members depends on the relationship between the resident and family members and geographical distance. Closely related family members living near-by are likely to visit residents frequently. Social contact is a two-way process and if residents are mobile, they are likely to visit family, friends and neighbours if transport is provided. Geographical distance appears to be a major factor in preventing social contact between residents and their relatives particularly when both parties are elderly. However, for elderly residents who are not ambulant, the question of going outside the home is totally dependent on the goodwill of others. Contact by telephone and by letter are also important ways of keeping in touch. This holds particularly for those residents whose children or close relatives are overseas. It is worth noting that female residents tend to use the telephone as a means of communication while male residents tend to use it to arrange future interaction.

Problems that have arisen in an individual's life at an early stage may have affected family ties, and these differences often are carried on into old age without resolution. Correspondingly, where family ties are strong during an individual's life, they are likely to remain strong in old age, wherever the elderly person may be.

Neighbours and friends often come to visit but illness and immobility can prevent this. Some of the elderly who were interviewed disliked travelling, sometimes because of fear of travelling or because of poor sight or hearing. Residents who had had very close relationships with their spouses felt that there was a vacuum after their spouses' deaths and there was often no one to keep contact with on such a close level. Other residents did not want friends and neighbours to visit. They had nothing to say and perhaps, more importantly, they felt that they did not want to betray to them their lack of concentration or tendency to repeat themselves. The level of privacy offered in some homes was inadequate and discouraged their social contact as far as some residents were concerned. There was one resident who fitted the stereotype of the forgotten elderly person in residential care but this person was an exception. As we have already seen, relatives play a central role in residents' lives. The frequency and level of satisfaction with visits varied considerably. Several factors such as location of the home, residents' health and disposition and the conditions under which the residents entered the home initially, impinged on this. Female relatives tended to visit residents more frequently and, when visiting, to stay for longer periods. Feelings of guilt were common. Many felt that they were shirking their responsibilities and their relationship with the resident tended to be fraught with difficulties. Relatives were torn between what they saw as responsibilities to their own family conflicting with those towards their parents. Some relatives did not feel this way, as the practical implications of looking after a relative in their own home made the decision easy for them to make.

Relatives had good relationships with staff and most did not contribute to the upkeep of the residents in care. They were generally satisfied with the standard of care, but they did emphasise that care was focused very much on the physical aspects. The fee one paid in a nursing home gave no indication of how residents' needs would be catered for, or the standards in the home. Relatives gave a number of suggestions regarding care, most of them focusing on the importance of treating residents as individuals with particular needs and the importance of the homes encouraging social contacts, both inside and outside the home. Generally, relationships had not changed since their relative went into care. However, the health of the resident did affect relationships. Some also felt that the interests of the residents had narrowed, leaving little to discuss when they made their visits.

Overall, the findings indicate that social contact is central to the lives of the residents and to those who visit them.

CHAPTER 8

LIVING IN CARE: LEVELS OF SATISFACTION AND CONCERN

Residents' views of life in care have been given in the preceding chapters, focussing on the daily dimensions of their lives as well as their social contact patterns. In this chapter, we look more closely at living in care by considering residents' perceptions of the best features of life in residential care as well as some of their concerns.

Best Features of Care

For active male and female residents, life in care offers a life where your day-to-day needs are being looked after; for women, in particular, the security and protection of the home is seen as being of major importance. It is important to note here that an increased sense of security appears to be a compensatory feature of living in care although it is rarely given as a reason for entering into residential care. The responses of the female residents indicate that residents are often happy to avail of the opportunity to 'do nothing'. Reasons for this appear to be:

- The cost of living in residential care
- Residents see themselves as old
- Residents see themselves as retired.

Being old and retired means no longer having to work and worry about daily life, particularly if others are being paid to take care of them. Amongst many active female residents this appears to be a deliberate decision not to become involved in day-to-day affairs of the home. It is not an apathetic response. Residents see themselves as old and retired, and retirement gives them the freedom to do as they want.

The good features of home life mentioned by incapacitated residents

correspond to those mentioned by other residents. The less favourable features reflect, to a large extent, their lack of control over their own lives which is due more to their disabilities than to life in residenctial care. The responses from incapacitated residents suggest that ill health was perceived as the basis for unhappiness and apathy more than the residential environment. Residents have low levels of expectation relating to their life other than their physical needs. They expect their physical needs to be looked after, especially if they are paying for them. In other areas of their lives they have lower expectations and, consequently, appear not to voice their other needs or expect that issues like this can be changed or improved.

Making Decisions and Having More to Say in One's Daily Life

Residents were asked about the level of decision-making in their daily lives and if they would like to have more say. They were also asked the question "Are you your own boss?". Thirty-eight active female residents feel that they have no decisions to make in their daily lives although a few of them qualified their response to say that they had some decisions to make in personal areas but none in the day-to-day routine of their lives. Twenty-one of the active female residents state that they do not want more say in the daily running of the home. A few residents feel that you have to go by the wishes of the staff; however, 7 feel that they would like more s ay in dietary affairs. The following responses illustrate these attitudes:

"I have no decisions to make, but I don't want any say."

"I have no decisions about my daily life — except my income and I get my accountant to do that."

"All my decisions are made for me which means I have less to worry about."

"I would like more to say in dietary matters, we get way too much food — too much waste — a dietician in the kitchen would solve a lot of problems."

"I would like to have more say. I would like to have a choice of things to do in the evening rather than watching telly."

Fourteen of the active residents feel that they have no decisions to make in their daily life in the home, 10 do not want to have more say in these matters, and 4 feel that they would like to be more involved:

"No, I wouldn't like to have more say in the running of the home — I don't feel up to it."

"I don't ever find it monotonous here. I feel very happy indeed. At my

age, eighty-six, you don't really look for things to do."

"I don't make any decisions about life in the home directly — but I make decisions about my own life."

"You are in charge of all your own affairs and what to do. There is no restriction. The room is your home, you can do what you like in this room — apart from breaking up the furniture — the freedom to do as you please."

Those active male residents who would like more say want this to be mostly in the areas of recreation and activities:

"I'm often trying to find things to do. I would like to do some light gardening, play snooker."

"I would like more games like billiards organised in the home."

"I'd like to do a bit of gardening but the garden is so overgrown that there would be too much heavy work to be done."

"I'd like more say in certain areas, for example, some of the residents here are very senile — disturbed, and I feel the authorities should be more selective about their residents."

Fifteen of the infirm residents feel that they play no role in decision-making in the home. Four of these residents feel that they should have more say, and one does not want any say in the day to day affairs in the home. Two residents feel that they must go by what the staff say. Two others feel that they would not hesitate to make their views known if they wanted more say:

"I haven't any decision to make about my daily life — except about my financial affairs. Nobody has any say in the running of the home, you just have to fit in with the routine. If you can't fit in you must go."

"I have no decision to make about my daily life — I would like more say."

"The committee have no understanding of the needs of people like me."

"You have to go by what the staff say, to a certain extent — all decisions are made for me ... I'd like more say in the type of meals provided, the food is very monotonous at present."

"All my decisions are made for me but if I wanted a say I would have one."

"If I didn't like things I would say so."

Being Your Own Boss

Altogether 38 elderly people felt that they were their own boss, whereas 17 felt that this was not the case. Twelve residents, although they felt they were their own boss, qualified this statement to some extent:

"I wouldn't say I'm really my own boss, but there are not many restrictions on what I do."

"I am my own boss, they treat me well here. It's home."

"Own boss? Are you joking me, are you? Not at all. There's not many regulations but you must do what you are told ... I have everything I want, I'm treated all right."

"I'm not really my own boss — I have to conform to the pattern of the home."

"You're your own boss to some extent but when you're not running your own place you're not really your own boss."

"You are not your own boss here, you are very dependent."

What is the reasoning behind the mixed attitudes shown bay the residents? A large majority of the residents interviewed, although they do not want any say in their daily affairs, still feel that they are their own boss and are also happy with their lifestyles. How can this be explained? In many homes, the ethos of the home conveys a good sense of freedom to the residents. As they see it, rules and regulations in the homes visited are kept to a minimum and those rules which exist are accepted mostly as necessary for the efficient running of the home. In many cases, rules are confined to attending for meals and informing a staff member if you are going out. However, the mental and physical condition of some residents is such that they are not allowed out alone, and one such resident says:

"It's like a prison here ... they keep the door locked."

Because some homes do not accept residents who are either mentally confused or physically infirm, this situation does not always arise and where it does, not all homes resort to locking their doors in order to confine confused residents. In this study, many of those interviewed commented on the sense of freedom they felt in the home.

The Issue of Privacy for Active Residents

For residents the issue of privacy while living in residential care is related to

whether their accommodation is a single or multiple room. Rarely are other issues relating to privacy raised. Thirty-two active female residents have private rooms, 19 are sharing accommodation with others and 10 residents did not respond to the question. Generally those who have private rooms are happy with this situation.

"I have a room of my own. I suppose you are better off on your own."

"I wouldn't like to share in case I wouldn't get on with my room mate."

"I wouldn't be too keen on sharing but those who are sharing seem to get on quite well together."

"I have quite enough [privacy], more than you want sometimes — then you can go out and have a natter."

The responses highlight the differences in the atmosphere in the home towards privacy among individual residents. While one resident can say, "I never lock my door except when I am going out", another one in a different home says "there is not much privacy here, some of the others come in without even knocking."

Amongst the active male residents interviewed, 9 men had private rooms, and 8 others were in multiple rooms, which accommodated from 2 to 10 people. One of this group shared a room with his wife, and 2 others who shared with the largest number of other residents i.e. 6 and 10 people respectively, are short-term residents. Interestingly, both these residents feel that they have enough privacy. One of these men says:

"I don't mind sharing — there are curtains around the bed."

Of the remaining 5 who share with other residents, with the exception of one man who 'shares with a friend', all sh are with 3 or 4 other residents. Excluding the married couple and the 2 short-term male residents, 3 of the remaining group of 5 feel that they do not have enough privacy:

"I could do with a bit of privacy but it's expensive for a private room."

"No I have no privacy — there are three others in my room."

Only 1 of the remaining 2 residents in this group states definitely that they have enough privacy. Because of the small number of males in the study, one hesitates to assume that the majority of active men who share a room in long-term residential care feel that they have not got enough privacy. All 9 of the male residents who have private rooms agree that they have enough privacy. Having one's own room is a key factor in this issue:

"I have enough privacy — I have my own private bedroom — I wouldn't have shared."

Having one's own room gives residents more freedom:

"I have a room to myself — I can go to bed anytime I like."

For residents in this group, having enough privacy is definitely associated with having one's own room. This allows the resident a retreat from communal life and, if he is lucky, his right to privacy will be recognised by other residents. One such resident says:

"People don't disturb me — they know I value my privacy."

Of the active female residents who share accommodation and who gave their opinions, many like to share and have no objection to this arrangement. Others do not like sharing, and the issues which arise in this context are lack of privacy in one's room and being disturbed during the night by a sleepless or ill room mate. Finally, very few residents interpret the issue of privacy apart from the context of the accommodation available to them. For a few, privacy is seen as having the freedom to live one's own life with minimum interference from others.

Taking One's Possessions into Residential Care

A good variety of possessions and personal effects are mentioned by residents who took some of their belongings with them when they moved into residential care. The variety of objects chosen by residents spreads over both sexes, but the grouping of objects varies from one sex to the other.

Clothes: Many male and female residents mention that they took their own clothes with them to the nursing home. Not all residents mention clothes, but it is most likely that this holds for the majority of residents. Only one resident (male) mentions that he is not allowed to wear his own clothes, despite the fact that he took these to the home with him.

Furniture: A large number of residents took items of furniture with them to the home, and just two residents specifically state that they were not allowed bring items of furniture, and in one case an elderly woman was prevented from taking any possessions other than her clothes. Undoubtedly, taking one's possessions into residential care can create problems for staff with regard to storage, cleaning and general lack of space and different homes had different policies regarding this matter. Some of these problems were highlighted by a resident when he said:

"You are allowed to bring in a certain amount but you cannot obstruct the place where the staff do all the cleaning. So they provide you with all the furniture required, but you are allowed bring in certain things

of your own. Well ... lockers or chest of drawers. I did that you see but then this is our own room, [he and his wife's]. We have our own carpet cleaner in the wardrobe, we do all our own washing and cleaning up, all of that, sinks and mirrors and everything else. We do all of that so there is precious little for anyone else to do ... I do, yes, [prefer it] it's my own home, and it's our home, the only home we have."

Other Possessions

It is in this area, that the main difference in objects chosen by males and females to bring with them into residential care arises. Women prefer to take items with them that remind them of home, including china, ornaments, pictures, religious objects, electric irons, bedclothess, other objects often described as 'bits and pieces' and radios and television sets:

"I brought my rocking chair, all my ornaments and pictures — they cheer me up."

Male residents, on the other hand, are more likely to take objects that enable them to pursue an existing interest or objects that could be termed 'tools of their trade'. Two male residents, both infirm, took a typewriter and a drawing board with them to the home. Both of these residents had undertaken some work since their admittance to the home. Other items mentioned by male residents include books, a musical instrument, records, record player, electric razor, pictures, television sets, radios and a bicycle. A few residents have cars, and in some instances at least, keep them at the nursing home address. The number of residents who own cars is very small.

Problems over Possessions

Taking one's possessions into the nursing home can help residents maintain lifelong interests, and can also help create a more homely atmosphere. The number and type of possessions that residents can take with them to the home will depend on the policy of that home. While we do not have much information on this topic, it seems that some homes forbid residents to take in any possessions apart from their clothes. Losing possessions or having them borrowed and not returned can be a source of great annoyance to residents as can be the problem of petty theft which was hinted at occasionally by residents. The problem of looking after one's possessions appears to be more acute in homes which have a large number of confused residents, but it can also be problematic when staff members treat an individual resident's property as community property. An account of one resident's experience makes the point. When the owner enquired about an item, the reply was that it did not belong to her. Consequently, the owner

was very upset about this incident, and was tempted to retrieve the item herself, but was afraid of causing trouble. Trivial incidents like this can create upset and ill feeling amongst residents out of all proportion to the original incident. Staff need to be sensitive to these concerns.

The Issue of Privacy for Infirm Residents

Eleven of the infirm residents interviewed had a private room, 6 shared rooms and 1 resident did not respond. When one considers the position of infirm residents in residential care, particularly those that are bedfast, three issues arise: loneliness, incompatible room mates, isolated and alone in public.

Seven infirm residents with private rooms felt that having a private room was necessary in order to guarantee one's privacy:

"I have a room of my own, it's essential if you want privacy."

"This is better than a hospital ward system."

"I have plenty of privacy — I can do what I like in this room."

"I wouldn't like to share a room."

Other infirm residents who have a private room are undecided about its benefits. One elderly woman has some reservations about being on her own, but overall feels that it is probably the best. This resident is unable to leave her room and would occasionally appreciate the company of other residents. Her fear is, however, that she would not find a compatible room mate and then "life wouldn't be worth living".

In another instance, an elderly woman alleges that she is not allowed to leave her room, or mix with other residents. She is very unhappy in the home and is not on good terms with the matron. Privacy is not the issue for this resident.

Things that may seem to be trivial can sometimes make a great difference to an elderly person in care. One elderly woman interviewed was recovering from an operation and, while she was convalescing, she was moved to a ground floor room. Unlike her own room, this room did not have a lock on the door. The resident's usual practice had been to wash all over in her own room, and having a lock on the door gave her extra privacy. Because of her age, she was afraid to use the baths, "baths are slippy things". This resident hopes that when she has recovered, she will be allowed back to her own room.

It was pointed out by one of the male interviewees that health board regulations do not permit locks or bolts on the doors to residenst' rooms, in order to allow staff access in case an emergency should arise. During the

course of this study, it transpired that some residents have keys to their doors, and one male resident had actually put a small bolt on his door to prevent other residents from wandering in, particularly during the night. He says:

> "It's against the rules of the health board, you cannot lock a door, although we have a bolt on ours. I had to put that on because of patients getting up at night rambling, going around. Sometimes I had to get out of bed in the middle of the night and drag them along the passage way and put them back to their beds with their clothes half naked on them. One woman from across over there, came down here and came in here in the middle of the night and tried to get into bed with me, thinking she was in her own room. So I put on the bolt lock to stop that sort of thing."

While there is need for staff to have access to residents in their rooms, there is also the resident's need for privacy which, in many homes, is exceedingly difficult to maintain because of a general lack of recognition of that right to privacy and, particularly, because of the number of confused elderly people who reside in care.

One female resident in this study was exceptional in that she did not look at the issue of privacy simply in relation to having a room of one's own; for her, the issue of personal privacy was concentrated on other matters, in particular the toilet facilities available to her in the home. This resident, a stroke victim, is mostly confined to a wheelchair. In the morning, she and other residents are taken downstairs to the dining and recreation area. Residents are not allowed back to their own rooms during the day. Taking a nap during the day is strongly discouraged, because staff feel that it will interfere with residents' sleep at night. Sitting in the recreation and dining area all day can be very tiresome, and this resident finds that sometimes she "longs to be alone". She describes herself as a 'sociable type of person' and feels obliged to maintain the appearance of being in good form and being receptive to the conversation of others, at times when her spirits are low. However, this is not the biggest issue for this resident.

The major complaint is that there is persistent invasion of her privacy when she is taken to the toilet. The first point this resident makes is that her personal hygiene is taken care of by a male attendant, which is for her a source of embarrassment:

> "A male attendant brings you to the toilet and pulls your pants down around your ankles."

The layout of toilet facilities means that while the resident is in this situation, she is exposed to anyone who comes into the room. There is one

door leading into the block of toilets but each cubicle does not have its own door. This resident is persistently annoyed by a male resident who comes in and stares at her while she is using the toilet. When she tells him to go away, he abuses her verbally. When this woman complained to the male attendant, he replied "he doesn't know what you are doing" but she says "I don't believe that, do you? He knows." Because this resident feels that this situation is accepted as being normal by other residents and staff, she too should be able to accept it, but has great difficulty in doing so. This incident highlights the vulnerability of the elderly and their inability to deal with a difficult situation, in particular, when the elderly person alone appears to be the sole objector. This resident is being harassed by another resident and the situation is being trivialised by staff members.

Six infirm residents share a room with one or more others. Three of them don't mind sharing with other residents:

"I share the room with one other woman, I like the company."

"I share a room with five others but I don't mind at all."

The remaining 3 residents did not like sharing, or, more accurately, one of these respondents did not like sharing with her present room mates. This resident's 2 daily companions are both confused and are unable to carry on a conversation with her. In addition to this, they persistently interfere with her visitors. Because she is confined to bed, and has not been out of her room for two years, this resident is unable to seek company elsewhere and her only wish now is to share a room, preferably downstairs, with non-confused companions. The remaining 2 residents would prefer not to have private rooms.

Monotony

A large number of residents do not complain about the monotony of their daily lives. This is particularly true for male and female active residents, the majority of whom do not find life in residential care monotonous. Only 5 male residents in this group found this to be the case, whereas 21 females found life monotonous. However, not all of these respondents found life monotonous all of the time — some, occasionally, find life monotonous during bad weather, when they are ill, or unoccupied:

"Oh yes, naturally it gets monotonous, I tidy my bedroom when I'm looking for something to do."

"I very seldom find it monotonous. I was used to finding ways of filling up the day from living alone."

"Nothing very exciting happens here. Sometimes I find it monotonous—

I feel very lonely."

"No, I don't find it monotonous — except when the weather is bad."

"It's only monotonous, if I'm ill — that's once in a blue moon."

Feeling of Monotony among Incapacitated Residents

It is not surprising that infirm residents differ from ambulant residents in that a majority found life in residential care monotonous. The issues which arise in this context are centered around topics which have already been discussed, namely, loneliness, physical handicaps, isolation, lack of occupation and compatible companions. These present particular problems for the infirm elderly and knowning that their general situation is unlikely to improve adds to the discontent, and for some in the words of one resident, the only option is:

"If you can't fit in you must go".

For others, this option is not open, they cannot go because there is no other place open to them. As one infirm woman said:

"Residents are happy here because they have nowhere else to go, and this is the crux of the whole thing".

A male respondent points out that his activities and interests are limited by the fact that he is in residential care:

"I find it quite monotonous here — I am not realising my full potential — I am denied my fuller capabilities."

Consequently, infirm residents, particularly those who are confined to bed, find the day very long; quite a few wake up early after a particularly sleepless night. By afternoon the day seems endless:

"I find it monotonous sometimes especially in the afternoons — the mornings are the best times."

Not all the infirm elderly complain of the monotony of their lives. Those who have enjoyed solitary pastimes or occupational activities such as reading, writing or other activities, are sometimes able to pursue these, if their state of health permits. An acceptance of one's limitations and one's situation in life at this point allows these residents to enjoy a few pastimes in spite of their infirmities. Typical of this attitude is the ability of such a resident to say:

"I've had a good life — what more could I ask for?".

The care and consideration shown by some staff members can also ease

the burden of monotony for infirm residents.

Summary

For many of the residents living in care, the best features are that day-to-day needs are being looked after, the security and protection offered by the home and the fact that there is no need to worry about things as they are paying others to look after them. Residents make a deliberate decision not to get involved in the home: they feel that they have "retired" from the main stream and are quite entitled to do nothing. For those who are disabled or infirm the lack of control over their own lives poses a problem for them. Here, however, ill health rather than the environment forms the basis for unhappiness and apathy. The more negative features of residential care for both male and female residents centre around the problem of ill health, loss of friendships and lack of "real home life". Attention is also drawn to the personal loss of control over day-to-day activities, lack of a real relationship between residents and the lack of choice over diet or recreational facilities. It is worth noting that our study revealed a conflicting attitude to control of one's life among some residents: they feel they have control over their own life and yet they do not want to have any more say or choice in the running of the home.

There are also mixed attitudes towards the lack of privacy in nursing homes. The issue of privacy seems to be mainly related to whether accommodation is in single or multiple rooms and other issues relating to privacy are rarely raised. For residents who are infirm or immobile this issue raises very serious problems of loneliness and isolation. In particular, an unhappy atmosphere is created when residents share rooms with incompatible room mates. Lack of privacy is also closely related to being unable to have full control over where to go and what to do without the help of others. This study revealed a serious breach of privacy for one resident when taken to the toilet and while this incident was an isolated one, it does highlight the vulnerability of the elderly when confronted and harassed by another resident.

It is important for staff to realise that when they trivialise or dismiss complaints or incidents reported by residents, this can cause distress even though the matter may seem unimportant, and the resident is left feeling that little or no comeback is possible.

For the majority of active male and female residents, life is not monotonous in residential care. This appears to be associated with being active and residents finding many things to do to fill their time, both within and outside the home. The second feature is that residents consider themselves retired and can therefore relax and enjoy life as they find it. These residents have adapted to this new lifestyle. If life is monotonous it is

because of the bad weather, ill health or because they have nothing to do. Life is more likely to be seen as monotonous by those who are immobile. However, if we look at the overall attitude of residents to their homes, almost three-quarters of all residents are happy or contented and just over a quarter say that they are unhappy or isolated, although there are differences between private and voluntary homes. More women than men appear to be happy or contented.

CHAPTER 9

PLANNING FOR OLD AGE AND RETIREMENT

Retirement can be viewed as a process, as one of the major stages of the life cycle which is now receiving considerable attention. It is increasingly evident that many more people are retiring while they are still active and both can and want to continue their activities and involvement in major areas of their life and lifestyle. Modern science and technology have created a world in which people live longer, but society's ability both to face and handle such a transformation has been disappointing. In looking at retirement, three broad perspectives have been adopted to view the transition and adjustment to retirement. These are role activity, disengagement theory and continuity theory.[1] None of these theories has universal application but do help to put retirement in a context. However, it is worth noting that the theories are male orientated and that the nature and meaning of retirement for women is often assumed to be similar to that of their male counterparts. This chapter looks at residents' views on planning for old age and retirement.

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[1] *Role Activity:* This perspective is based on the assumption that work is the only activity from which an individual derives a legitimate activity. Retirement results in the loss of identity for the individual. It is seen in a negative light. To balance this, people seek some kind of compensatory activity to take the place of the loss of work roles.

Disengagement Theory: sees retirement as a process through which the individual withdraws from the social system and prepares the person for later life.

Continuity Theory: views retirement as part of a process where the impact of retirement is minimised by certain continuities in people's lives such as family, friends and church. These roles are the sources of satisfaction and identity in later life.

When speaking to the elderly about old age and retirement, it becomes clear that not all elderly people make a distinction between these two categories. Talking about retirement generally, female residents tend to reveal their feelings more quickly than males, who are somewhat more reticent in their replies. Former housewives in particular, have difficulty in relating the concept of retirement to their own lives. For them, retirement comes when age and or infirmity prevents them from following their usual routine. Retirement for these women is not a personal issue that can be planned for; retirement is something that happens to others in what is more generally recognised as the world of work outside the home. Retirement is seen as a distinct entity by those who have retired from a job and have gone through a very noticeable period of change in their lifestyles in the process of doing so. Some residents equate retirement with old age and interchange these terms during the course of conversation. Others retired early to take up other jobs or continued to work as long as they were able. Retirement does infringe on married women's lives in that they can associate themselves with retirement through their husbands. However, that event might make only a minimal difference to their life styles in that external pressure of time and deadlines will become less important:

> "When my husband retired from work — this didn't make any changes in my life —except he took over some of the cooking."

> "Day-to-day living can become more relaxed and take on something of a holiday atmosphere. We used to lie on in bed in the mornings. One week I would lie on and my husband would bring me my breakfast and we would sit and have breakfast. We had plenty of time, so we just took it easy. When my husband retired we used to plan trips to the seaside and to visit other relatives."

Men, Retirement and Old Age

Amongst the men interviewed, like those who were disabled, some look at old age as the period in their lives after retirement. Others have a different outlook on life after retirement and see it as a time in which to relax, take up a hobby or pursue some existing interests. Very few of the men interviewed had actually made plans for their retirement and old age. In all, 11 did not make any plans for retirement, and 5 say that they had thought about it and made some plans but these plans did not always work out.

Types of Plans Made

Making plans for retirement was necessitated in some cases because the residents did not own their own home. None of the plans made appear to

have been very specific: 2 had decided to come into a home after retirement but do not give details about the type of arrangements they had made or the degree to which they had finalised their plans:

"I always visualised that I would come to a nice home like this."

Plans made by other male residents were also vague and, in reality, tend to be speculative rather than strict planning:

"I used to visualise what I would do, for a few years before I retired. I thought that I would go into town and sit in St. Stephen's Green for a few hours on a fine day but circumstances changed and we settled for the home."

Sometimes retirement catches people by surprise in that they are forced to retire early due to ill health or accident. One of the male residents to whom this had happened offers the following advice:

"People should start to make plans for their old age in their forties and fifties, before their minds start to deteriorate".

View of Planning

The views of the male residents generally suggest that there is a need for planning for retirement and old age, which they did not recognise in the years before retirement. Basically, their suggestions fall into two categories:

- Occupying one's time after retirement
- Financial planning.

Other residents see no point in planning since there is no guarantee that plans will ever come to fruition.

Occupying One's Time after Retirement

Retirement can come as a shock to the individual who is not prepared for the trauma of the experience. The words of 2 residents express these feelings:

"I should have planned better for my retirement, I was totally involved in my work and suddenly I was at a loose end. I felt totally empty as if I was in a huge vacuum. My whole routine, my whole life had changed."

"People should plan for their old age, think about it at least and prepare and read as much as they can in the papers and in what's written about it — so they won't get a shock when the time comes.

You should make financial plans and family plans if you have a family. How are you going to dispose of your things? Where are you going to live, on your own, in a nursing home or what?"

A few of the active male residents express the need to have ways of occupying their free time:

"It is vitally important to plan for retirement and not to leave it too late. One should be educated for this new way of life, for the whole concept of leisure and free time. It is very important to make financial plans and to develop hobbies and interests that will fill one's time. There's greater freedom when you've retired but there is the problem of not having anything to do."

The general impression given is that the active residents like to have some free time but would also like to be usefully involved in some work or activity. This is not to say that these residents do not appreciate their freedom in not having to work and the chance to enjoy a slower pace of life. Time tends to hang heavily on their hands especially if their health is good and pastimes have not been developed which could occupy that time. These mixed feelings may well be reflected in the residents' attitudes towards retirement age which will be dealt with later in this chapter.

Financial Planning

Financial planning is the most important type of planning which is envisaged by the residents. However, this is only mentioned by a small number of residents. Looking at their lives in retrospect, making financial plans and provisions for old age and retirement are considered to be vital by many residents:

"People should make plans for their old age particularly those who have no pension scheme — they should take out a pension plan."

"People should save so that they could afford little luxuries at home."

"I think the government should organise a compulsory savings programme so that people have some money when they retire."

Retirement Age

The question of the age at which people should retire was responded to more readily by the male residents, than the other questions on retirement. The responses break down into three categories:

- People should retire in their own time
- People should retire at an early age

- People should work as long as they can.

Retiring in your own time: The idea that retirement was very much a matter for the individual was mentioned by several residents. This allows the individual a choice in that he/she can retire early or late as he or she wishes. It allows the individual to take into account their own circumstances. Sometimes the resident suggests what he considers to be an ideal retirement age:

> "Retirement is an individual choice, it varies from case to case. I think people should retire at about sixty so that they can adjust to this second life, while they are still mentally and physically alert, and not to leave retirement go too late."

People should retire at an early age: The issue which is considered here is the one of young people without jobs:

> "I think people should retire when they are sixty to make way for younger people."

> " People should retire in their early fifties to leave room for younger people."

People should work for as long as they can: Some male residents when they suggest that retirement is a matter for the individual, are really expressing their disagreement with the idea of a compulsory retirement age. Some favour early retirement, others would prefer the option of staying at work for a longer period. Residents who have been self-employed had remained on in their business for some years past the normal retirement age:

> "I was seventy-three when I gave up my public house, it was tough work."

Others had taken up part-time jobs or wished that they could get part-time work after their official retirement:

> "I found it hard to retire, I would like some form of light work to occupy my time."

Other residents said that their state of health had enforced an early retirement and they would have preferred to continue to work for a longer period of time.

The idea that the individual should be allowed to choose the time they retire could be linked to the responses for planning for the future. Many elderly people find that, having devoted most of their lives to their work or business, they are left without anything to do or anywhere to go. This break from work, although expected, is often a shock:

"When you retire, although you know it's coming — farewells and all the rest, the first morning it's a shock — you don't have anywhere to go, you're in the way in the house — because your wife isn't used to having you around. So you get outside and stay out. It takes a whole while to adjust."

This is one of the main problems with retirement. Active people who have devoted themselves almost entirely to their work during their working lives find that there is a vacuum to be filled. Whereas many would be content to fill their lives with leisure-time pursuits, others are prepared to do voluntary work or enter into paid employment — especially if they need to supplement their pension. As one ex-garda said:

"That's the only thing, I can tell you, the only bit of news I can give you in relation to planning for retirement, ninety per cent of it is concentration on another job in order to supplement your pension."

The second major issue in relation to retirement is the problem of having adequate finance for the individual's latter years. Neither of these issues are always taken care of while the individual is still working. Several reasons may account for this state of affairs, not the least being the major financial drain on an individual's income during their working life.

Neither is there an awareness of the exact nature of the problems and the daily life situation of the elderly by younger age groups. The evidence indicates that it is difficult for the individual to imagine him/herself in a situation where he/she can no longer provide their own care. As one elderly woman said:

"Nobody understands what it's like to be old until you are old".

Useful Work that the Elderly Can Do

Very few of the elderly men interviewed put forward concrete suggestions as to the type of work which could be carried out by the elderly. One resident suggests that this is something that should be sorted out before retirement. Two others suggest that the elderly can become involved in social work, particularly with the aged and infirm.

Women, Retirement and Old Age

The vast majority of active female residents in this study report that they did not make definite plans for their retirement. For the most part, these residents never gave serious consideration to how they expected to cope in their retirement and old age. Very few gave consideration to how they would cope in their old age, but did not make any definite plans:

"I knew I would go into some place where I would be taken care of".

Many of the residents in this group thought that planning was futile:

"I never planned. I don't think anyone can plan for their old age. Who knows how long we are going to live. I don't ever plan 'cause I might die this evening."

One resident felt very negative about planning:

"I never thought about old age. I don't think people should make plans — they should rely on prayer."

Others are still troubled about their present situation or about what the future may hold, but make no effort to change things:

"The trouble was I did not plan at all for my old age. I am the same spirit now, I get very frustrated at times. I often think of what I will do if I can no longer take care of myself. If you are really sick you cannot stay here."

The rationale behind planning is foreign to their way of thinking:

"I never gave old age a thought — what would you plan?"

Forty-two active female residents say they never planned for their old age, but 21 of these, with the benefit of hindsight, now see the need for planning.

Areas where Planning Should Take Place

The female residents point to a variety of areas in which they feel planning for old age and retirement should be considered. Making financial arrangements is frequently mentioned by these residents. These plans range from the question of saving, taking out insurance policies, to ensuring that an individual has made financial provision for their funeral:

"I think people should at least make financial plans, take out life insurance and that."

"People should see that they have money to meet all their liabilities and not live in a fool's paradise."

Maintaining one's independence and having a place to live in are also mentioned by several residents:

"It's vital for the elderly to make plans for their retirement, to find a place where they will be catered for in their less capable years. They shouldn't be dependent on their families. Families to-day are different, there's so much social activity that they haven't got time for

anything outside the immediate family. You need to consider where you are going to live and what you are going to do."

Being dependent on one's family was seen by one resident as putting the elderly person in a very insecure position:

"They should have security, it must be dreadful to be depending on others — it must be awful for a woman to be depending on her family for support, though some families are very good."

Women who Planned for their Retirement

Eleven female residents made some plans before coming to the home. In some instances these plans were long-term plans calculated to meet their needs in retirement and old age. In others the plans were a response to a suddenly perceived need or situation. It needs to be stated that planning is interpreted differently by different residents. Some consider 'planning' as being distinct from making financial arrangements or provision. Therefore one resident could say:

"I never considered old age — I lived from day to day, the Lord had the last word ... I planned financially for my retirement — the only care you can really plan. I could have been less extravagant when I was younger."

Others see the need for planning for old age as a modern phenomenon. It is a present day response to changing circumstances for the old:

"People have to make plans for both retirement and old age these days. Nobody wants to keep the old folks anymore — we live in such a hectic busy world."

Amongst this group, financial planning was considered important by 7 residents. Others made plans which concerned their living accommodation in their old age and retirement. Four residents chose to come to live in self-contained flats. They saw this as a solution to the difficulties which they believed would arise from living at home as they grew older. Sometimes this decision was planned well in advance, but for 1 woman the decision was made suddenly because of her dependence on her next door neighbour who had to go to hospital.

The other main areas in which these residents saw a need for planning was that of activities and leisure-time pursuits:

"Planning for retirement is a must, there should be some kind of a course or some preparation for retirement — some community service."

"When my husband retired we did a course on retirement which I found marvellous but I wish I had made plans earlier. You should make plans when you are still in your fifties — a man should retire in his sixties so that you can still do things together — to be able to enjoy this freedom".

This need to plan early was stressed by another resident because the day will come when they will not be capable of making plans. This woman also feels that the elderly should move to a home while they are still active because it would enable them to settle more quickly.

Retirement Age

All of the 5 single women had worked — 4 as employees and 1 caring for an elderly relative. In their answers to the question of retirement age, the married women were far more likely to respond to the question of retirement age, as a general concept rather than in a personal vein, whereas some of the single women tended to reply from their own personal experience. All 16 single active women had worked — 13 outside the home, and 3 had cared for relatives. This helps to explain why the married residents gave replies of a general nature. Many of these had not worked outside the home and, therefore, their responses had to be of a general rather than a personal nature. In addition to this fact, these respondents had been asked to consider retirement as retirement from running their home and this could well have an influence on their concept of the ideal time to retire.

The theme of making way for younger people was highlighted by some of the residents who suggested a definite retirement age of sixty, sixty-five or in the sixties. Other reasons for comparatively early retirement were, to give the individual time to enjoy life and to make plans for the future.

Seven residents suggested that people should continue to work for as long as possible, one of these suggesting seventy-five as an age for retirement:

"People should retire at seventy five years, it's not too old to come in here. A housekeeper never retires — I never thought of retiring. Arthritis just came upon me and I could not cope."

Others felt that they were still working, this was particularly true of those who had self-contained flats:

"People should work as long as possible, I am still working taking care of my flat."

More miss their old routine:

"I think people should work for as long as they are able. Some people just can't cope with retirement — they have so much time on their hands. I always used to be busy — shopping and pottering around the garden, I miss all of that now".

Disabled Residents, Retirement and Old Age

Many of the disabled elderly consider making plans for retirement and old age a futile exercise. Looking at their own situation in retrospect, particularly in view of their ill health, disabilities and living situation, the general feeling is that making plans would not have altered their present situation in any respect:

"I never planned this, I never thought I would end up here. Anyway when you get sick you can no longer stick to plans, I never plan anything."

"I don't think people can make plans for their old age as they get twisted around. More power to people who make plans for their retirement if they can carry them out."

The fact that their own plans did not work is sometimes offered as proof of the futility of planning:

"I had planned to live with my sister but this fell through."

One resident felt that, looking at the situation in retrospect, he could have made better plans if he had anticipated his current situation; this lack of anticipation and foresight is very prevalent. The evidence would suggest that people rarely see the need to plan for the future and find it difficult to visualise themselves in a situation where they can no longer care for themselves, even when they have first hand experience of caring for elderly relatives:

"I could never visualise not being able to look after myself. My generation was used to looking after their parents in their old age. I hadn't expected this [the nursing home] I was always doing things —not planning — people can't plan."

"I never thought about old age, I just presumed someone would look after me. You can't make plans if you have no one to plan with."

"I thought I could work until the day I died."

For some the knowledge that they should plan is in the back of their minds, but not completely acknowledged. One elderly man made his point very clear, because he said his work brought him into close contact with others who were sick and alone. He goes on to say:

"It [planning] depends on the way your health can hit you, if your health hits you suddenly, the truth is you find yourself without any plan, but if you enjoy good health, as I did up to my first heart attack, you don't make any plans for nursing homes or where you die. The necessity isn't there and after all it's the necessity that creates the effort. When I got the heart attack I concentrated deeply on how I would finish up, what place I could go to."

Some disabled residents regretted not having made plans for their old age:

"I never considered old age. I think people should make plans. I never made plans."

For others, the only area in which you can make plans is in the financial area. Having money is seen by some as giving an elderly person security and independence and this can provide the elderly with a choice if and when they go into residential care. In all, four residents in this group thought that financial planning was an important way of planning for one's old age and retirement:

"People should make plans because everything is too expensive. I think people should make plans if they cannot afford to pay for a nursing home."

But as one resident said, saving isn't always easy:

"I always tried to save, but I found it hard to put the few shillings aside."

Making Plans at Present

Not all disabled residents answered this question directly, some answered that they never made plans and they indicate that the future seems too uncertain for them to make any plans. Their lives are lived now one day at a time. As one resident put it:

"The truth is you have no future".

The feeling is that it is pointless to plan in advance if you can expect to die at any moment. One resident says:

"The only thing left to do is die — it's the next thing on the programme."

The fact that elderly people living in residential care have to come to terms with the realisation that death is imminent reflects on their attitude to the future but it also reflects the level of control they have exercised over

their life events during their life time. A fatalistic outlook on life in old age may simply reflect a personal attitude towards life and the life events of an individual at any stage in their life. One resident could say:

"I hope I can get as much as I can out of life before I die".

While another resident states:

"Once you have to live in a nursing home your life is over — you're boss of nothing you have to fit in with everything. You only go into a nursing home to die."

Old age and ill health also prevent the elderly from making plans:

"I haven't the strength to live any other life."

Summary

The issue of retirement and planning for old age once again reveals that elderly residents are not a homogeneous group. Furthermore, attitudes and experiences are influenced by life events, health issues and gender. If you are a male resident who is active, content and in good health your views and experiences are different to a woman in similar circumstances. Retirement is portrayed as a male phenomenon, it is to do with retiring from hard paid work outside the home. For some, old age comes after retirement and for elderly male residents it often comes as a shock with feelings of emptiness and lack of purpose. For those who think about it at all, it is the financial aspects that are emphasised. Financial independence is seen as being very important. The loss of the work role leaves a vacuum and one that residents feel could be filled by either having another job or following other pursuits. Adjustment has been difficult. The main problem area to be addressed is to convince people in the middle age group of the necessity of making such plans. The evidence suggests that people cannot visualise themselves as being old and dependent on others until the situation actually arises. If the individual considers old age at all, there is no sense of urgency present, particularly with regard to where one will live and how one will spend one's time. The main task of planners of retirement courses will be to create that sense of urgency which will provide the impetus for individuals to face up to this issue. The fact that situations change and plans may have to be adapted must be accepted by the individual.

The fatalistic approach and the feeling of having no control over your future is particularly acute for disabled residents. The feeling that you cannot plan for the possibility of bad health or even if you did you could have no effective input to your life is very strong. It is also clear for some that being in a nursing home signals that life is now over. It is now a question of waiting.

For women, retirement is different: it is something they associate with their husband's retirement for they are in the world of work outside the home. They appear to define their retirement as an adjustment to the retirement of their spouse. Financial planning is seen as important and crucial. It is something that is essential to ensure independence. However, personal planning for a change in role is not thought of systematically nor is the fact that life is continuously changing. For some of these residents, both male and female, planning for the next stage in the process of ageing is vital. The homes they are now in will not be able to cater for them. They are not thinking or talking about the future and feel, in some ways, it will take care of itself. As they see it, there is always the possibility that the issue will not arise, as they may die before any decision is necessary.

CHAPTER 10

MAIN ISSUES

This report is written as a contribution to the current debate about nursing homes in the Republic of Ireland. In particular, it looks at the quality of life in nursing homes. On the basis of a series of in-depth interviews it outlines residents' perceptions of life in a nursing home together with the views of staff and relatives. This study helps to illustrate some of the essential issues relating to the provision of care for the elderly.

The following are the main issues that arise from the findings:

- Legislation
- Demographic Trends and Service Provision
- Professional Mode of Staffing and Career Development
- Choosing Residential Care
- Assessment
- Contracts of Care: The Residents' Right
- Residents' Rights
- Establishing a Residents' Charter
- Maintaining Links with the Community
- Choices
- A Public Life — A Private Life
- Determining One's own Choices and Options.

Legislation

The results of this study show that nursing homes cannot easily be classified in a clear cut way into 'good homes' and 'bad homes'. The reason for this is that the quality of a nursing home depends not only on the characteristics of the home itself but also on the characteristics of its residents. A nursing home may be 'very good' for an able-bodied, ambulant resident but 'very bad' for a disabled and confused resident. For example, stairs can handicap

a disabled resident but have no such effect upon an able resident. Thus a nursing home could be ideal when a person first enters it but become increasingly unsuitable as the ageing process renders the resident less able.

The implication of this is that it is necessary to evaluate the quality of a nursing home not only in terms of its observable characteristics but also in terms of its suitability for residents at varying stages of the ageing process. The policy implication of this, in turn, is that any legislative action should be sensitive to the problem of setting standards for nursing homes given that residents have heterogeneous needs and abilities. Despite this caveat, however, the results of this study show that there is a need to alter fundamentally the *Health (Homes for Incapacitated Persons) Act, 1964* which presently covers nursing homes. The study has shown that if the *Homes for Incapacitated Persons Regulations, 1985* were enforced then a number of nursing homes in the voluntary and private sector would have to be closed.

Comparisons with other countries place the Irish legislation in a most unfavourable light. The Simon Community points out that the provisions are much less than those for the public shelter systems for the homeless in New York. As an initial step, a code of practice needs to be established for both private and voluntary homes with mandatory provisions. This code of practice would enable standards to be clearly specified and monitored, as is the practice in other countries. We have deliberately avoided a detailed prescriptive approach but the results of this study clearly indicate that radical action is needed. New legislation must face two principal challenges — firstly, the wide range of homes and residents covered and, secondly, the need to address a number of audiences at the same time. The legislation, however, must ensure that the stated aims and objectives of the homes are adhered to, and that they respond to the needs of the residents. Clear, unambiguous standards will need to be specified with the legal power of enforcement. Legislation should cover both the voluntary as well as the commercial sector.

One area that legislation needs to address, apart from the issues of registration, enforcement and monitoring of basic standards of care, is the issue of rights of residents, which will be addressed in a later section.

Demographic Trends and Service Provision

In 1900, life expectancy at birth was forty-six years for males and forty-eight years for females. While most women did not work outside the home once they married, two-thirds of all men over sixty-five years were still in the work force. Many men retired due to poor health and retirement often consisted of a few years of declining health. The role of the family in the provision of care for the elderly was well integrated into family roles and

traditions. Since 1900, life expectancy has improved substantially. Now a man who is approaching the end of his working career can expect to spend about fifteen years in retirement. More and more spouses are also making the transition from paid worker to retirement, or housewife and mother to retirement.

There are two issues here, the first being the increasing number of elderly people and the resultant impact on service provision. The second issue, often not addressed, is that the analysis of service provision seldom looks at gender as an important factor that needs to be fully integrated into theories and practice of service provision. It should be underlined that life expectancy has increased more for women than for men and, therefore, the years after sixty-five are especially important for women. We know that, for women, these years are likely to be faced alone: two-thirds of women over the age of seventy-five years are widows and, on average, it is estimated that widows live sixteen years beyond their husbands. In this study, the profile of residents shows that they are more likely to be female, aged over seventy-five years and in care on a long-term basis.

Concern about demographic trends has made welfare and health services an area of political concern in the 1980s in a way that was not the case in the late 1960s and 1970s. In the Republic of Ireland, population projections of the dependency ratios make the point clearly in relation to the issue of demographic trends affecting service provision in the future. For example, population projections show that the number of persons aged seventy-five years and over is expected to increase much faster than the population as a whole: by 20.6 per cent between 1970–91, by comparison with 13.6 per cent for the population as a whole. Further detailed work shows that this population trend will be further concentrated not, as traditionally happens, on the western seaboard, but in the Eastern Health Board area.

Some commentators highlight that it is important to distinguish between resource allocation for state services for all elderly (pensions, etc.), and services for those elderly people with specific service needs as a result of sickness or frailty, pointing out that it may be justified to assign a low priority to those specific service needs. This is seen not only in the United Kingdom but in the United States of America where the general economic status of the elderly is seen to have improved over the past three decades. In the US, good retirement policies are seen as providing the elderly with more security. There is evidence however that even there, problems arise regarding the position of the elderly and an increase in poverty levels and homelessness.

The second issue, the fact that the main body of 'frail' elderly people over seventy-five years are women is rarely addressed. There are also basic assumptions about 'family' and 'community' care and elderly people.

Policy towards sick and frail elderly people has always been dominated by assumptions about the caring role of female relatives. A number of questions remain unanswered. For example, do these assumptions help to explain the form services took over the last few decades, or the slow overall development of welfare services for elderly people in general? Do they help to explain the form these services took from the 1950s, 1960s and 1970s? Alternatively, what is the foreseeable role of the family and the community in the care for the aged?

Family networks are more dispersed than they used to be. Much of the discussion about the care of the elderly centres on the formal provision of statutory or voluntary social services. This often disguises the fact that the care of elderly people is provided 'informally' by friends and neighbours and particularly family. The statistics show that the majority of the elderly are women and, furthermore, that community care, in reality, means largely family care and this in practice tends to be care provided by women. Study of the family shows that it has managed to change and adapt itself to the rest of society. However, if official policies work against it, ignore its existence or fail to recognise its contribution as an important instrument of welfare, community care as a policy is unlikely to become a reality. A policy agenda needs to be addressed for community care. A series of questions are posed in relation to community care.[1]

Health Services

- How can public health nurses, GPs and other health service professionals meet more effectively the needs of carers, as well as those cared for?
- What are the implications of faster hospital 'throughput' for community services?

Personal Social Services

- What resources do personal social services require to keep pace with the pressure of demographic change?
- What practical assistance do carers require, in terms of respite care, aids and adaptations and domiciliary services, and how might the development of these be located within an overall service strategy?

Social Welfare

- What priority should be given to the extension of the prescribed relatives

[1] These questions are based on the issues raised in M. Henwood and M. Wicks in *The Forgotten Army: Family Care and Elderly People*, London: Family Policy Studies Centre, 1984.

allowance to married women?

- How should the social welfare system adjust to ensure that the needs of frail elderly people can be met adequately without imposing intolerable financial burdens on those who provide care?

Taxation

- Should the taxation system recognise the financial costs incurred by those who provide care?

Employment

- How can the problems of those who are both employees and carers be eased? What are the implications of caring responsibilities for hours of work and leave opportunities?

Housing

- What should be the balance between special needs, accommodation for the very elderly (including sheltered housing) and more general policies, to improve housing environments?
- What are the implications for housing policies of caring tasks within the extended family, in terms of tenure and geographical mobility, home improvement policy and housing design?

The answers to these questions are difficult because the whole issue of community care has not been fully explored in a systematic manner and researchers are only now aware of the importance of exploring these issues. Policy makers and service providers will also need to take the gender aspect of demographic trends into consideration.

Professional Mode of Staffing and Career Development

The heterogeneous nature of the elderly in nursing homes and the multiplicity of their concerns requires a wide variety of skills and services to deal with them effectively. It requires an understanding of the ageing process as well as the individual needs of the elderly with whom they work.

We have seen from the results of this study that staff feel that they should spend more time talking to or being with residents. The ideal is to treat each resident as an individual with his/her own particular needs. In reality, however, staff indicate that lack of time and the undertaking of practical tasks often means that this is ignored. It is important therefore to establish that the social relationship between staff and resident has a high priority. The training of staff who work with the elderly is of paramount importance. In the training of medical students, nurses, physiotherapists, occupational therapists and social workers the area of gerontology needs to be fully addressed. It is a matter of concern that no career path exists for

those who work in nursing homes. More attention needs to be given to the professional concerns of staff in terms of training and promotion.

Choosing Residential Care

Before going into care, a prospective resident needs to be given a clear and unambiguous statement of all the options available in relation to staying in the community and all the facilities in the home. Furthermore, the rules and regulations, staffing levels and professional background of staff needs to be discussed. It has been shown that a crisis often precipitates the decision to go into care. We see no reason why the 'crisis' should be further exacerbated by inadequate discussions and evaluation of a person's future living arrangements. A visit to the home, prior to going into care, is considered most desirable. This will enable an evaluation of the ethos of the home and ensure that the practice of putting residents in rooms from which they cannot move because of the physical structure of the building and their particular disability is less likely to occur.

Assessment

The results of the study highlight the importance of residents assessing the residential care setting. It is equally important that a comprehensive assessment procedure be established by the care-providers. Assessment should be a two-way process and strict criteria established for entry to nursing homes by an assessment team. This assessment would be broadly based to include care providers, community based social workers, medical personnel, physiotherapists and occupational therapists in conjunction with the relevant family and relatives. This assessment would also help the elderly person and their relatives make the choice of a home, if this was deemed necessary. In this way options and choices are maximised.

Contracts of Care: The Residents' Right?

Concern is growing, on an international front as well as in Ireland, with the provision of care and the rights of the elderly residents in insitutions. Any new legislation in relation to the provision of care is going to affect fundamentally the rights and well-being of residents. When this legislation is being prepared the opportunity should not be lost to improve the dignity and status of the elderly resident. The Federal German Republic's legislation, which is ten years old, offers a good example. It shows what can be achieved in terms of the development of the dignity and independence of the elderly themselves. There are two main features in the West German legislation, which are outlined by Ross:

"First is the requirement that a contract be made between all

residents in all homes, that is private, voluntary and local authority; next is the setting up of a homes' council in homes with more than six people."

Briefly the main provisions of the residents' contract are:

- Provision of information in advance of a contract being entered into by the resident. The act itself contains no model contract, although the legal handbooks dealing with the legislation regulating homes usually have contracts that are appropriate for a nursing home. Model contracts are available from voluntary welfare associations.
- Specifications of types of accommodation, services provided and their cost, conditions which would lead to the termination of a contract, bringing in possessions, pets, house rules.

These contracts are available, not only to the resident but must, for example, be submitted when a private home is seeking the obligatory permission to open. Voluntary and public homes have to submit a contract to the registration authorities when registering the home.

The other important element of the legislation is the setting up of a home's council. The main thrust of the council's work is to enable the residents to have a say, not just in the running of the home, but also a channel for complaints to official inspectors.

The essential role of the home council is principally that of participation, information and consultation. There are of course limitations to these contracts, but their provision underlines the rights of elderly residents. This type of provision promotes a more positive view of the elderly, emphasising both their abilities and their right to have a say in the running of their own lives.[1]

Residents' Rights

The importance of placing the resident at the centre of the care system is emphasised in this study. The main focus and concern has been to look at the quality of life of residents in care. It would seem appropriate that in all homes the quality of life of residents will be the main focus and orientation of the care system. A residents' charter should incorporate a list of residents' rights that range from personal issues, to the right of independence and choice, to the right of full involvement in community activities.

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[1] See Appendix 4 for outline of scheme operating in the North Western Health Board.

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Add below "Complaint mechanisms and forum".

Respect for Residents

The following check list, suggested by Fitzgerald[1] as a means of assessing

Establishing a Residents' Charter

In establishing a resident's charter two main steps are involved:

- Establishing a philosophy of care where the quality of life is the central focus.
- Establishing a framework by which the practical application of residents' rights, responsibilities, and day to day activities are built into clear and workable guidelines for care.

It is not our intention here to give details of a charter but rather to suggest areas that might be mentioned in such an undertaking.

- Choosing residential care
- Coming to live in the home
  - Initial visit with friend or relative
  - Discussions with staff
  - Review after first three months
- Rules and routines to facilitate the quality of life of residents and the development of an ethos which maximises the full potential of an individual.
- Private living being facilitated and the use of public space maximised to increase social contact and the freedom of the individual.
- Belongings
- Provision of services
  - G.P.
  - Occupational Therapist
  - Physiotherapist
  - Public Health Nurse
  - Dentist
  - Chiropodist
  - Counselling, e.g., bereavement
  - Rights
  - Holiday and recreational activities
- Financial matters
- Making decisions for residents
- Forum for discussing the policies of the home
- Complaint mechanisms and forum.

[1] Fitzgerald, B., "Nursing Attitudes Affecting the Care of the Elderly", Paper presented to *Annual Conference of Federated Dublin Voluntary Hospitals and St. James's Hospital,* Dublin, February 1986.

how the geriatric ward environment encourages maintenance of independence and individuality for patients, can equally well be applied to the nursing home environment:

- How much privacy is available to the patient?
- Are there effective curtains around the bed space?
- Is the patient exposed as little as possible during examinations and nursing procedures?
- Is there a separated excluded area which can be used (a) by staff to interview patients and (b) by patients wishing to discuss matters with relatives, social workers, their minister of religion?
- When the patient needs supervision of toiletting or bathing, is this done discreetly and unobstrusively?
- Are there locks on lavatory and bathroom doors (with adequate safety aids and call bells)?
- Are "accidents", incontinence and communication difficulties dealt with promptly in a sympathetic but professional manner?
- What evidence is there of respect of individuality?
- Does the patient wear his own clothes?
- Are the terms 'Granny' or 'Grandad' used or is the patient referred to by the names of his/her choice?
- Is the patient included in conversation? Is his/her opinion sought?
- What evidence of home is found around the patient? Does he or she have photos, pictures, ornaments from home around his/her bed space?
- Is there a multichannel aerial available to allow the patient choice of viewing on television?
- Has the patient a choice of menu?
- Within the limits of his condition, is the patient free to get up, to retire, to take a rest on his bed when he chooses?
- Are restraints used freely or does some risk filter into the choice the patient has of maintaining his own independence?
- Are patients encouraged to carry out their own grooming?

The above questions must be addressed in assessing the quality of a nursing home environment to avoid the more extreme aspects of institutionalisation and to maintain the freedom, dignity and independence of the residents. It is to this end that legislation and regulations should be aimed.

Maintaining Links with the Community

The importance of the elderly keeping up contact with the community cannot be emphasised enough. Structures and supports to facilitate this kind of institution need to be put in place. Consideration should also be

given to enabling the elderly people to use their accumulated experience and expertise for the benefit of themselves and their community. Thinking in terms of dependence/independence underlines the position that mutual help can be very rewarding for all people. It affords all concerned a sense of well-being and dignity and recognises the potential and wishes of each individual.

Choices

It is important for residents to be able to make choices. From the results of the study there appears to be little real choice offered in homes. The orientation of the homes seems to be clearly on groups, on elderly people living together and the management and organisation of group living. Could the perspective be changed to an emphasis on individuals who happen to be living together? Because the emphasis is on the group, homes develop an ethos where passivity is encouraged. Choices about what time residents get up, when they can eat meals, were in most cases outside the influence of the residents. A more flexible approach, a changed orientation could help enormously to make home life one that has some of the qualities of living in one's own home. There are implications in this for the management and organisation of the homes as well as the professional training of staff working in homes.

A Public Life — A Private Life

The results of the study have clearly shown us that, at present, living in a nursing home is a very public and communal experience. For the most part a great deal of the time is spent during the day sitting in lounges. Activities are often organised for groups and not for individuals. For some, meal times are always a public affair. However, for the incapacitated elderly who cannot leave their rooms, being in a room with others with whom they are unable to communicate gives another meaning to the reality of living in public. A private occasion such as a visit by family and friends and even personal activities such as taking a bath or going to the toilet are made public when staff and nursing home routines are organised in an impersonal way. There are few opportunities for residents to develop and spend their time in a way that enables them to lead more fulfilled lives. As one staff member commented:

"A person's room is their home, it's their space".

An emphasis on the private and personal nature of living in nursing homes rather than the public and communal needs to be developed.

Planning for Later Life and Retirement: Determining One's Own Choices and Options

The study clearly showed the lack of planning for later life. Most residents had never planned, some never dreamed of living their later life in a nursing home. It highlights the importance of pre-retirement planning at an early stage in people's lives. This is particularly important when we look at the changing nature of society and, in particular, the changing nature of work. Choices can be made about family life, work, leisure and self-development. While some elderly residents are not ambulant, often their minds are very active. They would welcome development of their skills within the context of their physical limitations while acknowledging their intellectual and mental facilities.

Adapting to Change

In the light of the changing nature of work and leisure, we need to identify and develop our own resources, opportunities and talents. We need to create our own choices and become more creative and assertive in our approach to shaping our lives. This requires active interventions in lifestyles by individuals themselves as well as by organisations that currently employ people.

The next generation of elderly people will not allow themselves to be provided for on the basis of the lowest common denominator. The greater number of people retiring with pensions and the higher percentage of the population owning houses means that an increasing number of people will be financially independent in their old age. However, the position of women in relation to pension rights needs to be carefully established and monitored. Research from North America and Europe indicates that women are less likely to belong to a pension plan. Furthermore, if they are, they are less likely to qualify for a full pension (although some would be covered by their spouse's pension). Similar issues have been raised in the Republic of Ireland.

When using retirement to describe a stage in people's lives special attention needs to be given to the meaning of 'retirement' for women working in the home. Discussions in this area tend to place the debate around paid work outside the home. Educators, policy makers and service providers will need to be more sensitive to the gender aspect of retirement and to take it into consideration when discussing the role of the 'family' and the 'community' in the care of the elderly.

Conclusion

This study profiles the quality of life in nursing homes. It explores, from the resident's point of view, what it is like to live in a nursing home, how people

come to live there and the choices they make. It also provides us with the views of relatives of residents as well as the staff who care for them.

The study gives a description of the nursing home setting, buildings, staffing arrangements and facilities. These are only indicators of the possible quality of life afforded to those in care. The context of care is of fundamental importance. The evidence suggests that not all nursing home facilities offer a living environment that either meets the needs of the elderly or fosters an environment that helps create and maintain independence particularly for those who are sick, infirm or immobile. Few of the buildings are purpose-built or have facilities that foster the potential and broaden the recreational experience of residents. The environment in many homes entails living a passive life in a public place.

The quality of life needs to include the prevention of avoidable mental decline and the maintenance of physical and social function. The restoration of, or compensation for, loss of diminishing function is central to establishing the quality of life as the main theme of care. Studies such as this provide a basis for policy making by preparing information on the system and provision of care. It provides systematic information on the quality of life in homes and a platform for debate about the provision of care for the elderly. In this situation the questions can be asked: Are nursing homes necessary? What are the alternatives? The quality of life of the elderly should be the central focus for the provision of care. Can this challenge be met?

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APPENDIX 1

TABLES RELATING TO CHAPTER 3

Table A.3.1: *Status of nursing home Q.2*

Status	Total Nursing Homes %
Voluntary	60.0
Private	40.0
	N = 20

Table A.3.2: *Applied for approval under Section 54 of the Health Act (1970) Q.3(a)*

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Applied for approval	87.5	58.3	70.0
Not applied for approval	12.5	41.7	30.0
	N = 8	N = 12	N = 20

Table A.3.3: *Success of application for approval under Section 54 of the Health Act (1970) Q.3(b)**

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Successful Application Under Section 54	83.3	100.0	92.3
Unsuccessful Application Under Section 54	16.7	0.0	7.7
	N = 6	N = 7	N = 13

*Non-respondents are excluded in all instances. This is reflected in all succeeding Tables with N numbers less than 20.

Table A.3.4: *Length of time nursing home in existence Q.1*

No. of Years	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
- 2	0.0	0.0	0.0
3-5	28.6	0.0	11.1
6-10	14.3	18.2	16.7
11-25	42.9	45.5	44.4
26-50	14.3	0.0	5.6
51-75	0.0	18.2	11.1
76-100	0.0	0.0	0.0
100	0.0	18.2	11.1
	N = 7	N = 11	N = 18

Table A.3.5: *Year nursing home was built Q.8*

Year	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Pre 1850	28.6	10.0	17.5
1850-99	14.3	40.0	29.4
1900-29	42.9	10.0	23.5
1930-49	0.0	0.0	0.0
1950-69	0.0	0.0	0.0
1970-79	0.0	20.0	11.8
After '79	0.0	0.0	0.0
Don't Know	14.3	20.0	17.6
	N = 7	N = 10	N = 17

Table A.3.6: *Previous use of nursing home, if not originally built as nursing home Q.7(b)*

Previous Use	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Private residence	62.5	50.0	56.3
Hotel/Guest house	12.5	12.5	12.5
Institutional	25.0	37.5	31.3
	N = 8	N = 8	N = 16

Table A.3.7: *Structural condition of building Q.4*

Condition	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Excellent	25.0	41.7	35.0
Very Good	25.0	41.7	35.0
Fair	37.5	16.7	25.0
Poor	12.5	0.0	5.0
Very Poor	0.0	0.0	0.0
	N = 8	N = 12	N = 20

Table A.3.8: *Size of garden Q.10*

Size	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Large	25.0	100.0	70.0
Small	75.0	0.0	30.0
	N = 8	N = 12	N = 20

Table A.3.9: *Monitoring of temperatures in the home Q.16*

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Temperature monitored	87.5	75.0	80.0
Temperature not monitored	12.5	25.0	20.0
	N = 8	N = 12	N = 20

Table A.3.10: *Reasons given for not having a fire escape Q.53(b)*

Reasons	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Groundfloor residence	0.0	0.0	0.0
Sufficient access to outside	0.0	50.0	33.3
Not required by fire regulations	100.0	50.0	66.7
To be installed	0.0	0.0	0.0
Finance	0.0	0.0	0.0
Patients could not use a fire escape	0.0	0.0	0.0
	N = 1	N = 2	N = 3

Table A.3.11: *Presence of anti-fire safety measures in the nursing home Q.54*

Safety measures	Private Nursing Homes %		Voluntary Nursing Homes %		Total Nursing Homes %	
	Yes	No	Yes	No	Yes	No
Fire extinguisher	87.5	12.5	100.0	0.0	95.0	5.0
Smoke detector	87.5	12.5	50.0	50.0	65.0	35.0
Fire-proof door	87.5	12.5	75.0	25.0	80.0	20.0
Alarm bell	87.5	12.5	91.7	8.3	90.0	10.0
	N = 8		N = 12		N = 20	

Table A.3.12: *Whether fire drills are conducted in nursing homes Q.55(a)*

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Fire drills conducted	62.5	33.3	45.0
Fire drills not conducted	37.5	66.7	55.0
	N = 8	N = 12	N = 20

Table A.3.13: *Location of drugs and medicine Q.14*

Location	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Staff office	37.5	41.7	40.0
Locked room	0.0	25.0	15.0
Drug safe or other locked cupboard	62.5	33.3	45.0
Residents keep own drugs/ medicine	0.0	0.0	0.0
	N = 8	N = 12	N = 20

Table A.3.14: *Provision of specially designated sluice room in nursing home Q.13*

Provision	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Specially designated sluice room	62.5	66.7	65.0
No specially designated sluice room	37.5	33.3	35.0
	N = 8	N = 12	N = 20

Table A.3.15: *Number of floors in nursing home Q.9(a)*

Number	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
One	0.0	0.0	0.0
Two	14.3	66.7	47.4
Three	85.7	25.0	47.4
Four	0.0	8.3	5.3
Five	0.0	0.0	0.0
Six	0.0	0.0	0.0
	N = 7	N = 12	N = 19

Table A.3.16: *Provision of lift/elevator in nursing home Q.9(d)*

Provision	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Lift provided	12.5	58.3	40.0
Lift not provided	87.5	41.7	60.0
	N = 8	N = 12	N = 20

Table A.3.17: *Residents required to use stairs Q.9(c)*

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Required to use stairs	87.5	66.7	75.0
Not required to use stairs	12.5	33.3	25.0
	N = 8	N = 12	N = 20

Table A.3.18: *Provision of equipment and aids in the nursing home Q.17*

Equipment	Private Nursing Homes		Voluntary Nursing Homes		Total Nursing Homes	
	Provided %	Not Provided %	Provided %	Not Provided %	Provided %	Not Provided %
Walking aids	100.0	0.0	83.3	16.7	90.0	10.0
Wheelchairs	87.5	12.5	83.3	16.7	85.0	15.0
Handrails in corridors	37.5	62.5	66.7	33.3	55.0	45.0
Handrails in dining/ sitting room walls	12.5	87.5	25.0	75.0	20.0	80.0
Ramps	37.5	62.5	50.0	50.0	45.0	55.0
Elevator/lift	12.5	87.5	58.3	41.7	40.0	60.0
Automatic doors	25.0	75.0	0.0	100.0	10.0	90.0
Grab rails in showers/baths	50.0	50.0	75.0	25.0	65.0	35.0
Grab rails in WC's	75.0	25.0	83.3	16.7	80.0	20.0
Special eating utensils	62.5	37.5	16.7	83.3	35.0	65.0
Special writing utensils	0.0	100.0	0.0	100.0	0.0	100.0
Stripes on floor to indicate location	12.5	87.5	0.0	100.0	5.0	95.0
	N = 8		N = 12		N = 20	

Table A.3.19: *Provision of sitting room(s) for residents' use Q.10(a)*

Provision	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Sitting-room provided	87.5	100.0	95.0
Sitting-room not provided	12.5	0.0	5.0
	N = 8	N = 12	N = 20

Table A.3.20: *Provision of reception area for residents to entertain visitors. Q.11(a)*

Provision	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Reception area provided	75.0	91.7	85.0
Reception area not provided	25.0	8.3	15.0
	N = 8	N = 12	N = 20

Table A.3.21: *Assistance of residents in running of Nursing Home Q.39(a)*

Assistance	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Regular help by residents in running of home	0.0	50.0	30.0
No regular help by residents in running of home	100.0	50.0	70.0
	N = 8	N = 12	N = 20

Table A.3.22: *Activities of the residents who help in the running of the Nursing Home Q.39(c)*

Activities	Private Nursing Homes		Voluntary Nursing Homes		Total Nursing Homes	
	Yes	No	Yes	No	Yes	No
	%		%		%	
Washing/drying dishes	0.0	0.0	100.0	0.0	100.0	0.0
Laying tables	0.0	0.0	66.7	33.3	66.7	33.3
Serving food	0.0	0.0	16.7	83.3	16.7	83.3
Cooking	0.0	0.0	0.0	100.0	0.0	100.0
Cleaning Rooms	0.0	0.0	33.3	66.7	33.3	66.7
Making Beds	0.0	0.0	50.0	50.0	50.0	50.0
Gardening	0.0	0.0	50.0	50.0	50.0	50.0
	N = 0		N = 6		N = 6	

Table A.3.23: *Provision of personal services for residents Q.36(a)*

Personal Services	Private Nursing Homes		Voluntary Nursing Homes		Total Nursing Homes	
	Provided	Not Provided	Provided	Not Provided	Provided	Not Provided
	%	%	%	%	%	%
Hairdressing	87.5	12.5	75.0	25.0	80.0	20.0
Chiropody	87.5	12.5	66.7	33.3	75.0	25.0
Dentistry	62.5	37.5	33.3	66.7	45.0	55.0
Optician	75.0	25.0	41.7	58.3	55.0	45.0
Physiotherapy	75.0	25.0	58.3	41.7	65.0	35.0
Occupational therapy	37.5	62.5	36.4	63.6	36.8	63.2

Continued on page 148

Table A.3.23: *Provision of personal services for residents—contd.*

Personal Services	Private Nursing Homes	Voluntary Nursing Homes	Total Nursing Homes
Hairdressing	N = 8	N = 12	N = 20
Chiropody	N = 8	N = 12	N = 20
Dentistry	N = 8	N = 12	N = 20
Optician	N = 8	N = 12	N = 20
Physiotherapy	N = 8	N = 12	N = 20
Occupational therapy	N = 8	N = 11	N = 19

Table A.3.24: *Provision of selected recreational facilities for residents Q.37(a)*

Personal Services	Private Nursing Homes		Voluntary Nursing Homes		Total Nursing Homes	
	Provided %	Not Provided %	Provided %	Not Provided %	Provided %	Not Provided %
T.V.	100.0	0.0	100.0	0.0	100.0	0.0
Newspapers	75.0	25.0	75.0	25.0	75.0	25.0
Library/book lending	50.0	50.0	66.7	33.3	60.0	40.0
Games	50.0	50.0	75.0	25.0	65.0	35.0
Musical instruments	25.0	75.0	75.0	25.0	55.0	45.0
Shop	25.0	75.0	33.3	66.7	30.0	70.0
Public telephone	100.0	0.0	100.0	0.0	100.0	0.0
Tea/coffee when requested	100.0	0.0	58.3	41.7	75.0	25.0
	N = 8		N = 12		N = 20	

Table A.3.25: *Whether head/joint heads of nursing home on nursing register Q.23*

Category	Private Nursing Homes		Voluntary Nursing Homes		Total Nursing Homes	
	On Register %	Not on Register %	On Register %	Not on Register %	On Register %	Not on Register %
Head on nursing register	87.5	12.5	80.0	20.0	83.3	16.7
	N = 8		N = 10		N = 18	
Joint Head on nursing register	0.0	100.0	100.0	0.0	66.7	33.3
	N = 2		N = 4		N = 6	

Table A.3.26: *Provision of staff on duty at night Q.20(a)*

Provision	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Staff on duty at night	100.0	83.3	90.0
No staff on duty at night	0.0	16.7	10.0
	N = 8	N = 12	N = 20

Table A.3.27: *Number of RGNs among those night staff normally on duty at one time Q.20(c)*

Number	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
None	12.5	20.0	16.7
One	87.5	70.0	77.8
Two	0.0	10.0	5.5
Three	0.0	0.0	0.0
Four	0.0	0.0	0.0
Five	0.0	0.0	0.0
	N = 8	N = 10	N = 18

Table A.3.28: *Full-time staff living in the same building as residents Q.21(a)*

Residence	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Living in the same building	37.5	66.7	55.0
Not living in the same building	62.5	33.3	45.0
	N = 8	N = 12	N = 20

Table A.3.29: *Links between full-time staff (not living in the same building as residents) and nursing home Q.21(b)*

Links	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Use of on-call/ paging service	80.0	66.7	75.0
No use of on-call/ paging service	20.0	33.3	25.0
	N = 5	N = 3	N = 8

Table A.3.30: *Whether nursing home has own doctor Q.22(a)*

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Has own doctor	12.5	66.7	45.0
Has not own doctor	87.5	33.3	55.0
	N = 8	N = 12	N = 20

Table A.3.31: *Frequency of doctor's visits to each resident Q.22(c)*

Frequency	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
As needed	100.0	12.5	22.2
More than once a week	0.0	37.5	33.3
Once a week	0.0	50.0	44.4
Once a fortnight	0.0	0.0	0.0
Monthly basis	0.0	0.0	0.0
	N = 1	N = 8	N = 9

Table A.3.32: *Main reason for admission of residents to nursing home Q.31*

Reason	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Unable to look after self	50.0	33.3	40.0
Family unable to look after resident	12.5	8.3	10.0
In need of nursing care	37.5	8.3	20.0
Convalescence	0.0	16.7	10.0
Fear of living alone/loneliness	0.0	33.3	20.0
	N = 8	N = 12	N = 20

Table A.3.33: *Conditions for taking-up residence in nursing home Q.33*

Conditions	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Resident is mobile	0.0	80.0	47.1
Resident is not senile	14.3	0.0	5.9
Resident is not ill	0.0	0.0	0.0
Approval by doctor or social worker	0.0	10.0	5.9
Resident able to pay	0.0	0.0	0.0
Resident over a certain age	14.3	0.0	5.9
Resident is of limited means	0.0	10.0	5.9
No conditions apply	71.4	0.0	29.4
	N = 7	N = 10	N = 17

Table A.3.34: *Whether waiting list for admission to nursing home exists Q.34(a)*

Category	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
Waiting List	50.0	75.0	65.0
No waiting list	50.0	25.0	35.0
	N = 8	N = 12	N = 20

Table A.3.35: *Main reason why long-term residents left the nursing home Q.12*

Reason	Private Nursing Homes %	Voluntary Nursing Homes %	Total Nursing Homes %
To live with family	0.0	25.0	16.7
Needed nursing care	50.0	62.5	58.3
Financial reasons	25.0	0.0	8.3
Did not settle	0.0	0.0	0.0
Needed psychiatric care	25.0	12.5	16.7
	N = 4	N = 8	N = 12

APPENDIX 2

QUESTIONNAIRE DESIGNS[1]

LONG-TERM CARE ACCOMMODATION FOR THE ELDERLY IN PRIVATE AND VOLUNTARY NURSING HOMES

Census and Notes to Interviewers

This Census was designed to elicit information on both short-term and long-term residential care in the Republic of Ireland. The aim of the Census is to provide a profile of residential care facilities, staff, admission procedures and residents. To structure and facilitate the collection and analysis of data the following framework was designed. The facts deemed necessary for this framework are as follows:

Nursing Homes

- Type
  - — voluntary
  - — private
  - — other
- Approved/Non-approved

Physical Characteristics

- Number of beds
- Number of patients
  - — short-term
  - — long-term
  - — receiving subvention from Health Board
- Number of rooms
  - — single

[1]The Census Questionnaire on which this study is based is available on request from the National Council for the Aged.

— double floor space
— multiple

- Reception area
- Dining room
- Sitting room Separate or Combined
- Sanitary facilities
  - — No. of W.C.s
    - — wheelchair W.C.s
  - — Grab rails provided
  - — No. of baths
    - — whether assisted
  - — No. of showers
- Sluice room
  - — separate
- Heating
  - — type
  - — temperature
- Separate office
  - — location for drug storage
- Type of building
  - — No. of floors
  - — Are residents required to use stairs?
  - — Are ramps (for wheelchairs) provided?
  - — Was building specifically constructed as nursing home?
    - — If no, what was it used for previously?
  - — Age of building

Personal Services

- Hairdressing
  - — nursing home staff/fellow patients (home perm, wash and shampoo etc.)
  - — visiting hairdresser
  - — charge
  - — regularity
- Dentist
  - — visiting dentist
  - — charge
  - — regularity
- Shop
  - — for individual sundries: toothpaste, soap, razor blades, newspapers, cigarettes ...

Recreational Services/Facilities

- T.V.
  - — special room
  - — in each room
- Newspapers
  - — provided by home
  - — bought by patients
- Books
- Musical instruments
  - — piano etc., for general use
- Recreational area
  - — specially designated room available?
  - — for meeting friends, games (cards, chess), etc.
- Games
  - — chess, cards, etc. made available?
- Other recreational/educational facilities
  - — woodwork, pottery ...
- Supplied entertainment
  - — staff
  - — residents
  - — visiting groups

Staff

- Does home have G.P.?
  - — frequency of visits to patients by G.P.
- Number of qualified nurses employed (RGN's)
  - — minimum number on duty at any time
- Number of nursing aides
  - — duties
- Administrative and ancillary staff
  - — duties

Privacy

- Curtains around beds in multiple rooms
- Facility for locking own cupboard or drawer
- Allowed to keep personal possessions in the home
  - — clothes
  - — furniture
  - — other items
- Allowed to smoke
  - — unsupervised/supervised
  - — own room

— specially designated areas

Admission/Discharge

- General policy
  - — medical/nursing care v. welfare
- Conditions for admission
  - — medical, social circumstances of resident
  - — finance
    - — fees
    - — policy in cases of financial hardship
    - — health board subventions — is admission allowed before health board approval of subvention?
  - — special conditions
    - — residence
    - — religion
    - — other
  - — role of family
  - — role of G.P.
- Discharge
  - — oriented to long-term or short-term care
- Conditions for discharge
  - — medical, social circumstances of resident
  - — wishes of resident
  - — finance
    - — failure to pay fees
    - — failure to secure health board subvention
- Discharge procedure
  - — period of notice
  - — notification of relatives, G.P.
  - — arrangements for alternative accommodation

Residents

- Number
  - — male/female
  - — age
  - — number receiving health board subvention
- Independence of residents
  - — personal care
    - — incontinent or unable to feed
    - — no difficulties
  - — mobility
    - — walks without difficulty, including stairs

  - — walks only with difficulty or with aids or personal assistance
  - — chairfast or bedfast
- — mental state
  - — normal, alert
  - — confused
  - — dementia
- Social environment of residents prior to entry
  - — living alone
  - — living with spouse only
  - — living with children or others
- source of application
  - — resident
  - — family
  - — family doctor
  - — other
- Reason for application
  - — welfare
  - — nursing care

RESIDENTS

Structured Interview
This interview was designed to explore the world of the elderly in residential care. The following framework for analysis helped structure the interview, the main focus of which was to enable the elderly person to describe their world in their own way.

Context: The nursing home
Staff
Going into care
Living in an institution
Daily dimension of their lives
Services and facilities: social and recreational
Social contact patterns and support network
Fears and worries
Attitudes to ageing and old age
Planning for old age and retirement

STAFF

Background information on staff, staff attitudes towards the elderly.

Qs. 1 and 2. Length of time and number of homes worked in. Job title.
Q.3. Nursing experience if any, qualifications if any, RGN number.
Q.4. Present job title

Awareness of the needs of the elderly.

Q.5. (a)(b) Care of the elderly, main needs of the elderly.
Q.6. Need for special training to take care of the elderly.
Q.16. Need for social worker in home.
Q.20. Respondents description of an ideal home.
Q.21. Improvements if money is available.
Qs.8, 9. Ideal living environment for the elderly and reasons why the elderly came to live in homes.
Q.17. Helping new residents to settle in.

Stereotyping of residents in the nursing home environment.

Qs.10, 11, 18. Stereotyping of residents, typical resident, typical 'career' of residents, ideal resident.
Q.12. Feelings of respondent towards working with the elderly.

The ethos of the home reflected in the type of care provided. Custodial v. rehabilitative care.

Qs.12, 13, 14, 15, 25, 24. Coping with patients on a daily basis.
Q.22. Recreation facilities available to the residents.

Work load.

Q.19. Time available for the residents.
Q.7. How the job is seen by the staff member, (relates also to the needs of the elderly).

Personal experience with the elderly.

Qs.23, 24. Staff views on the contribution of the elderly to society, and changes in attitude due to work experience with the elderly.

Career expectations.

Qs.27, 28, 29. Staff development plan, career planning and expectations.
Q.30. Open question.
Q.31-36. Socio-economic background details.

RELATIVES

The world of the elderly: the extent and nature of contact and communications between residents and their relatives in the community.

Section 1
Reason for placement of elderly person in nursing home.
Q.1. Relationship of respondent to nursing home resident.
Qs.2, 3, 4, 5, 6, 7, 8, 9, 10. Background information of the elderly person's lifestyle before entering the nursing home. Whom he/she lived, medical condition, level of activity, who cared for the nursing home resident.
Qs.11, 12, 13, 14, 15, 16, 17, 18. These relate to the decision to enter a nursing home, whose decision, initial reaction of the resident to the decision, why this home was chosen.

Section 2
Feelings of relative on placement of his/her relative. Feelings of the resident.
Qs.19, 20, 23. Relate to the relative's feelings and level of satisfaction with the decision.
Q.21. Relates to a consideration of the decision by the relative.
Q.22. Relative's perception of the resident's initial reaction to living in nursing home.

Section 3
Relative's level of communication with nursing home resident.
Q.24. Level of physical contact. (Visiting by respondent).
Q.25. Level of contact. (Visiting by other family members).
Q.26. Establishment of regular visiting pattern by respondent.
Q.27. Establishment of other family members visiting patterns.
Q.28. Planning of visits.
Q.29. Does the respondent visit alone?
Q.30. Adequacy of visiting hours.
Qs.32, 33. Writing by respondent, 'phoning between visits.
Qs.34, 35. Writing and 'phoning by other family
Q.36. 'Phoning and writing by residents to family, delivery of messages to the resident.
Q.37. Visits outside by resident.

Section 4

Effect of residential care placement on the quality of communications between the resident and family members.

Qs.38, 39. Change in attitude and relationship between resident and relative.

Q.40. Ease of spoken communication.

If experiences and/or has always experienced some difficulty *must* ask Q.40(b).

Qs.41, 42. Improvement over time. Methods of coping with tension-filled visits.

Qs.43, 44. Benefit to resident of visits. Level of satisfaction achieved by relative and resident from visits.

Section 5

Relationship between relative and staff. Constraints arising from the nursing home. Effect of nursing home on quality of relative's lives. Relative's satisfaction with the level of care, services.

Qs.45, 46. Perceived relationship of relative with staff.

Q.47. Relative's experience of accommodation standards in nursing homes.

Qs.48, 49, 50. Effect of the environment on the mental, social, physical well being of resident.

Qs.51, 52. Comparison of physical and mental condition before and after entering residential care.

Q.53. Relative's satisfaction with the level of care.

Q.54. Resident's perceived level of satisfaction with the level of care.

Q.55. Suggested improvements.

Q.56. Satisfaction with services (relative).

Q.57. Relative's financial contribution.

Q.58. If more aid available, would you reconsider the decision of placement of elderly relative in residential care?

Q.59. Open.

Socio-economic background details.

Q.60, Q.61, Q.62, Q.63, Q.64, Q.65, Q.66.

Reception and Comments.

APPENDIX 3

SAMPLE SELECTION WITHIN THE NURSING HOME:

INTERVIEWER INSTRUCTIONS

At the training session you will be given a list of randomly selected nursing homes. You will be required to interview a pre-designated number of residents in each home on your list as well as a relative of one resident and one staff member. In order to ensure a systematic and random procedure for selection of each individual, the following procedure must be followed in the selection of each respondent.

Selection of Residents

You will be provided with a list of homes at the training session. This will indicate the number of residents to be interviewed in each home. It will also indicate one or more bed numbers for each home — you are to interview the occupant of the designated beds in each home. For example, if the designated beds for nursing home A are 4 and 7 then you must interview the residents occupying the fourth and the seventh beds in the home.

If the beds in the nursing home are not numbered then you must identify the respondents by the following procedures. Start with any bed in the home as number one and count from there, in any direction, until you have identified the beds corresponding to the pre-designated number for that home.

If the resident occupying a selected bed is incapable of being interviewed you must contact the Social Research Centre.

Selection of Relatives

Towards the end of the interview with the nursing home residents explain to each resident that, in order to provide a comprehensive picture of nursing home life, we would also like to talk to residents' relatives. Ask each

resident who they would like the home to contact in case of an emergency. Then explain that we might like to interview this person and, if the resident has no objection, ask for his/her name, address and telephone number.

By following this procedure you will be able to compile a list of relatives of elderly nursing home residents for each home. Only *one* of these relatives is to be interviewed. At the training session you will be given a number for a relative in each home. If, for example, the number for relative in home A is 5 then you are to make arrangements to interview the relative of the fifth resident you interviewed in the home.

In some cases it may prove impossible to interview the relative identified in this way — e.g. if he/she is living outside the country. If this happens you must contact the Social Research Centre.

Selection of a Member of Staff

One member of staff in each nursing home is to be interviewed. The staff member selected must be involved in the provision of nursing care to residents of the home. Cleaners or cooks, for example, are therefore excluded while nurses, nursing aides and, in some cases, the matrons are included.

The staff member interviewed must be on duty the day you decide to do the interview. You may select the day for interview and person to be interviewed in accordance with your own schedule in the home.

APPENDIX 4

PROGRAMME OF CARE FOR THE ELDERLY

NORTH-WESTERN HEALTH BOARD

This appendix outlines the programmes of care for the elderly in Buncrana Community Nursing Unit. It is based on correspondence with Mr. Donal O'Shea, CEO, North-Western Health Board and Mr. Michael McLoone, Programme Manager, Community Care. Mr. McLoone sets out the guidelines in relation to the programme of care.

These guidelines are used to draw up personal care plans for each resident which will endeavour to meet their total needs — physical, personal, social, emotional and spiritual. These plans replace the traditional patterns of institutional care. The underlying philosophy is to promote independent living for the residents consistent with their common needs in sharing a home.

Guidelines

1. To maintain a flexible programme of care endeavouring always to respect the privacy and freedom of the residents and upholding suitable community values.
2. To develop with the residents a feeling of togetherness and belonging.
3. To ensure that the homely community atmosphere is maintained, the staff will not wear uniforms except for protective use. The pattern of each day will be flexible with no rigid timetable or rules.
4. To endeavour to delegate duties to residents and motivate and train residents to accept these responsibilities.
5. Involvement of family and volunteers will be encouraged. Volunteers will be encouraged to befriend residents on a personal 'one to one' basis so as to facilitate residents to exploit their personal interests and revisit old friends, relatives or their home district.

6. The role of all staff in the unit, irrespective of profession or grade, in meeting the total needs of residents, will be recognised in drawing up the practice of care.

Practices

The practice of care will include:

1. Admission Procedure

(a) Meeting with Matron, Assistant Matron, Staff Friend and Family. Informal welcome and tea.

(b) Staff Friend then accompanies Resident for the next few days. The staff duties will include the introduction, *questionnaire, arranging possessions and bed, listening and talking.

(c) After a few days there will be a triangular meeting with the Assistant Matron, Staff Friend and Resident to discuss how the Resident is settling in.

(d) A meeting to discuss results of the questionnaire with Assistant Matron, Youth Employment Supervisor, Craft Therapist and Staff Friend.

(e) With temporary admissions it is important to involve the family and to show them the Care Practice in the Unit.

(f) A review meeting before discharge.

2. The Pattern of the Week

(a) High Dependency Care — Will Include:
Nursing
Dressing (promote independence, extra time and encouragement).
Bathing (discuss at community meeting organised over 7 day period).
Feeding (Residents may help. Where possible Residents taught skill).

(b) Menu

— Breakfast:	9–9.30 a.m.	Those who wish to eat earlier will be provided for as will Residents who wish to rise later.
	11.00 a.m.	Tea Break.
	1.00–2.00 p.m.	Lunch.
	4.00 p.m.	Tea Break.
	5.30 p.m.	Tea.
	8.00 p.m.	Supper.

*Questionnaire on Life Style before entering: Interests, Friends, Birthdays, Anniversaries. Questionnaire on Social Interests.

The Staff agreed to organise their mealtimes around the Residents' timetable and to join the Residents for tea breaks.

(c) Community Meeting: Weekly meeting of Residents with Staff. Residents will discuss matters of interest. Decide on group social activity. All Residents are expected to attend this meeting.

(d) No Visiting Restrictions

(e) Craft and Leisure Activities
Will cater for both group and individual needs.
There will be a wide range of activity.
Independent life skills will be taught.
This activity is open to members of the Day Centre.
There will be T.V.'s and quiet rooms.
Evening activities.
Letter writing — assistance to Residents who are unable to write.
There will be a shop in the Unit — Residents will be involved in managing it.
A bar for Residents' use will also be provided.
Small industry — to be explored.

(f) Individual Time for Residents
To discuss effects of bereavement.
Loneliness.
Fear of death and other immediate problems.

(g) Outdoor Activity
Shopping.
Visits to Pubs.
Families will be encouraged to take Residents out.
Involvement with Voluntary Groups.
Trips to old "Home Lands".

(h) Religious Practice
  (i) Every Resident wishing to attend Mass/Service will be encouraged to go to the local Church.
  The family will be encouraged to take them.
  The Parish will be asked to provide helpers.
  (ii) Weekly Mass/Service for Residents and Staff in the Unit.
  (iii) Pastoral care of the dying.
    (a) Each dying Resident will not be left alone. Staff will be present and Residents will be encouraged to visit.
    (b) Remains placed in Oratory. Staff and Residents may visit to say prayers. Family may wish to take remains.
    (c) Mass/Service in Community for deceased.
    (d) The whole Community will be given time to grieve the loss of

one of the Residents or Staff.
3. A fortnightly Newsletter will be published for distribution in the Community. It will keep people up to date with all developments and activities within the Unit.

4. *Use of Space*
(a) Rooms will be used to ensure the *integration* of the Community.
(b) Rooms will be used to cater for various *preferences* and *activities.*
(c) Rooms will be used to ensure *privacy.*

5. *Maintenance of Interpersonal Relationships In The Community*
(a) Weekly Resident Community Meeting with Staff. Residents will be encouraged to be iinvolved in a variety of decisions affecting the Community.
(b) A weekly Senior Staff meeting to monitor the Care Performance.
(c) Full staff meetings from time to time.

NATIONAL COUNCIL FOR THE AGED

The National Council for the Aged was established by the Minister for Health in June 1981. The terms of reference of the Council are 'to advise the Minister for Health on all aspects of the welfare of the aged, either on its own initiative or at the request of the Minister'.

To date the following reports have been produced:

1. *Day Hospital Care,* April 1982
2. *Retirement: A General Review,* December 1982
3. *First Annual Report,* December 1982
4. *Community Services for the Elderly,* September 1983
5. *Retirement Age: Fixed or Flexible (Seminar Proceedings),* October 1983
6. *The World of the Elderly: The Rural Experience,* May 1984
7. *Incomes of the Elderly in Ireland: And an Analysis of the State's Contribution,* May 1984
8. *Report on its Three Year Term of Office,* June 1984
9. *Home from Home? Report on Boarding Out Schemes for Older People in Ireland,* November 1985
10. *Housing of the Elderly in Ireland,* November 1985
11. *Institutional Care of the Elderly in Ireland,* November 1985
12. *This Is Our World: Perspectives of Some Elderly People on Life in Suburban Dublin,* September 1986
13. *Nursing Homes in the Republic of Ireland: A Study of the Private and Voluntary Sector,* September 1986
14. *"It's Our Home": The Quality of Life in Private and Voluntary Nursing Homes,* September 1986
15. *The Elderly in the Community: Transport and Access to Services in Rural Areas,* September 1986

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