Older People in Long-Term Care;

A Qualitative Study

by

The Department of Public Health Western Health Board

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OLDER PEOPLE IN LONG TERM CARE;
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Final Report Prepared on Behalf of
Services for Older People
Western Health Board

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EXECUTIVE SUMMARY

Long term care throughout the Western Health Board is provided in District Hospitals, Long-Stay Hospitals and Community Nursing Units. With the proportion of over 65's in the Western health Board higher than ever before and steadily increasing, it is likely that additional demands will be placed on these services.

To ensure that the best possible services are provided and that needs are met, the Western Health Board is developing a strategy for older people. A strategy group has been formed which is consulting widely with users and providers of services for the elderly in order to develop the strategy. One key issue that has emerged from this consultation process is that service providers of long term care facilities believe that there is a need (both in general terms and in terms of developing a strategy for the elderly) to obtain feedback from the perspective of the users of the services. As a consequence, the Department of Public Health was asked to examine ways in which the perceptions of service users could be explored and levels of satisfaction assessed.

The aim of the research was to determine perceptions and views of Long Stay Hospitals, Community Nursing Units, and District General Hospitals. This was to ensure that these services are meeting the needs of elderly users and to identify any potential areas of improvement.

A series of depth interviews with service users and relatives of service users were undertaken. A total of 38 interviews took place (22 interviews with service-users and 16 with relatives). The key findings of the research can be summarised as follows:

1. Most service users were content to go into care and were content with being in care.
2. Lack of privacy was not an issue for those interviewed.
3. Service users believed the quality of the food to be very good. Although content with the choice of food there did appear to be scope for improvement, particularly with regard to flexibility of mealtimes.
4. Access to washing facilities varied. Some had unrestricted access whereas others were restricted to set days and times.
5. Overall, a wide range of daily activities was offered, although some believed more activities could be organised, particularly for those who were less mobile.
6. The staff were perceived as being very pleasant and helpful. Some relatives and residents however were unhappy with the attitude of some staff.
Overall it was concluded that long term care facilities are perceived by those staying in them and their relatives as being very good. Nevertheless, a number of issues did emerge that would warrant further attention. The following recommendations are suggested to ensure that long stay care facilities provide the optimum quality of care in the future:

1. More daily activities should be organised, particularly for those staying in Long Stay Hospitals and District hospitals. Variety and choice should be provided as well as the opportunity to 'opt out.' The need to promote physical activity in particular should be examined.

2. Ensuring all patients have sufficient access to washing facilities

3. Adopting a more flexible approach to meal and bed times.

4. Ensuring staffing levels are sufficient to provide a high quality level of care. Protocols of 'best practice' should be adopted and adhered to.

5. Ensuring all staff treat patients with the dignity and respect they deserve.

6. Facilities should provide a client focused service as opposed to a service provider focused service.

7. The evaluation was only able to provide an overview of each of the three types of facilities visited. It could not provide results specific to individual facilities. In the future, it is recommended that individual facilities should evaluate their services and that this process is ongoing, so that performance can be monitored to ensure a high quality service is provided.
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1. INTRODUCTION

1.1 Research Background

Life expectancy throughout the western world has increased with improvements in sanitation and health care. Chronic diseases have replaced infectious diseases as the principal causes of death, and medical advancements have resulted in improved survival rates and increased life expectancies. This has led to an increase in the elderly population. In Ireland, the proportion of over 65's is higher than ever before and is steadily increasing. Population projections indicate that this trend is likely to continue. Fahy (1995) has estimated that there will be a 26% increase in the number of people over the age of 65 years in Ireland by the year 2011.

The increase in the elderly population is a particular issue within the Western Health Board because it has a higher proportion of elderly people than in Ireland as a whole. In 1996, 14% of the Western Health Board's population (approximately 50,000 people) were over the age of 65 years (compared to 11% for Ireland as a whole; Central Statistics Office, 1997). Population projections for the elderly population within the Western Health Board and for Ireland are shown in figure 1.1. These figures demonstrate that all areas of the Western Health Board (with the exception of Galway County Borough) have a higher proportion of elderly than Ireland as a whole. This trend will be maintained up to the year 2011 with all areas experiencing an increase in the elderly population. In the future it seems likely that additional demands will be placed on health services by the elderly, particularly long term care facilities.

Figure 1.1 Projections of Persons Aged 65 Years or More as a Percentage of Total Area Population

1.2 Hospital and Long Stay Care Facilities for Older People Within the Western Health Board

The Western Health Board, in line with government strategy (Department of Health, 1994) aims to encourage the care of older people in their own homes for as long as possible. Where this cannot be achieved, care is provided throughout the Western Health Board region in Long Stay Hospitals, Community Nursing Units, and District Hospitals. There are 17 facilities in the Western Health Board area providing extended care (figure 1.2).

Figure 1.2 Hospital and Long Stay Care Facilities for Older People Within the Western Health Board

![Map of Western Ireland showing facilities](image)

**Key**
- Community Nursing Unit
- District Hospital
- Long Stay Hospital

1.2.1 Long Stay Hospital
Long Stay Hospitals provide care for the elderly who require long term continuing care on a 24 hour a day basis. These facilities tend to have a more intensive level of nursing care than is provided in other long stay settings. Long-Stay Hospitals are the largest type of long-stay unit for older people.

Most of those staying in Long Stay Hospitals are suffering from dementia or terminal illnesses. The majority (73%) of the residents in Long-Stay Hospitals are in the high or maximum dependency category (Keogh and Roche, 1996). There are three long stay hospitals in the Western Health Board area (one in each county).
1.2.2. Community Nursing Units
Community Nursing Units were previously known as Welfare Homes. These homes were designed to provide residential care for the frail ambulant elderly, or those who had difficulties in living independently, or for other social reasons such as living alone in remote areas.

Community Nursing Units were not originally well equipped to provide high levels of nursing care as the facilities were initially designed for people without a significant mobility problem or a high level of dependency. Despite this, almost a third of residents are in the high or maximum dependency categories according to Department of Health figures (Keogh and Roche, 1996). This is because the residents have become progressively more dependent as they have grown old within the homes (National Council for the Elderly, 1996). Only a small proportion of clients in Community Nursing Units suffer from dementia. There are ten Community Nursing Units in the Western Health Board area (four in Galway, four in Mayo, and two in Roscommon). In addition, it is planned to open St Fionan’s Community Nursing Unit in Achill later this year.

1.2.3. District General Hospitals
District Hospitals are local hospitals staffed by GPs and nurses; they provide medical services for those with medical conditions that can be treated without the need to use acute hospital facilities. In addition, respite care, rehabilitation, and convalescence are offered. Although not specifically designed to serve elderly patients, due to the nature of the services provided, most patients tend to be elderly.

District hospitals have the highest proportion of their patients in the maximum dependency category. They also have the shortest average length of stay with 85% of patients residing for less than three months (Keogh and Roche, 1996). There are four District General Hospitals in the Western Health Board area (one in Galway, and three in Mayo).

1.3 Current Developments in Services for Older People
To date there have been a number of developments in terms of expansion and upgrading of long stay facilities in the Western Health Board area. The Western Health Board Annual Report (Western Health Board, 1998) lists the following developments which occurred during the year 1998:

1. Upgrading and extension of St. Anne’s Ward in St. Brendan’s Hospital, Loughrea.

2. Provision of a reminiscence room in St. Francis Community Nursing Unit, Galway.

3. Opening of a long-stay care unit in Aras Mac Dara, Carraroe providing 20 additional places.

4. Replacement of accommodation for 13 residents in St. Anne’s Community Nursing Unit in Clifden and the appointment of six extra staff.
5. Commencement of the construction of a Community Nursing Unit in Achill, Co. Mayo.

To ensure that the best possible services are provided for older people and that their needs are met, the Western Health Board is also developing a strategy for older people. A strategy group has been formed which are consulting widely with users and providers of services for the elderly in order to develop the strategy. One key issue that has emerged from this consultation process is that service providers of long term care facilities for the elderly (i.e. District Hospitals, Long-Stay Hospitals and Community Nursing Units) believe that there is a need (both in general terms and in terms of developing a strategy for the elderly) to obtain feedback from the perspective of the users of the services. As a consequence, the Department of Public Health was asked to examine ways in which the perceptions of service users could be explored and levels of satisfaction assessed.

1.4 Aims and Objectives

The aim of the research was to determine perceptions and views of Long Stay Hospitals, Community Nursing Units, and District General Hospitals. Perceptions were determined from the perspective of individuals using these facilities, in addition to their relatives. This was to ensure that these services are meeting the needs of elderly users. More specifically, the research aimed to determine:

1. Levels of satisfaction with key elements of the service.
2. Potential areas for improvement.
2. METHODOLOGY

2.1 Introduction

In devising the methodology consideration had to be given to the following factors:

1. The ability of patients to communicate their views and perceptions.

2. The ability of the research to provide meaningful results for each of the three types of elderly services provided by the Western Health Board.

In order to establish how these issues could be addressed, the study team undertook a series of meetings with representatives of each of the three types of elderly services. This also aimed to ensure that key areas of concern were addressed by the research. The interviews took place in June/July 1999. The following issues emerged from the interviews:

1. It was felt that elderly clients may have difficulty completing structured questionnaires. However patients who were not suffering from dementia would have no difficulty discussing issues on a one to one basis.

2. The perceptions and views of relatives of patients were believed to be important, particularly for hospitals where a large proportion of patients were suffering from dementia. It was also thought that service users may not wish to appear critical of their care.

3. Particular issues that would require consideration included:

   - The need to become patient focused
   - Giving patients the choice to do whatever they wanted
   - Patients having a say in their care
   - Timing of meals and location
   - Rushing patient mealtimes to fit into staff rosters/dinner hours
   - Patients being able to get up and go to bed whenever they want
   - Putting patients to bed early because there are less staff available in the evenings
   - Everything being a routine
   - Whether incontinence is adequately addressed
   - Adequacy of visiting time arrangements
   - Availability of a designated smoking area
   - Creating a pleasant/friendly atmosphere
• Ease of obtaining access to other health facilities/services
• Strains on staff
• Motivating staff to treat the same people all of the time
• Adequacy of staffing levels to give sufficient time to each patient (i.e. time talking to patients in addition to day to day tasks).

In view of the findings of the meetings, the methodology comprised the following:

• Depth Interviews with service users.

• Depth Interviews with relatives.

This approach was chosen because:

1. It was felt that a less structured approach to data collection would yield more meaningful results from elderly clients, many of whom may have difficulty completing structured questionnaires. An unstructured approach whereby a number of key topics are discussed was thus thought to be more appropriate. It would also provide a deeper insight into the issues of concern by giving service users the opportunity to develop their answers and by allowing the interviewer to probe responses that might be unclear or ambiguous.

2. A quantitative approach representing the views/opinions of service users and their relatives for each type of facility throughout the Western Health Board would entail a significant amount of data processing and analysis. This was deemed outside the time and cost constraints of the study. Depth interviews by comparison would require less data collection whilst at the same time providing meaningful results for each type of facility.

3. Relatives, in addition to service providers were included in the study to ensure that the opinions of those unable to communicate to the study team (e.g. due to illness/frailty) were included in the study. Relatives also provide opinions from a different perspective.

2.2 Depth Interviews With Service Users

A series of depth interviews were undertaken with service users; 12 interviews of those residing in Community Nursing Units, and ten attending District General Hospitals. Clients in Long Stay Hospitals were not interviewed as it was anticipated that it would be extremely difficult to obtain valid and reliable responses due to the high proportion of patients suffering from dementia in these facilities. Community Nursing Units were selected using a random sample based on a list of Community Nursing Units in the Western Health Board area. The sample of Community Nursing Units was evenly distributed between the three counties in the Western Health Board area. The following Community Nursing Units were selected:

• Aras Mhuire, Tuam, County Galway (four patients)
• McBride Home, Westport, County Mayo (four patients)
• Plunkett Home, Boyle, County Roscommon (four patients)

Two out of the three District Hospitals within the Western Health board area were randomly selected:

• District Hospital Clifden, County Galway (five patients)
• District Hospital Swinford, County Mayo (five patients)

Those interviewed were selected randomly from a list of patients believed by the matron of the facility to be capable of answering questions and discussing issues (mental test scores, which provide a more objective assessment, were not available for most patients). The interviews aimed to ascertain key issues raised in the meetings with representatives of each of the three types of service. As such, the themes addressed by the interviews included:

- Choice of location and happiness with decision to go into care
- The nature of the institutional regime that exists
- Level of independence
- The reality of living in care on a daily basis
- Social contact patterns
- Attitudes of staff to residents
- Facilities and services available in the institution
- Access to facilities and services outside the institution
- Comfort and privacy

The interviews were undertaken in July/August 1999. A copy of the interview schedule is given in appendix 1.

2.3 Depth Interviews With Relatives

Depth interviews were undertaken with 16 relatives; nine were undertaken of relatives of those staying in Long Stay Hospitals, three in Community Nursing Units and four in District General Hospitals. The long stay facilities were selected using a random sample based on a list of long stay facilities in the Western Health Board area. Where possible the sample of facilities was evenly distributed between the three counties in the Western Health Board area. The following facilities were selected:

• Long Stay Hospitals
  ⇒ Saint Brendans Home, Loughrea, County Galway
  ⇒ Sacred Heart Home, Castlebar, County Mayo
  ⇒ Sacred Heart Hospital, Roscommon

• Community Nursing Units
  ⇒ Saint Anne’s Home, Clifden, County Galway
The interviews aimed to ascertain:

- Choice of location and happiness with decision to go into care
- The nature of the institutional regime that exists
- Level of independence
- Social contact patterns
- Attitudes of staff to residents
- Facilities and services available in the institution
- Access to facilities and services outside the institution
- Comfort and privacy
- Perceived workload of staff

The interviews were undertaken in July/August 1999. A copy of the interview schedule for relatives of people staying in Long Stay Hospitals and Community Nursing Units is given in appendix 2. Relatives of people staying in District General hospitals were asked slightly different questions due to the different nature and function of such hospitals. The interview schedule for District General Hospitals is given in appendix 3.

2.4 Interview Procedure

Prior to undertaking the interviews, all interview schedules were piloted to ensure that the questions could be easily understood. Two trained interviewers were present throughout the interview procedure. One interviewer asked all the questions with the second interviewer taking notes and checking to ensure that all topics were covered by the interview. The purpose of the interview was explained to the interviewee and their consent was obtained to conduct and tape (audio) record the interview. Each interview took approximately ten minutes to complete.

2.5 Analysis of Interviews

All the interviews were tape (audio) recorded and transcribed. Each transcript was then checked by a member of the study team to ensure that the transcript was accurate. The responses on the transcripts were then grouped into key themes that emerged. A number of direct quotes from the transcripts were then used to demonstrate each of the emerging key themes. This process (qualitative content analysis) focused on the meaning of responses as opposed to their quantification. To ensure reliability in the research results the key themes which emerged were based on agreement obtained by three members of the study team who viewed the transcripts independently. In addition, notes taken during the interview process (of the interview itself and of
general observations) were also utilised to confirm the emerging themes and to ensure important areas were not omitted.
3. INTERVIEWS IN LONG STAY HOSPITALS (RELATIVES)

3.1 Introduction

Patients residing in Long Stay Hospitals were not asked any questions as discussions with matrons revealed that only a small minority would be able to participate in an interview (due to ill health). Interviews were therefore undertaken only with a sample of relatives. A total of nine relatives were interviewed. The following represents the key themes that emerged.

3.2 Going Into Care

Most patients had little choice in the decision to go into a Long Stay Hospital because they were too ill. Many were referred to Long Stay Hospitals from acute hospitals. Most of those interviewed stated that their relatives could not be looked after at home either because they were too ill or because there was nobody to look after them.

Patients that were not too ill were thought to be very happy about being in care. In addition to the care given, some commented on the increased social contact with staff and visitors. For example, when asked how a patient felt about being in care one relative stated that:

"She was quite pleased, delighted. If you were home, and you're on your own it's lonely, so she'll be here and she has plenty of visitors and staff are nice to her."

Only a minority did not like being in care. A large number of patients were thought by their relatives to be too ill to have an opinion about whether they liked being in care.

3.3 Type of Accommodation

All relatives stated that patients stayed in shared wards. Despite being on a shared ward, most believed that there was enough privacy and that their relative did not mind sharing a ward. The curtain could be pulled around patients if more privacy was needed, and this was believed to be sufficient to ensure adequate privacy. Some however commented that their relative was too frail to be concerned about privacy.
The shared wards gave patients the opportunity to talk to each other which most enjoyed. Some commented that the shared wards were beneficial in that it gave their relative something to occupy themselves with during the day:

"In one sense, rather than if she was in a room on her own she probably has more to occupy her because there are other people there and the times she wouldn't have visitors, she would be not as with it. She has more to concentrate on at the moment if it is only talking to someone else even the odd time or whatever. If she is on her own, she would have nothing to occupy her that way, she's better probably to have other people with her given her complaint."

3.4 Meals

There were no complaints about the quality of the food. Some relatives believed a choice of food was offered, whilst others were uncertain. Meals did appear to be served at specific times that were perceived as being somewhat early by some relatives. For example, one relative commented:

"I think the dinner comes a bit quick after the breakfast here. I think he never had his dinner in his life at 12 o'clock. I think 12 o'clock is a bit early for dinner."

3.5 Washing Facilities

Assistance was required to access washing facilities due to frailty/ill health. Some relatives were uncertain if washing facilities could be accessed at any time, or whether there were facilities on the ward. Others believed there were set times and days for baths (approximately once a week). There were no complaints about washing facilities from relatives. One relative explained how it can give a boost to the person being cared for:

"She likes the shower and it is very refreshing obviously for her. They are very good really. They wash her hair and put in curlers and that gives her a bit of a boost. She feels that she is looking better as well."

3.6 Daily Activities

Patients followed a set pattern of routine activities (e.g. being awakened, breakfast, dinner, and tea, going to bed). These were set to a particular time of day with little evidence of any flexibility.

During the day, most patients either read newspapers, watched the TV, or listened to the radio. Some patients were also taken for treatment (e.g. physiotherapy), whilst it
was reported that others did nothing all day. Some relative reported that the lack of activities was a problem:

"She doesn't seem to do anything at the moment. That's the problem, that's what she is finding hard, to sit around all day. The day care facilities are down there but there is only one nurse on and until such time as she is well enough to go down there, they cannot do anything about it. I think the Mass is the highlight of her day at the moment."

The hospital was visited by a priest, and most had the opportunity to attend or hear mass. Most relatives thought that religion was very important to patients. Some relatives stated that patients who were more dependant were unable to attend Mass as there was not enough staff to bring or supervise them. For example, when asked if the person they were visiting went to mass, one relative commented:

"No, she doesn't get to go because there isn't enough staff to bring her as she has to be supervised down there. She hears it over the intercom."

Most patients did receive visitors and it was believed to be a very important element of their day:

*She would have visitors we'll say most days, some of the family and other visitors as well, quite a range of relatives. They are very good at keeping up the visits which sort of gives her something to occupy her to think about I think you know.*

Some relatives however stated that some patients did not have any visitors, and that these patients were very lonely. One relative commented how this perhaps could be addressed:

"If there were one thing I would wish for people is that there would be people who would come in and sit down beside them and listen to them. It is so sad and they are so delighted when you sit down and talk to them."

Two relatives commented about additional organised activities, which it was believed patients found very rewarding. For example:

"...and they had a week of festival out here and I didn't see one thing in the paper about it. You could not believe how tremendous those nurses were and all the staff. They did everything for them and they had parties and they even had a fancy dress. It made life so much bearable for these patients."
3.7 Likes and Dislikes About Being in Care

Overall, relatives reported that patients were happy about being in care. In particular, relatives commented on the quality of care, the good staff and the 'homely' environment. Home was missed by some, although relatives believed most would prefer to stay in care as they could not be looked after themselves in their own homes. Some missed being independent and being able to do things for themselves. Others missed being with their relatives at home:

"She misses obviously the company in her own home, her husband and family and grandchildren I think especially. She had three grandchildren living next door and they were in and out quite a bit in the evenings and that you know after school and I think she misses that really. And obviously the day to day things like you know she would have done her own cooking, baking and all that type of housework. She was quite, she was very active and I think she just misses being able to do things for herself. She was always busy with her own jobs, etc. you know so she probably misses all that. It is difficult really when you can't move even to do the basic things for yourself you know to get up and dress yourself, go to the toilet and to be depend on someone to do everything for you. I think it is a big change really and it is very traumatic as you can imagine."

Some relatives anticipated that the patients they were visiting were hoping to return home when they got better.

3.8 Attitudes Towards Staff

All relatives believed that the staff were very good, and that they had no real complaints. All staff called patients by their first name and this was liked by all patients. Few patients had favourite members of staff. Those who did have favourite members of staff felt that these individuals were more pleasant in the manner in which they did their job. For example, one relative stated:

"...some people she would warm to more than others—which—is natural, and I suppose some people were probably more pleasant about it than others and she would probably get on better with people like that."

3.9 Discussion

The interviews with relatives of patients in Long Stay Hospitals revealed that overall they were very happy with the care provided and the facilities in general. The social contact with staff, other patients, and visitors were key beneficial aspects of being in care. However, the interviews did indicate that more daily activities may be required,
particularly for those who are confined to bed due to ill health or have no visitors. Clearly there are some patients who may appreciate something more to occupy them during the day. Perhaps extending day care facilities to wards for certain patients would help resolve this problem.
4. INTERVIEWS IN DISTRICT HOSPITALS

4.1 Introduction

A sample of patients residing in District Hospitals and relatives of patients residing in District Hospitals were interviewed. A total of ten patients and four relatives were interviewed. The following key themes emerged.

4.2 Going Into Care

Most patients were happy about being in hospital. This was also confirmed by relatives. Some patients commented that they were not strong enough to go home. Although happy with being in hospital, most believed that they would not be staying in hospital too long and were looking forward to going home. For example, when asked how she felt about being in hospital, one patient said:

"Well, it is very nice and good. I have no fault about it now, but like everybody I'd like if my time came to go."

4.3 Type of Accommodation

All patients were staying in shared rooms/wards. Despite this both patients and relatives believed there was sufficient privacy and did not mind sharing. If they wanted a quiet moment, for example to say a prayer, there was no difficulty. The shared ward gave the opportunity for patients to chat to each other which all enjoyed. The interaction with others was very important to most patients. Some patients got very attached to the people they met. One lady when asked if she minded sharing stated:

"No. They are very nice. There was one woman there for a good while. She was a grand lady and she went home yesterday and I'm lonesome after her. There was another lady that went home a few days prior to that and she was also lovely. We'd be up and down talking to each other. First thing in the morning, I'd say 'How are you Kate' and she'd say 'how are you' and so forth. There is another lovely girl the other side of me and she is awfully obliging, no matter when you'd call or ask her she'd come to you."
4.4 Meals

Both patients and relatives thought the meals were very good. Some patients stated that they had a choice in what they ate whereas others reported not having a choice. Some however were unhappy about the timing of meals. For example, one relative commented that:

"They have a fairly early tea, very early, which makes it a very long evening, I think for the patients- that is my own private view. I think that applies to most hospitals though because of staff, and all the rest of it. But it is a pity. I think if patients had an evening meal, it would break up the evening for them better."

Other relatives commented about the tea, in terms of its quality and also that patients should be offered tea more often. One relative commented that the patient they were visiting had great difficulty chewing meat (no teeth) and had lost weight because of the lack of soft foods.

4.5 Washing Facilities

All patients had relatively easy access to washing facilities, either on their ward or close to their ward. Most could have a wash or go to the toilet whenever they wanted. Some patients and relatives reported that a bath/shower could be had whenever a patient wanted, whereas others stated that the nurses dictated when a bath could be had. One relative in particular was most dissatisfied with the frequency with which baths could be had:

"...it has been some time now since he had a bath and I did ask them if they would give him a bath or shower but I think they were rather busy then. He has problems with his circulation and I just felt it might help."

4.6 Daily Activities

As with Long Stay Hospitals, a routine pattern of daily activities was followed (e.g. being awakened, breakfast, dinner, and tea, going to bed). These were set at particular times of the day and there did not appear to be much flexibility in these times.

Watching television, listening to the radio, reading, and walking were the main daily activities. Some patients commented that they did nothing all day, which in some cases was due to poor health. One relative was very concerned about the lack of daily activities:

"I don’t know how he manages it but that is what he does is sit down all day except when he goes to the toilet."
Both relatives and patients stated that Mass could be attended in the Hospital, in addition to a priest who visited patients. Religion seemed very important for both patients and relatives. For example, regarding Mass, one patient commented:

"Oh, there is Mass here. We had Mass today thank God. We may not have Mass tomorrow if the Doctor comes. We'll just wait and see."

Most patients received visitors although some reported not receiving visitors that often. One patient who did not receive visitors reported being lonely. Visitors were an important part of the patients day, for most it was the highlight of their day giving them immense pleasure:

"I had a girl in yesterday who was here from America. She bought me a beautiful bunch of flowers and one of the nurses took a picture of us together. My neighbours come to see me on and off and pretty often take my washing home for me and bring it back again."

### 4.7 Likes and Dislikes About Being in Care

Both patients and relatives were very happy about being in the District Hospital. In particular, the nurses, the pleasant atmosphere, and the company were highlighted. For example, when asked what she liked, one patient stated:

"The atmosphere, it is so pleasant. It is a really lovely place."

Only a minority reported any dislikes. The dislikes mentioned were being away from home, and being woken up too early in the morning:

"Well, I don't mind but in the morning if I could lie in a bit I would. Apart from that you have to follow the rules."

One patient in particular did not like anything about being in care, mainly because the staff expected him to do more than he was able to. When asked what he liked about being in care he said:

"I don't like anything about it now. I am longing to get out or to get away to east Galway. I couldn't be any worse than I am here."

### 4.8 Attitudes Towards Staff

Most patients and relatives were very happy with the staff, stating that the staff couldn't do enough for them. Most staff called patients by their first name which was liked. However, a minority were not happy with the attitudes of some staff. One relative for example stated:

"Maybe it is part of the system, I don't know what it is. Maybe it is
just overwork, but the elderly people don't seem to be given enough respect just as human beings, they are almost treated as non-humans. They are looked after, fed and cleaned but really just if they had a little bit more respect for them as human beings.”

4.9 Discussion

The interviews in District Hospitals revealed that overall, both patients and relatives were happy with the care provided. However, a number of areas of concern emerged that were experienced by a minority of patients:

- Lack of daily activities
- Timing of meals
- Frequency of baths
- Attitudes of some staff

Although only experienced by a minority, the above issues do warrant further attention.
5. INTERVIEWS IN COMMUNITY NURSING UNITS

5.1 Introduction

A sample of those residing in Community Nursing Units and a sample of their relatives were interviewed. A total of 12 patients and three relatives were interviewed. The following key themes emerged:

5.2 Going Into Care

The majority of patients went into care due to ill health. Some went into care after being in hospital. Others reported that they did not want to live on their own, or that there was no-one to look after them and felt that they could not cope. Some who had been living alone were fairly dependent on their families and neighbours and decided to go into care as they no longer wanted to be a burden on them. Similar reasons were also given by relatives. In addition, some relatives who previously had looked after the person in care felt that they could no longer cope with looking after the person. For example, the following quote from a relative demonstrates how traumatic caring for someone at home can be:

"Well, I decided to put her into care because I couldn't cope in the house. She was sleeping by day and awake by night and literally I was working 5 days a week and once I got home at 5.30 p.m. I had her until the morning. She was fine for the first 1½ years, (I had her for 3 years altogether), and then after that she was a disaster absolutely — calling me half the night, getting out of the bed, she was getting some of these T.I.A., clots and for about 48 hours before she got these she was so unsettled. She has this thing in her head that she is still 50 years old and she can do what she did at that age. She is now 90 years old. Another thing that is wrong with her is that she wants to be walking all the time but you really cannot trust her because she had a stroke and she needs help walking. It is very hard to watch her."

Although involved in the decision to go into care, patients did not appear to have much choice in the decision to stay in a particular care facility. Some had visited in the past to see other residents, but none had visited to decide if they wanted to live there.

Patients overall were happy with the decision to go into care. Most had accepted that the care facility was now their home and were happy to stay in care. Some relatives
reported that the person going into care was initially upset, but soon came to terms with being in care.

5.3 Type of Accommodation

Residents either had their own room or stayed in a small shared room with 2-3 others. All believed the accommodation gave them sufficient privacy.

5.4 Meals

Most were happy with both the quality and the choice of the food provided. Meals were provided at specific times of the day. Although most appeared happy with the mealtimes, a minority would have preferred the meals to be given at different times. For example, one man, when asked whether the mealtimes were suitable said:

"Yes, there is nothing wrong with them. It is a bit near from breakfast to dinner, but nevertheless I'll settle for it."

The above quote demonstrates how some residents have become accepting of their situation, despite the fact that some things don't suit them. This suggests that some residents have low expectations.

5.5 Washing Facilities

Some residents had a toilet and a sink in their bedroom. Bathrooms generally were easily accessible and residents had little difficulty having a bath whenever they wanted. Some commented that a hairdresser came in every week to wash and set hair if required.

5.6 Daily Activities

As with Long Stay and District Hospitals, a set pattern of routine activities was followed (e.g. being awakened, breakfast, dinner, and tea, going to bed), with little flexibility in terms of the timing of these activities.

A wide variety of daily activities were undertaken by patients including watching television, reading newspapers, listening to the radio, walking, physiotherapy, day care activities (e.g. games and crafts), and organised trips outside the unit. Only a minority reported that they did nothing. There appeared to be more activities for patients in community nursing-units than in long stay and district hospitals. The following two patients descriptions of a typical day demonstrates the type of activities available:

"After Mass, I come out to the dining room and have soup and then the day cares are in. On Mondays and Thursdays we go down again to the chapel and say the Rosary. We go in to the Day Room at 4.30"
and we say a Rosary. A Craft Teacher comes in Mondays to Thursdays and we knit beads and all that kind of thing.

I get up about 7.30. I get ready and say a few prayers; breakfast at 8.30. Most days I go back into the room again and have a read or say a few prayers. We have soup then at 11.00 a.m. and I probably go to the Day Room for a while then. Dinner then at 12.00 or 12.30. Then, we have an hour with the exercise (physiotherapy) and after that, I go back to the room again and have a bit of a read or something like that until teatime again. Then, we have tea at 5.00, rosary beforehand at 4.30. Then back to the room again, reading, watching the television until suppertime. Supper would be about 9.30 p.m. or thereabouts. I'd like if the supper was a bit earlier. It is a bit late; I'd like if it was at 9.00 p.m.”

Nevertheless, some did suggest that more daily activities could be organised. For example, one relative commented:

“I think that it would be nice if they had tours; day trips and maybe a weekend away, to bring them somewhere in the Summer. She loves to be spinning around. I brought her to a friend’s house a while ago and she sat in the garden for an hour, she loved that and remembered that.”

The Community Nursing Units were visited regularly by a priest who spent time with individual residents, and all residents and relatives of residents reported that Mass could be attended. Religion was a very important part of residents’ daily activities:

“We get Mass twice a week. It is a great comfort to the people who aren’t mobile. It gives them a great lift up.”

All those interviewed stated that visitors came in frequently to see residents.

5.7 Likes and Dislikes About Being in Care

Overall, both residents and relatives were happy about the care given. In particular, the nurses and staff, the company, the food, and the pleasant atmosphere were highlighted. For example, one patient when asked if there was anything she would change said:

“No, I wouldn’t change anything. They are very good and we have an excellent chef and if you don’t like what you get for your dinner, he will give you something else, isn’t that something. You can tell him what you want and if he has it he gives it.”

Only one patient that was interviewed had any dislikes about being in care (bossy domestic staff). One relative commented that staffing levels were too low which was causing exhaustion for nurses. Although very happy with the Community Nursing Unit, some did miss home and the life they had before:

“I have days when I think of home and what we used to do. We used to go down to visit my sister every Monday night but now they are gone. I think of all that.”
Although some missed home, most would prefer to stay in the Community Nursing Unit if they had a choice, as they knew they were no longer able to look after themselves:

"Well, there are times I do feel like going home but what can I do when I go home. I have no-one to ready meals or anything like that and people living a distance away. I will settle for the present situation until it changes."

Patients overall did accept that they would not be returning home. Some commented that they would go home if their health improved.

5.8 Attitudes Towards Staff

Most patients and relatives believed that the staff were very good, and that they had no real complaints. Most staff called patients by their first name and this was liked by all patients. Few patients had favourite members of staff.

5.9 Discussion

The interviews in Community Nursing Units revealed that both patients and relatives were happy with the care provided. The only main area of concern that emerged was with the timing of meals. This was only a difficulty for a small number of patients.
6. DISCUSSION

The study aimed to determine perceptions of Long Stay Hospitals, Community Nursing Units, and District General Hospitals to identify any potential areas of improvement. A series of depth interviews with service users and relatives of service users staying in each type of facility were undertaken. The study was intended to provide an overview of each type of facility within the Western Health Board, rather than draw conclusions for each specific facility visited. The study gives a useful insight which all facilities for the long term care of the elderly can utilise in planning for the provision of services in the future.

Most patients were content with the decision to go into care. Although some were initially upset about going into care, they soon got used to being in the care facility and had little difficulty adjusting. There was a recognition that they could not be looked after at home. Some of the comments from relatives demonstrated how difficult it can be to look after someone at home who is dependent. In addition to the care, the increased level of social contact was highlighted. Many of those in care would otherwise be alone in their home.

In terms of the care facility itself, those staying in Long Term and District Hospitals had to share a ward (approximately six people) whereas those in Community Nursing Units either had a private room, or shared with 2-3 people. Lack of privacy was not an issue for those interviewed. Indeed those sharing enjoyed the company, yet could get sufficient privacy at the same time. Nobody commented on the quality of accommodation, although it must be noted that questions did not specifically address this issue. Specific questions would have to be asked before any conclusions can be drawn regarding the quality of accommodation.

The quality of the food provided in all the facilities visited appeared very good. Although a choice in food was not always offered, there were no complaints about the choice or variety of the food provided. In some cases the canteen staff were very accommodating in providing whatever someone wanted to eat. However, there may be scope to improve the amount of choice of meals those in care have on a daily basis. There was some evidence those staying in care had low expectations and this may be why they were content with the limited choice of food. Providing a choice can help promote independence and also give individuals the opportunity to exercise some control over their routines, which can in turn help to avoid a deterioration in mental health (Regnier and Pynos, 1992, cited in Woods, 1999). Another issue about food which was raised by a minority in each type of facility was the timing of meals. It was felt that both the dinner and evening meals were given too early. In all facilities there did seem to be set times for meals. Whilst there may have been some flexibility in the timing of meals, this issue does warrant some attention. Mealtimes can be an important...
activity for people staying in care, particularly if they are unable to undertake any other activities. It is therefore important that attempts are made to make the timing of meals suitable to all. Having flexible daily routines has been emphasised by the UK Department of Health in its development of national standards for residential and nursing homes for older people (Department of Health, 1999).

Access to washing facilities seemed quite varied. Some commented that they could have a bath or a wash whenever they wanted, whereas others seemed more restricted to set days and times. It appeared that staff were not always able to assist in washing, perhaps due to busy workloads. Some relatives of those staying in District Hospitals were particularly concerned about this issue. Community Nursing Units appeared to have the best access to washing facilities, and flexibility as to when they could be availed of.

Woods (1999) has suggested that a good indicator of the quality of institutional care is the level of activity and interaction. The current study reported a wide range of activities both by those staying in facilities and their relatives. Some activities were organised by the facility (e.g. mass, craft classes, reminiscence therapy) whereas others were at the discretion of the individual (e.g. reading, watching television). Any organised activities were greatly appreciated. Most of those staying in care received visitors which was an important part of their day. The other key activities were attending Mass, seeing the priest (who frequently visited all facilities), walking, and attending the day room. Religion was very important to most staying in long term care facilities.

Although most were content with the level of activities there were some relatives of patients in Long Stay Hospitals and District Hospitals who thought that more activities could be organised. They felt that all their relative did during the day was sit down and do nothing. This issue was raised mostly in Long Stay Hospitals and for patients who were more dependent. In some cases it appeared that if a patient was not able to go to the day room without assistance, they could not take part in the organised activities which took place there (as staff did not have the time to assist them). A lack of daily activities has also been found in other studies of long stay facilities (Hegarty, 1999, Woods, 1999). Another issue about the daily activities that were listed by service users and their relatives is the lack of emphasis on physical exercise. Physical activity is important both for physical and mental health (Emery and Gatz, 1990, Centres for Disease Control and Prevention, 1996). Whilst long term care facilities might provide physical exercise, the lack of emphasis indicates there may be a need promote this activity.

It is important that long term care facilities ensure that all those staying there have the opportunity to become involved in daily activities. A range of activities suitable for differing levels of dependency should be offered. Any organised activities must be seen as being meaningful by residents and participation must be optional (Woods, 1999). This would help ensure that each patient’s quality of life is maximised. Staff levels should be sufficient to ensure that dependant patients can take part in daily activities if they want to.
Most of those interviewed liked being in care. In particular, the staff and quality of care, the company, the food, and the pleasant atmosphere were highlighted. For many it was apparent that being in care helped alleviate the loneliness of being at home. Nevertheless, home was still missed. Some hoped to return home when they got better, whereas others would prefer to stay in care, as they knew that they could not be looked after on their own at home.

Staying in a long term care facility can restrict the degree of independence someone has compared to their home where an individual can do whatever they want. Those staying in long term care facilities have to come to terms with the fact that they may not be able to do things themselves anymore (due to illness/frailty, and having to fit in with the ‘institutional regime’). Long term care facilities do aim to create a ‘homely’ environment as far as possible. For example, some have built rooms that aim to resemble a ‘typical’ living room. Whilst the home environment can never be recreated, any attempt to make facilities more homely and facilitate independent living is welcomed. Flexibility in relation to meal and bedtimes may also facilitate this by making the facility feel less like an ‘institution’ (with rules and regulations to follow).

In terms of the staff themselves, most were perceived to be very pleasant and helpful. Staff called everyone by their first name and most were willing to assist in whatever way they could. Most residents were very appreciative of the care received from staff. In District Hospitals however, a minority of staff were perceived to have an inappropriate attitude. One relative for example believed that ‘those in care were not treated as human beings, and that staff did not give them enough respect. Whilst only a minority, it is important that all staff aim to make an individual’s stay in care as pleasant as possible. Woods (1999) for example in discussing institutional care states that “...negative staff attitudes and practices negate the effects of the best physical environment (p201).” The only other negative issue regarding staff was that there was a perception that staffing levels may at times be inadequate which can affect the quality of the care given and impose limitations on the freedom enjoyed by the residents. As many of those in care are dependant, they may place additional demands on staff. This should be taken into consideration when staff levels are determined. In addition, staffing levels should be set to allow staff sufficient time to talk to those in care. This is particularly important for the emotional health of those who do not have visitors.
7. CONCLUSIONS AND RECOMMENDATIONS

The study has provided a useful insight into facilities for the long term care of the elderly within the Western Health Board. The key findings of the research can be summarised as follows:

1. Most service users were content to go into care and were content being in care.

2. Lack of privacy was not an issue for those interviewed.

3. Service users believed the quality of the food to be very good. Although content with the choice of food there did appear to be scope for improvement, particularly with regard to flexibility of mealtimes.

4. Access to washing facilities varied. Some had unrestricted access whereas others were restricted to set days and times.

5. Overall, a wide range of daily activities were offered, although some believed more activities could be organised, particularly for those who were less mobile.

6. The staff were perceived as being very pleasant and helpful. Some relatives and residents however were unhappy with the attitude of some staff.

Overall it can be concluded that Long Stay Hospitals, District Hospitals, and Community Nursing Units are perceived by those staying in them, in addition to their relatives as being very good. Nevertheless, a number of issues did emerge that would warrant further attention. The following recommendations are suggested to ensure that long stay care facilities provide the optimum quality of care in the future:

1. More daily activities should be organised, particularly for those staying in Long Stay Hospitals and District hospitals. Variety and choice should be provided as well as the opportunity to ‘opt out.’ The need to promote physical activity in particular should be examined.

2. Ensuring all patients have sufficient access to washing facilities

3. Adopting a more flexible approach to meal and bed times.

4. Ensuring staffing levels are sufficient to provide a high quality level of care. Protocols of ‘best practice’ should be adopted and adhered to.

5. Ensuring all staff treat patients with the dignity and respect they deserve.
6. Facilities should provide a client focused service as opposed to a service provider focused service.

7. The evaluation was only able to provide an overview of each of the three types of facilities visited. It could not provide results specific to individual facilities. In the future, it is recommended that individual facilities should evaluate their services and that this process is ongoing, so that performance can be monitored to ensure a high quality service is provided.
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The Interview Schedule
With Patients

A flexible framework for the interview and ideas for questions to generate conversation and discussion.

The sections consists of open-ended questions for each section (in bold) and detailed probe questions (normal indented). The detailed probe questions will only be used if conversation dries up or to guide the discussion if certain issues have not been mentioned.

Introduction
My name is Jackie Ni Mhuircheartaigh, I am conducting research on behalf of the Western Health Board. I want to know how you feel about being here (name of the institution). Is it a happy place, are you comfortable, what is it like to live here.

Confidentiality
I assure you that what you tell me is totally confidential and I will not be using your name in connection to anything you tell me.

Consent for taping
I would like to get your consent to tape record the discussion to ensure that I have a complete transcript of what you say. If you would like assess to the transcript at a later stage, please contact me. No statements will be connected to your name and only I will have access to the tape. There will be no way of tracing any comment to you and your name will not be mentioned in any report arising from this research.

Section 1 Pre-Service Context
Aim of the interview questions:
To explore reasons for deciding to go into care, to elicit the extent to which the client was involved in the decision to go into care and the choice of residential home.

Why did you decide to come into care
- Did you choose the residential home
- Did you visit this residential home before you decided to live here
- Where did you live before you came here
- Was that with your family
- How did you feel about it

Section 2 Actual Service Contact
Aim of the interview questions:
To explore and illustrate the reality of living, on a daily basis, in long-term care. To explore the social and psychological consequences of living in long-term care and to identify what kind of institutional regime exists in the residential home.
What is it like to live here?
• What do you miss since you came here. Is there anything that is better here for you than before you came
• How do you feel about living here.
• What do like about living here.
• What do you dislike about living here

Socio-environmental context
• Do you have visitors, how often
• Who comes to visit you
• Do they live near here
• Do you ever feel lonely
• Is it comfortable here
• How do you feel about your bedroom, do you share, if so do you talk to them (seeking are they compatible)
• Do you have enough privacy, to change, to pray, to be by yourself
• What about bathroom facilities, are they near, what if somebody is already there before you
• Can you have a bath or wash your hair when ever you want (if not how does this make you feel)
• Do you feel safer here than where you lived before

Spiritual
• Do you get to go to mass/church or does a priest visit you?

Independence v homogeneity
• Tell me about your day
• What do you do in the morning, in the afternoon
• Do you have any hobbies, if so can you do these here.
• Have you taken up any new hobbies since you came here
• Do you watch T.V, do you get the opportunity to watch your favourite programmes.
• Do you get a say in what you do everyday
• What time do you have breakfast, dinner, supper
• Do you have a choice in what you eat
• Do you go on any day trips, if so where have you gone
• What about getting your hair done, shopping for birthdays etc.
• Do you ever get frustrated about things
• How are you addressed by the staff, How do you feel about this
• How do you feel you fit in here
• Do you feel you are the same as everyone else
• Do you think that the staff see you this way
New family
- How do you feel about the people who look after you
- Do you have a favourite member of staff, what do you like about him/her
- If you had a choice in the morning would you like to stay here
- Is there somewhere else you would like to be

Section 3  Future Service Development
Aim of the interview question
To identify unmet needs of the resident.

If you were in charge here would you like to make any changes?
- What would you change

Ending
Thank the interviewee for their time and explain that the results will be very useful.
Reiterate confidentiality and take details of participants who want a transcript or further information about the results of the study.

Probes for use During the Interview
1. The silent probe
2. The ‘Go on I’m listening’ probe
3. The journalists probe e.g. Who? What? When? Where?
4. The immediate elaboration probe
e.g. Can you tell me a bit more about that
   What happened after that
   What do you think/feel about that
   Why is that? Why do you think that is
5. The retrospective probe
e.g. Can I take you back to something you said earlier
   You said ‘...............’, could I ask you a bit more about that?
The Interview Schedule
With Relatives
(Long Stay Hospitals and Community Nursing Units)

A flexible framework for the interview and ideas for questions to generate conversation and discussion.

The sections consists of open-ended questions for each section (in bold) and detailed probe questions (normal indented). The detailed probe questions will only be used if conversation dries up or to guide the discussion if certain issues have not been mentioned.

Introduction
My name is Jackie Ni Mhuircheartaigh, I am conducting research on behalf of the Western Health Board. I want to know how your relative feels about being here (name of the institution). Is it a happy place, is he/she comfortable, what is it like to live here.

Confidentiality
I assure you that what you tell me is totally confidential and I will not be using your or your relatives name in connection to anything you tell me.

Consent for taping
I would like to get your consent to tape record the discussion to ensure that I have a complete transcript of what you say. If you would like assess to the transcript at a later stage, please contact me. No statements will be connected to your name and only I will have assess to the tape. There will be no way of tracing any comment to you and your name or your relatives name will not be mentioned in any report arising from this research.

Section 1 Pre-Service Context
Aim of the interview questions:
To explore reasons for deciding to go into care, to elicit the extent to which the client was involved in the decision to go into care and the choice of residential home.

Why did he/she decide to come into care
- Did he/she choose the residential home
- Did he/she visit this residential home before he/she decided to live here
- Where did he/she live before he/she came here
- Was that with his/her family
- How did he/she feel about it

Section 2 Actual Service Contact
Aim of the interview questions:
To explore and illustrate the reality of living, on a daily basis, in long-term care. To explore the social and psychological consequences of living in long-term care and to identify what kind of institutional regime exists in the residential home.
Why did he/she decide to go into care
• What does he/she miss since he/she came here. Is there anything that is better here for him/her than before he/she came
• How does he/she feel about living here.
• What does he/she like about living here.
• What does he/she dislike about living here

Socio-environmental context
• Does he/she have visitors, how often
• Who comes to visit him/her
• Do they live near here
• Does he/she ever feel lonely
• Does he/she think it’s comfortable here
• How does he/she feel about his/her bedroom, does he/she share, if so does he/she talk to the other(s) (seeking are they compatible)
• Does he/she they have enough privacy, to change, to pray, to be by themselves
• What about bathroom facilities, are they near, what if somebody is already there before him/her
• Can he/she have a bath or wash his/her hair when ever he/she wants (if not how does this make him/her feel)
• Does he/she feel safer here than where he/she lived before

Spiritual
• Does he/she get to go to mass/ church or does a priest visit him/her?

Independence v homogeneity
• Tell me about his/her day
• What does he/she do in the morning, in the afternoon
• Does he/she have any hobbies, if so can he/she do these here.
• Has he/she taken up any new hobbies since he/she came here
• Does he/she watch T.V, does he/she get the opportunity to watch his/her favourite programmes.
• Does he/she get a say in what he/she does everyday
• What time does he/she have breakfast, dinner, supper
• Does he/she have a choice in what he/she eats
• Does he/she go on any day trips, if so where has he/she gone
• What about getting his/her hair done, shopping for birthdays etc.
• Does he/she ever get frustrated about things
• How is he/she addressed by the staff, How does he/she feel about this
• How does he/she feel he/she fits in here
• Does he/she feel he/she is the same as everyone else
• Do you think that the staff sees him/her this way

New family
• How does he/she feel about the people who look after you
• Does he/she have a favourite member of staff, what does he/she like about him/her
• If he/she had a choice in the morning would he/she like to stay here
• Is there somewhere else he/she would like to be
Section 3 Future Service Development

Aim of the interview question
To identify unmet needs of the resident.

If he/she were in charge here would he/she like to make any changes?
• What would he/she change

Ending
Thank the interviewee for their time and explain that the results will be very useful.
Reiterate confidentiality and take details of participants who want a transcript or further information about the results of the study.

Probes for use During the Interview
1. The silent probe
2. The ‘Go on I’m listening’ probe
3. The journalists probe e.g. Who? What? When? Where?
4. The immediate elaboration probe
   e.g. Can you tell me a bit more about that
   What happened after that
   What do you think/feel about that
   Why is that? Why do you think that is
5. The retrospective probe
   e.g. Can I take you back to something you said earlier
   You said ‘...............’, could I ask you a bit more about that?
The Interview Schedule
With Relatives
(District Hospitals)

A flexible framework for the interview and ideas for questions to generate conversation and discussion.

The sections consists of open-ended questions for each section (in bold) and detailed probe questions (normal indented). The detailed probe questions will only be used if conversation dries up or to guide the discussion if certain issues have not been mentioned.

Introduction
My name is Jackie Ni Mhuircheartaigh, I am conducting research on behalf of the Western Health Board. I want to know how your relative feels about being here (name of the institution). Is it a happy place, is he/she comfortable, what is it like to live here.

Confidentiality
I assure you that what you tell me is totally confidential and I will not be using your or your relatives name in connection to anything you tell me.

Consent for taping
I would like to get your consent to tape record the discussion to ensure that I have a complete transcript of what you say. If you would like assess to the transcript at a later stage, please contact me. No statements will be connected to your name and only I will have assess to the tape. There will be no way of tracing any comment to you and your name or your relatives name will not be mentioned in any report arising from this research.

Section 1 Pre-Service Context
Aim of the interview questions:
To explore how the relative felt about going into short-term:

How did he/she feel about going into short-term care
• Has he/she been here before
• How long does he/she think they will be here

Section 2 Actual Service Contact
Aim of the interview questions:
To explore and illustrate the reality of staying in short-term care. To explore the social and psychological consequences of staying in short-term care and to identify what kind of institutional regime exists in the hospital.
How did he/she feel about coming here
• What does he/she miss since he/she came here. Is there anything that is better here for him/her than before he/she came
• How does he/she feel about staying here.
• What does he/she like about staying here.
• What does he/she dislike about staying here

Socio-environmental context
• Does he/she have visitors, how often
• Who comes to visit him/her
• Do they live near here
• Does he/she ever feel lonely
• Does he/she think it’s comfortable here
• How does he/she feel about his/her bedroom, does he/she share, if so does he/she talk to the other(s) (seeking are they compatible)
• Does he/she think that he/she has enough privacy, to change, to pray, to be by themselves
• What about bathroom facilities, are they near, what if somebody is already there before him/her
• Can he/she have a bath or wash his/her hair when ever he/she wants (if not how does this make him/her feel)
• Does he/she feel safer here than where he/she lives

Spiritual
• Does he/she get to go to mass/ church or does a priest visit him/her?

Independence v homogeneity
• Tell me about his/her day
• What does he/she do in the morning, in the afternoon
• Does he/she have any hobbies, if so can he/she do these here.
• Has he/she taken up any new hobbies since he/she came here
• Does he/she watch T.V, does he/she get the opportunity to watch his/her favourite programmes.
• Does he/she get a say in what he/she does everyday
• What time does he/she have breakfast, dinner, supper
• Does he/she have a choice in what he/she eats
• Does he/she ever get frustrated about things
• How is he/she addressed by the staff, How does he/she feel about this
• How does he/she feel he/she fits in here
• Does he/she feel he/she is the same as everyone else
• Do you think that the staff sees him/her this way
New family
• How does he/she feel about the people who look after you
• Does he/she have a favourite member of staff, what does he/she like about him/her
• If he/she had a choice in the morning would he/she like to stay here
• Is there somewhere else he/she would like to be

Section 3 Future Service Development
Aim of the interview question
To identify unmet needs of the resident.

If he/she were in charge here would he/she like to make any changes?
• What would he/she change

Ending
Thank the interviewee for their time and explain that the results will be very useful.
Reiterate confidentiality and take details of participants who want a transcript or further information about the results of the study.

Probes for use During the Interview
1. The silent probe
2. The ‘Go on I’m listening’ probe
3. The journalists probe e.g. Who? What? When? Where?
4. The immediate elaboration probe
e.g. Can you tell me a bit more about that
What happened after that
What do you think/feel about that
Why is that? Why do you think that is
5. The retrospective probe
e.g. Can I take you back to something you said earlier
You said ‘.................’, could I ask you a bit more about that?