

LONG TERM CARE PLACEMENT: THE FEMALE RESIDENT'S PERSPECTIVE

by

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## ABSTRACT

Title of Thesis: LONG TERM CARE PLACEMENT: THE  
FEMALES RESIDENT'S PERSPECTIVE

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The purpose of this study was to explore the "lived" experience of the female resident in a long-term care facility. A qualitative phenomenological approach was utilized.

Data were collected from nine female residents living in Wicomico Nursing Home. Unstructured taped interviews were conducted. Transcription of the data followed the interviews and resulted in coding of participant statements into groups of similar content. Four categories evolved containing sixteen total codes. Validation of the code and category analysis was achieved through follow up interviews with three of the participants.

The four categories that arose were as follows: beginning the experience, activity involvement, home versus alternative, and relationships. Viewing the nursing home as "home" was the predominant feeling in this study. It

was noted that all of the categories and corresponding codes contributed to this feeling of "home".

The female resident's perspective on long-term care placement is of significance as there is currently minimal data available on this subject. Further research that expands upon the findings in this study is needed to increase the knowledge base of the "lived" experience of the female resident in a long-term care facility.

## DEDICATION

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## TABLE OF CONTENTS

Dedication . . . . .	ii
Table of Contents. . . . .	iii
List of Tables . . . . .	iv
Chapter I: Introduction . . . . .	1
Chapter II: Review of Literature . . . . .	8
The Caregiver's Perspective . . . . .	9
Quality of Care . . . . .	10
Continuity of Care. . . . .	14
The Resident's Perspective. . . . .	15
Research Questions. . . . .	22
Assumptions . . . . .	23
Conclusion. . . . .	23
Chapter III: Methodology. . . . .	24
Identifying the Phenomenon. . . . .	24
Universe of Content . . . . .	25
Sampling. . . . .	25
Recording . . . . .	28
Codes and Categories. . . . .	28
Confirmation. . . . .	29
Chapter IV: Results. . . . .	30
Demographics of the Participants. . . . .	30
Codes and Categories. . . . .	32
Category 1. Beginning the Experience . . . . .	32
Category 2. Activity Involvement . . . . .	38
Category 3. Home versus Alternative. . . . .	40
Category 4. Relationships. . . . .	43
Confirmation. . . . .	45
Conclusion. . . . .	46
Chapter V: Discussion . . . . .	48
Meaning of findings in relation to Research Question. . . . .	48
Significance. . . . .	53
Limitations . . . . .	54
Implications for Nursing. . . . .	55
Future research . . . . .	59
Conclusion. . . . .	60
References . . . . .	61
APPENDIX A- Interview Guide Questions . . . . .	65
APPENDIX B- Description and Disclosure Form . . . . .	66

## LIST OF TABLES

1.	Demographic Information	31
2.	Categories with Codes and corresponding Number of participants reflected in each Code	33

## CHAPTER I

### Introduction

The population in the United States is aging. It is predicted that the 65 and over age group in the United States will increase from 13 percent in 1996 to 20 percent by 2030 (Friedman & Pollack, 1996). As people live longer and become more impaired, there is an increased risk of chronic ailments (Pearlin, Mullan, Semple, & Skaff, 1990). Long Term Care (LTC) placement is frequently an alternative as people get older and experience chronic impairments.

Long Term Care placement is one of several options available to an elderly person needing an alternate lifestyle. (Elderly, for purposes of this paper refers to an individual 65 or older). There are retirement villages, assistant living facilities, domiciliary care facilities, foster care homes, subacute care facilities, and nursing homes to name a few. Retirement villages, assistant living facilities, domiciliary care, and foster care homes are frequently utilized by those persons who need little or no help in their activities of daily living (ADLs). Activities of daily living include bathing, dressing, toileting, ambulation, and eating. Residents of these facilities may need help with medication administration or may need assistance with transportation. Subacute care facilities frequently cater to individuals with an acute medical condition needing constant medical and nursing care in

addition to assistance in several ADLs, i.e. dressing, bathing, toileting, and bathing. The subacute care facility is typically used for short-term therapy during the acute crisis.

The nursing home (long term care) is frequently used for a person who cannot live independently and whose health care problems are more chronic in nature. The resident of a nursing home is frequently in need of extended care, therefore, placement in a nursing home may be considered for a long term. These residents find themselves unable to provide care for their medical needs and ADLs in their usual living environment and either has no relatives able to care for them, or, is not eligible, medically or financially, for an assistant living situation. These persons may find their new LTC environment as a place they will reside for the remainder of their life.

Literature on the resident's perspective of this change of living environment is very limited. The decision for LTC placement can be a very emotional experience for both the family and the person being placed. Johnson (1990) found that frequently the initial decision for placement was made by others, often the doctor in the hospital or social workers. Johnson & Werner (1982) found that 80% of those in LTC moved from the hospital with little or no opportunity to seek an alternative. Brody, Dempsey, & Pruchno (1990) and Johnson (1990) found that placement of a parent in a nursing

home was the last resort after other alternatives were not successful.

A considerable body of research can be found on the caregivers perspective of LTC placement. Several studies noted caregivers felt less overwhelmed, tired and pressured, and had more time for social activities after placement of their family member in a LTC facility (King, Collins, Given, & Vredevoogd, 1991; Stephens, Kinney, & Ogrochi, 1991). Smith & Bengston (1979) support this by stating:

For a large number of families, institutionalization (nursing home placement) of the elderly parent resulted in a strengthening of family ties to a renewed closeness between parent and child. A major reason...was the alleviation of strain and pressure caused by the multiple physical and/or mental problems of the parent.

(p.446)

King et al. (1991) found those caregivers who institutionalized their relative exhibited a higher state of well-being than those who provided care at home. The role of the caregiver shifted from the day to day stressors of ADLs to a concern if staff within the facility were treating their family members properly (King et al., 1991; Zarit & Whitlatch, 1992). Kammer (1994) found that if there was not a mutual decision for placement made between the resident and caregiver then the caregiver's feelings of guilt

increased. Brody et al. (1990) found that distress was found prior to admission to a LTC facility as a result of help needed with ADLs. Pearlin et al. (1990) found that caregiver stress was related to a mix of circumstances, experiences, responses, and resources that varied considerably among caregivers. Any change in one of these areas could change another area. Depending on how these areas affected ones' life and the caregivers' perception could help to determine coping strategies in the caregiver role.

There were contradictory findings regarding the difference gender of the caregiver made on the caregiver's perspective to LTC placement. Kammer (1994) found that gender did not contribute to a difference in stress levels for the caregiver pre or post admission of the family member. Johnson (1990) found in her study that all daughters expressed ambivalence about placement of a parent in a nursing home setting. None of them expressed pleasure. Brody et al. (1990) further validated an existence of a gender difference by finding that daughters were more depressed than sons, had more negative emotional effects related to the parents living situation, and reported more health problems of their own. "That daughters experience higher absolute levels of parent care strain is unquestionable" (Brody et al., p. 218).

Documented research on the resident's perspective of

LTC placement is limited. Carboni (1990), in a qualitative field study, found that the elderly person entering the nursing home becomes homeless. She found that residents felt disconnected and reported a sense of placelessness, where the resident is a stranger in an unfamiliar place with little comforts. The residents felt what little space was theirs was open to intrusion at anytime. They felt powerless and dependent because the institution made the rules. Their life lacked meaning and distrust for the people around them was high. If the resident's home was sold and possessions dispersed, the resident felt finality and little, if any, hope. Carboni stated:

The elderly individual wandering the streets is easily identified as homeless, yet there is an entire population of elders who suffer silently, enduring the painful state of homelessness within the confines of the total institution of the nursing home. (p. 37).

Rossi & Wright (1987) describe homelessness as a manifestation of extreme poverty occurring among disabled and isolated people. They noted there is widespread disagreement on how to define homelessness in the less extreme cases (extreme case meaning a person living on the street with no resources). Homeless means to be without residence, lack food, clothing, medical services, and social support (Doolin, 1986). Homelessness is to lack customary

and regular access to a conventional dwelling unit (Rossi & Wright, 1987). Basuk, Rubin, & Lauriat (1984) concluded "...that the hallmark of homelessness is extreme disaffiliation and disconnection from supportive relationships and traditional systems that are designed to help" (p. 1549).

The purpose of this study was to investigate the experience of residing in a nursing home from the perspective of the female resident. This study attempted to bring about a greater understanding of the female residents' perspective regarding LTC placement and add to the body of knowledge that is limited but needed.

Increased knowledge of the female resident's perspective on LTC placement can be of great value to the clinician. The nurse is often the first person to greet the resident on admission to the LTC facility. Nursing staff interact with the resident more than any other discipline in the facility, thereby becoming intimately acquainted with the resident. Upon admission, the nurse orients the resident to the facility explaining meal schedules, activities, and bathing/showering schedules. The nurse obtains information regarding the resident's usual daily routine. The nurse can elicit information from the resident and begin to gain insight into their expectations of and reactions to placement in a LTC facility. This information can assist in making the admission process more palatable,

offering support to the resident and families where needed.

It can also offer insight into the resident's behavior and the adjustment process. Information gained from acknowledging and recognizing the alert and oriented resident's perspective may help nursing staff to better assist the residents who are cognitively impaired, offering insight as to how the resident feels and how nurses can help the resident with an easier adjustment. Information obtained from this study can assist the nurse in creating a more inviting environment for the resident needing LTC placement.

CHAPTER II  
Review of Literature

Cefalu (1995) stated:

In the United States, there are approximately 20,000 nursing homes and 1.5 to 2 million nursing home beds. At any given time, about 5% of the population age 65 and older lives in a nursing home, but the likelihood of institutionalization may be as high as 20 to 50%. (p. 37)

He further identified two types of nursing home populations; (1) those who stay 1-6 months and (2) those needing 6 months or longer. This study examined responses from the second group.

A review of the literature will be approached from two perspectives, the caregiver's and the residents. The first perspective will review the caregiver feelings regarding placement of their family in a LTC facility and the impact the institution has on their role after placement. The resident's perspective will introduce the concept of continuity of care with "aging in place". Phases of adjustment when living in a nursing home will be reviewed, as well as literature on the resident's perspective of LTC placement.

### The Caregiver's Perspective

Placement of an elder in a LTC setting provides stress for both the caregiver and the elder. A considerable amount of literature can be found on the caregiver perspective of LTC placement. King et al. (1991) studied 35 family caregivers utilizing in-home or phone interviews to elicit information on caregivers well-being following family institutionalization. Participation in this study was voluntary and required obtaining information at three points during a one year period. Caregiver well-being post-institutionalization was measured at a range of 4 to 29 weeks after resident admission. There were 6 men and 29 women caregivers. Thirteen of the caregivers were spouses, 13 were adult children, and 9 were other relatives. Neither socioeconomic status nor ethnic origin of the caregivers was identified, nor was it identified if placement was temporary or permanent. King et al. (1991) found that spouses reported an increase in stress related to their own health and finances after placement of a family member, while other adult caregivers reported a decrease in stress in these areas. However, the authors did find all caregivers reported a decrease in the burden of schedule demands following institutional placement of their relative.

Stevens et al. (1991) also found caregivers experienced relief in their social lives and schedule demands after admission of their institutionalized family member. Sharing

responsibility of care with nursing staff in the institution may free up caregiver's time and energy for other pursuits and reduce tension and conflict in the family. Findings from this study suggested caregivers, who maintain close contact with institutionalized family members, tend to experience events in caregiving (ADL and resident behavior changes) as more stressful than do noninstitutionalized family members. Respondents in this study included 120 family caregivers of older adults with Alzheimer's. One-half of the respondents cared for a family member in-home and the other half cared for a family member who had been placed in a nursing home. Nursing home caregivers were defined as those who visited care recipients at least once a week, and were responsible for providing direct aid or coordinating services for their relative. Placement had to have occurred within the previous 5 years (average stay was 2 years). The 60 nursing home caregivers consisted of 80% females, 97% were white, and 36% were spouses. Results of this study cannot be generalized to all caregivers due to the high percentage of white respondents and residents having only a diagnosis of Alzheimer's.

#### Quality of Care

The institutions themselves can have an impact on the caregiver's role after admission. A large proportion of families in one study, 83%, wanted to become involved and knowledgeable in regard to their relatives' care (York &

Calsyn, 1977). This study looked at the quantity and quality of resident-family interactions before and after placement in a LTC facility. A random sample of 76 residents and their families at three Michigan nursing homes were interviewed. The families lived within a 25-mile radius of the nursing home and the specific family member was defined as the person identified as "person to contact in an emergency". Sixty-four of the interviewees were adult children of the nursing home residents, while the other 12 were spread among spouses, nieces/nephews, and brothers/sisters. Eighty percent of the residents were females with a mean age of 81. The mean length of stay in the nursing home was three years. A 45 to 60 minute instrument of open and closed-ended questions was used to obtain data. The mean number of family visits per month was 12 and family involvement with the resident prior to placement was related to the number of visits after placement. The research indicated families expressed frustration, resentment, and guilt concerning visits as a result of the families' lack of knowledge concerning the resident's situation. No information on socioeconomic status or ethnic origin was available.

Hook, Sobal, & Oak (1982) found policies of the facility encouraging visitors to share indirect care increased meaningfulness and satisfaction of the caregivers' visit. A standardized questionnaire was administered to all

visitors on three consecutive October Sundays in 1980 in this study. Virtually all residents and visitors in the three nursing homes studied were white and came from rural areas. A total of 629 original visitors were surveyed in these central Pennsylvania nursing homes. Questions included frequency of visits, recency of last visit, number of miles traveled to visit, and relationship to the resident. Predominantly, the visitors were female children of the resident. Average length of stay for the resident was five years and average age of the resident was 80 years.

Flexible visiting hours was found to be needed by facilities to accommodate visitors schedules. It was noted in this study that a greater frequency of visitation correlated with shorter distances traveled by visitor, close kinship between visitor and resident and shorter length of residence in the nursing home. The researchers identified limitations of this study being a focus on a rural white sample and visits occurring on Sunday only. Limited representation was noted of nonwhites and other minorities. Quality of visitation was not fully explored.

Bowers (1988) found that families perceived good quality care by the staff dependent on the family's participation and input in the resident's care. Families held themselves responsible for monitoring and evaluating the effectiveness and quality of care and providing nontechnical tasks to the resident, i.e, letter writing,

reading cards, painting fingernails (Bowers, 1988; Shuttlesworth, 1982). The families assigned the responsibility to the nursing home for major tasks such as bathing, toileting, and medication administration (Shuttlesworth, 1982). Families also expected staff to provide care that was not insulting, demeaning, or upsetting (Bowers, 1988).

Bowers (1988) study interviewed 28 relatives of residents. Thirty-two percent of the respondents were daughters and 71% of the total respondents were female. All lived within 50 miles of the facility and visited from daily to once a week. Data were collected from a 130-bed nursing home in urban Wisconsin and staffing was consistent with other facilities in the area. Seventy-eight percent of the interviews were done in the respondent's home.

Shuttlesworth's (1982) study utilized open ended questionnaire forms in 1979 and 1980 by Administrator-in-Training students at the University of Texas. These forms were administered to a convenience sample consisting of administrators, relatives, and friends at the nursing homes where the students were training. The nursing homes were not identified in the study. Demographics of the respondents were not available. The researchers of this study recognized two limitations for generalizability. The nonprobability sample and uncertainty of representativeness

of the facilities, administrators, and relatives and concerns over validity of the inventory tool utilized.

### Continuity of Care

Managers of elderly housing have seen an increase in responsibilities as the resident reaches advanced age and experiences multiple chronic health problems. Elderly tenants who are "aging in place" need more supportive services (MacDonald, Remus, & Laing, 1994). Interest in multilevel accommodation for seniors requiring help in two or more levels of care has grown. A multilevel accommodation may include self-contained suites, intermediate, and skilled care areas that are provided in one building or several buildings on site. These multilevel accommodations reduce the stress of relocation as well as provide several advantages: ability to remain in close contact with family/friends, having appropriate nursing care available with fluctuations in health needs and in rural locations and economic advantage with all health resources at one site (Gutman, 1978).

The ability to age in place was a prime concern of all participants in a study by MacDonald et al. (1994). This qualitative research study utilized a stratified random sample of 29 respondents from rental and life-lease tenants of one housing facility in an urban Canada area. An open-ended, semistructured interview was used and results were validated with seniors in four other enriched house

settings. The tenants were predominantly of Mennonite-German background. Mean age of the respondents was 78 and 65% were female. They identified three themes prevalent to the elderly tenants; (1) importance of maintaining independence, (2) desire for continuity of care, and (3) preference for model of housing accommodation. All the participants of this study agreed adding a nursing home was the solution to providing continuous care for inhabitants with declining health and frailty. Generalizability of this study is limited due to the predominant Mennonite-German background of the participants.

#### The Resident's Perspective

A review of the literature revealed that there is a scarcity of research devoted to the resident's perspective on LTC placement. An article by Solomon & Peterson (1994) stated that for older (65 and above) individuals maintaining quality of life was very important to them. This maintenance included coping with physical and emotional stresses of aging, exerting some control over one's life, staying connected to family and friends, and seeing one's life as meaningful.

Activity and self-reliance were important strategies for residents living in a nursing home (Daly, 1993). This qualitative research study utilized 6 women, age 77-98, in a 96-bed nursing home. The participants had been residents for a minimum of eight months. All participants were

functionally impaired and required much assistance in ADLs, all were mobile with either a walker or wheelchair. The atmosphere of the nursing home was considered "friendly". Each participant was interviewed three times in a six-month period and was asked to describe her life in the nursing home.

Daly (1993) identified ten strategies used by these women for living in a nursing home. Assertiveness was identified by "I speak my piece when I have to speak. I let people know how I feel about things". Following a routine, whether decided by the nursing assistant or resident, was the second strategy. Self-reliance was noted in that each woman used her full potential for activity. Such statements as "There's no place I can't go with my walker" and "I like to be able to do what I have to do myself" were identified in this strategy. Keeping active involved watching T.V., reading, and going to activities. Keeping mentally alert was important to these women, each had a calendar and referred to this. Sociability was the sixth strategy. This involved being social and interacting with others. This would include sitting in the hall a lot, sitting near the entrance, and visiting other residents and staff. Family interaction was important as all participants had families who were geographically and socially close. This interaction was reciprocal in nature according to the resident's abilities. Visits were regular and telephone

conversations contributed to a feeling of connectedness. Positive perspective was the eighth strategy found in this study. All residents were realistic about living in a nursing home, but looked at the move from a positive perspective. One participant stated, "Of course I'm glad to be here and get the care I need and all, but there's no place like home". Acceptance was identified by the residents deciding to make the best of the situation, even though they would have preferred to be living in their own homes. The last strategy was determination. This was manifested in the participant's resilience and toughness once they made a decision.

As noted, this study dealt with all women who were cognitively aware and were assertive. This study did not address the participants as being submissive in nature and all the respondents could self motivate in the facility.

Brooke (1989) in a sample of 11 men and 31 women, age's 65-98 years old, identified four phases of adjustment that residents encounter in living in a nursing home. This study included participants admitted for an indefinite period of time to a 155-bed nursing home. Sixty-six percent of the respondents were moderately to severely cognitively impaired and 70% were dependent in 2 or more ADLs. Two to five times a week the researcher asked each resident such questions as "What is it like to live here? How has your week (day)

been?" Study participants and nursing home staff verified findings.

The first phase, disorganization, lasting 6 to 8 weeks, was characterized by feelings of displacement, vulnerability, and abandonment. Death wishes were common in this phase as well as statements such as "I don't belong here, it's a mistake." The challenge of this phase for the resident was dealing with losses as a result of institutionalization or aggravated by institutionalization. The losses could include death of a loved one, loss of another patient or mental abilities, and loss of cognitive ability (the most threatening). The loss of possessions or a home was also painful.

Phase 2, reorganization, occurred during the second or third month. The resident in this phase tried to find meaning in the experience of living in a nursing home. This involved problem solving, identifying preferred care and directing others in that care, and resolving or justifying why they live in a nursing home. During this phase residents asked more questions, complained of limited space, explained their needs to new staff, and identified health care problems.

Relationship building began around the third month and was the hallmark of the third phase. This was characterized by family relationships and engaging in conflicts with other residents and staff. The resident often preferred one staff

member over another or one resident over another and experienced a sense of loss when staff or other residents left. Residents with cognitive disorganization tended to be more sensitive to changes during this phase. Residents needed to establish/maintain links to family/friends, staff, and other residents during this phase.

The last phase, stabilization, occurred within 3-6 months of admission. Residents established working relationships with staff, developed personal ties, and settled in. The residents noticed things, i.e. changes in staff, and new resident admissions. The residents were more outgoing and secure in this phase.

Brooke (1989) found that usually a resident works through the feelings of initial alienation and becomes a member of the nursing home community. When the phases have been successfully worked through and a resident has stabilized, they may ask to go "home" to the nursing home when on a family outing. Within eight months, 93% of the residents had stabilized and called the facility "home". This study considered and elicited responses from those cognitively impaired as well as alert. The researcher, in this study, identified a limitation in labeling phases in that they may be taken as real points that all residents go through.

Carboni (1990) took a different approach than Brookes (1989) regarding the institution becoming "home". She

suggested that the nursing home in no way represented "home" to the institutionalized person. In her study the nursing home resident-faced non-personhood in that informants her felt their identity was murky and feelings of uprootedness and non-belonging was prevalent. A finality was felt by the residents upon placement in the nursing home, in all that was left was to die. A feeling of connectedness was lost or severely limited by spouses dying, children being unavailable and of familiar places or possessions being inaccessible. Carboni stated:

Because of the multiplicity of losses the elderly suffer and the consequent impairment or severance of their relationship with the environment, and because of the nature of the nursing home itself, it is suggested that the elderly individual who is institutionalized is located on the homelessness end of the continuum.

(p. 33)

Homelessness, in Carboni's (1990) study, represented non-personhood, disconnectedness, no journey, no boundaries, powerlessness/dependence, insecurity/uncertainty, and meaningless space. Carboni (1990) identified a core coping strategy of "pretending", which was used to avoid the pain of homelessness. "Pretending" included living in the past, keeping the secret, distancing, and surrendering. She feels a resident pretends effectively when they had convinced

themselves and others that they (the resident) have accepted nursing home placement or have at least adjusted to institutionalization.

This qualitative study involved two residents in a 120 bed skilled nursing facility in a large Connecticut city. These residents were permanently institutionalized. Data were collected by participant observation and unstructured interviews. Questions by the researcher included: Did either or both of the informants feel homeless? and Did "home" have a significant meaning for each of them and if so, what was it? There was no demographic data available for the two participants in regard to sex, age, or length of stay in the facility. No mention was made of how the respondents were chosen.

Other authors have different definitions of the concept of homelessness. Doolin (1986) defined the homeless older person as one who had these living conditions: lack of heat and protection from elements, lack of sleeping accommodations, and lack of resources for preventative medicine. He felt the homeless in the United States comprised three subgroups: the chronic or traditional homeless, the deinstitutionalized, and the "Dishoused" or temporary homeless. Doolin (1986) felt that most homeless elders fell in the first category. This writer presented a paper based on a Senior House program in Dorchester, Massachusetts for homeless older persons. This senior house

was the elderly nutrition project for one-third of the city of Boston. This program covered all of Boston's older ethnic inner-city neighborhoods having a total elderly population of 42,000. No information was provided on actual ages, number of participants, or socioeconomic history.

Bassuk, Rubin, & Lauriat (1984) studied 78 homeless men, women, and children in an emergency shelter. Ninety-one percent had some kind of psychological illness. The median age for this study was 33.8 years with 83% males and 17% females. Seventy-seven percent were white, 22% black and 1% Hispanic. The researcher recognizes these findings were based on a younger population but wanted to provide another viewpoint on the definition of homeless. Homeless people were recognized by Bassuk et al. (1984) as having limited, if any, appropriate medical treatment, humane living conditions, and psychosocial services.

Clearly, by this review, a resident in a nursing home may have a perception of being homeless or may consider the LTC facility as home.

#### Research Questions

The research questions for this study were: How do those who have resided in a LTC facility for a 1-4 year period describe their experiences? Does living in a nursing home feel like home to them? What is the basis for this answer?

### Assumptions

Several assumptions are made, for the purpose of this study. One, that the alert and oriented resident will have an opinion about their experience in the LTC facility and the resident will also be able to communicate their experiences about moving into and living in a nursing home.

### Conclusion

It is evident by the limited research on the resident's perspective on LTC placement that further research is needed. It is recognized that residents will experience adjustment periods, but their actual perspective on LTC placement will offer a rich source of material for further study.

## CHAPTER III

### Methodology

This study was a qualitative, phenomenological study looking at the lived experience from the perspective of the elderly female residing in a Long Term Care (LTC) facility. "Phenomenology is an approach to human inquiry that emphasizes the complexity of human experience and the need to study that experience holistically as it is actually lived" (Polit & Hungler, 1995, 649). The focus of this study was to understand how the female resident felt about LTC placement and living in a nursing home. Qualitative methods for collecting data were utilized such as participant observation, interview, and retrospective on description.

The following opening statement was used for all interviews: "Tell me how you feel about living in a nursing home?" Further questions were dependent on the participant's responses. A sample of guide questions were available to facilitate the interview process (see Appendix A). This approach allowed the researcher to gain knowledge of the participant's experience of life in a LTC facility from their perspective.

#### Identifying the Phenomenon

The phenomenon for this research method is the "lived"

experience of LTC placement and life in the nursing home for the female resident.

#### Universe of Content

The phenomenon investigated utilized participants in a rural Mid-Atlantic, 82-bed nursing home. The residents in this facility were no longer able to independently care for themselves at home and required assistance in their activities of daily living (ADLs). These residents required supervisory care 24 hours a day by a licensed practical nurse or higher. The facility was a non-profit organization owned by the county and built to provide access to 24 hour nursing care for all elderly citizens in the community. The interviews were held in the participants' naturalistic setting. The term "naturalistic" referred to the participants' actual living environment. Data were collected at a time arranged with the participant.

#### Sampling

The sample consisted of nine alert and oriented female participants (residents) living in the skilled nursing facility. The terms "participant" and "resident" were used interchangeably in this study. The sample was drawn from a non-profit organization representative of all socioeconomic levels. Every effort was made to obtain equal representation from socioeconomic background and ethnic origin.

A list of alert and oriented residents residing in

the facility was obtained from nursing administration. An alert and oriented resident one who was cognitively aware of their surroundings and feelings. The list of residents was picked by the Director of Social Services who was involved in the admission process and performs the initial assessment to determine the resident's cognitive status. Residents were deleted who had a diagnosis of Alzheimers or confusion was noted and addressed in either the history and physical or monthly progress notes. Cognitive status was based on several criteria. If at all possible, a home visit was performed to observe the resident in their usual living environment. Demographic questions were used to determine initial cognitive status such as name, age, birth year, current date, and current year. Other questions directed to the potential resident included history of illness, medication regimen, and usual pattern of ADLs. Observation was made of the potential resident and family members, including verbal and nonverbal communication patterns.

The initial sample population included eleven participants, however, data reduction techniques were utilized. Two participants were eliminated because the answers to demographic questions about race and presence of roommates were contradicted by the facts. Participants providing data that did not match reality at this stage were assumed to elicit data that would not provide an accurate "lived" experience. A pilot study was performed with one

participant to determine the effectiveness of the opening question. Meaningful data were collected in that interview and were included in the data analysis.

Participants were required to have been residing in the facility for at least one-year and not longer than four years. The researcher's experience has noted that people who have resided in a LTC facility for less than one year still have transition adjustments. This study was not intended to focus on the phases of transition to a LTC facility. The resident may still be in shock over the admission and has not yet totally settled in. Participants residing in the facility over four years may have settled in and consider the LTC facility as "home", forgetting the initial transition and placement period. One to four years also provided a greater sample from which to draw. The proposed range for length of stay provided a more accurate picture of the resident's perspective of the LTC placement process.

Demographic information (see Appendix A) obtained included length of stay in the facility, age, race, and marital status. Other areas of investigation included the following: participant's involvement in the decision making process for admission, whether the decision was made suddenly or over time, number, frequency, and type of visitors from others outside of the facility and the quality of those visits, presence of roommate, geographic

displacement, that is, moved to get closer to family, and presence of furnishings from home.

The researcher read the description and disclosure forms (see Appendix B) to each participant. Hearing impaired residents were given a copy to read. The researcher stressed participation in the study was confidential and voluntary and would in no way affect their care.

### Recording

The data were collected via unstructured interviews. Interview length was controlled by the participants and was no more than one hour in length. Participants were told they could terminate the interview at any time. Interviews were taped, with participant's consent, then transcribed later by the researcher. Each interview was coded with a corresponding code on the demographic questionnaire. Tapes were erased after abstracting information for transcription. The researcher, at the participant's setting of choice, collected all data. Three participants elected to have one family member present at the interview. A daughter was the family member in all three cases. Data were collected during a one-time interview with no relationship to major holidays i.e. Thanksgiving, Christmas, New Years.

### Codes and Categories

Qualitative data were analyzed for content. Data were carefully read for patterns and coded according to similar

information described by the participants. The researcher then extracted quotes from the interview according to topics and the reflected data.

Four categories were developed after reflecting on the codes and noting themes among the codes. Each category contained two to five codes per category. Codes, categories, and frequency of occurrence for each code will be reported in the following chapter.

#### Confirmation

Validation of the codes and categories were made with three of the nine participants. The female resident living in the nursing home is the expert on LTC placement and the most reliable person to validate the study. The researcher attempted to choose participants who varied in responses to the "lived" nursing home experience.

The categories were identified with corresponding codes. Validation was asked of the participant regarding code and category analysis. Several quotes were read to the participant for each code. The researcher was providing a total picture of the "lived" experience of LTC placement.

## Chapter IV

### Results

This chapter will present unique qualitative data with regard to the female resident's perspective on Long Term Care (LTC) placement and living in a nursing home. Data were collected in interviews with the resident alone or in conjunction with a family member present, with the resident's permission. The residents provided the core information at a one-time interview. The collected data will be reflected in four major categories with sixteen corresponding codes. The categories comprise the essence of the phenomenon studied and the corresponding codes are reflective of participant statements.

#### Demographics of the Participants

Demographic information on the nine participants is presented in Table 1. The initial sample population included 11 participants, however, data reduction techniques resulted in the deletion of two participants. Participants were eliminated if factual demographic questions, that is race, presence of roommates, were inappropriately verbalized. Participants providing data that did not match reality at this stage were assumed to elicit unreliable responses in the interview process. The participants were residents in an eighty-two bed rural nursing home for at least one year but not more than four years.

Table 1

Demographic Information

P	LOS	A	R	MS	IID	S/O	R	F/TV	GD	F
1	2y10m	90	W	NM	Y	S	3	FrWe	N	N
2	2y9m	63	W	Wi	N	S	3	FaWe	N	N
3	3y10m	86	W	Wi	N	O	1	FaD	N	Y
4	3y	84	W	Wi	N	O	1	FaD	N	Y
5	1y1m	74	W	Wi	Y	O	1	FaWe	N	N
6	3y	99	W	Wi	N	S	1	FaD	N	Y
7	2y3m	87	W	Wi	Y	O	0	FaD	N	Y
8	1y1m	88	W	Wi	Y	O	3	FaWe	Y	Y
9	1y11m	85	B	D	N	O	3	FrWe	N	N

KEY:

P= Participant

LOS= Length of Stay      y= years      m=months

A= Age

R= Race      W= White      B= Black

MS= Marital Status      NM= Never Married      W= Widowed

D= Divorced

IID= Involvement in decision      Y= Yes      N= No

S/O= Sudden or Over Time (decision for LTC placement)

R= Roommates

F/TV= Frequency Type of Visitors      FrWe= Friends Weekly

FaD= Family Daily      FaW= Family Weekly

GD= Geographic Displacement      Y= Yes      N= No

F= Furnishings brought from home      Y= Yes      N= No

## Codes and Categories

Codes arose from the data collected. The categories were developed after identifying common themes among the codes. Participants delivered clear, concise statements in regard to the guide question to provide a meaningful description of their "lived" experience. These codes and categories are presented in Table 2 with the corresponding number of participants making statements pertaining to that code. The four categories will be discussed in detail with the corresponding codes.

### Category 1: Beginning the experience

Moving into a nursing home appeared to be a major life change for these participants. Many participants were initially too sick to know how they felt during the initial placement. A period of settling in elicited a variety of responses. Some residents were not able to identify a settling in time period while other residents expressed it took several days to several years to feel adjusted to nursing home living. Three respondents mentioned being in control as being important. Family involvement during initial placement was discussed in the beginning experience of nursing home living. Four respondents, in discussing choices in Long Term Care (LTC) placement, stated they were involved in the decision for placement. Of the sixteen codes, five fell into this category and provided a lead in for further discussion.

Table 2

Categories with codes and corresponding number of participants reflected in each code:

Category 1: Beginning the Experience

Initial placement	8
Settling in	5
Control	3
Family involvement	2
Choices	4

Category 2: Activity Involvement

Activities	7
Spirituality	3

Category 3: Home versus Alternative

Home	7
Acceptance	5
Happiness	2
Sadness	4
Safety Issues	7

Category 4: Relationships

Staff	5
Residents	2

Family

4

Friends

2

### Initial Placement

This code was derived from the participants discussing what it was like for them when they first came to the nursing home. The initial placement of residents into the LTC facility elicited several statements. Six residents said they were too sick to really know how they felt the first few days to several months thereafter, while one discussed initial hatred about placement. Several statements that represent this code include the following:

- "I was out for a while" This participant defined "out" as "I didn't even know my name. I couldn't hardly do a thing for myself."
- "I guess I was out then" The daughter, present in the interview, said "Mom was so sick she couldn't even talk."
- "I was almost dead and it didn't suit them (children) to tend to me, they had to work"
- "I was in and out" The resident said she was "found in a coma in my apartment."
- "I must have been almost dead" The daughter, also present in the interview, said "Mother was unconscious but came around here in the nursing home"
- "I didn't know (much) at first" The participant stated she had a stroke and was unable to talk much

or do anything for herself on first coming to the nursing home.

- "I was sick and helpless"

- "Well, when I first came here I hated it. I hated the whole place and everybody in it"

#### Settling In

This code was reflected by five residents. Diversity was noted in this response in that some residents adjusted immediately, while others took several years. Time seemed to have no meaning to the first two participant responses. When asked how long "not long" was, they could not identify if it was 1 day, 6 months, or 1 year. These two residents seemed to have lost track of time. Both participants stated "I don't know " in reference to the time frame for settling into nursing home living.

- "Not long because everybody was so nice. You couldn't help but like it"

- "Not too long after I got here. It didn't take me too long to get use to it and then that was it"

- "(felt like home) the next day after I got here"

- "Just a couple of years (to feel like home)"

- "(felt like home) right away"

#### Control

Three respondents, in regard to living in a nursing

home, mentioned the need to be in control. These residents expressed a high degree of independence and wanting to do things for themselves.

-“I believe the resident has to be in control and handle themselves”

-“I like to do as much for myself as I can” This was explained as making decisions on what to wear, bathing times, and feeding themselves as much as they could.

-“I tell them (staff) how I feel” The resident and the daughter said the resident was very assertive in telling staff what she did and did not like.

#### Family Involvement

The two participants in this code were responding to the family's involvement during the initial placement in the LTC facility. These codes reflect family involvement as being positive in nature.

- “My sister and (nephew) explained it to me (before I came in)”

- “My son (helped more in moving into a nursing home).

Oh my son is here almost everyday.”

#### Choices

Choice was reflected in the residents' desire to either be somewhere else or to be involved in the choice of the nursing home in which they would live. As noted in the demographic information four residents were involved in the decision to come to a nursing home.

- "Well I really want . . .(another facility)  
. . .I read about them in the paper and really wanted to go there but one time I was in the hospital and they took me to (another facility). I was there four days and got out of that place . . .I had a beautiful room over (there), all carpeted . . .but I didn't like it"
- "I wish I could stay with my sister but I nearly got her down" The resident felt her sister was getting sick herself " . . .just taking care of me. She couldn't do it."
- "My husband died and I couldn't take care of it (her house) anymore . . .then I had a stroke. Children and I talk, it was too much for them to care for me so I come here."
- "It was completely my decision to come to a nursing home. I said if I ever have to go to a nursing home I wanted to come here."

#### Category 2: Activity Involvement

The five participants who stated they were involved in the nursing home activities were also residents who felt that living in a nursing home was like home. Hymn sing, bingo, and church were mentioned as favorite activities. Activities are held in the morning and afternoon everyday and at least three evenings per week. Smiles and chuckles were noted in response to attending activities.

Spirituality was mentioned by three residents in relation to God. Statements from the participants were as follows;

#### Activities

- "Every morning and evening I go" (referring to activities).
- "Yeah. When I get up. They're right nice (referring to activities). I like it"
- "Everything they have I'm into"
- "Involved up to here (pointed to her chin) . . .that girl (referring to Activities assistant) is all over me to help"
- "Everyday, something different everyday. Yeah I go one in morning and one in the afternoon"
- "No, I don't go much"
- "No, I don't feel good to go"

#### Spirituality

Three participants made reference to a strong religious belief. They felt they were in "God's Hands" and were positive and accepting of living in a nursing home. Church related events are held in the activities department within the facility and were important to these participants.

- "We have church (in activities). As long as somebody's having preaching it doesn't matter to me"
- "Jesus Christ makes me feel safe"
- "I keep on praying to get well"

### Category 3: Home vs. Alternative

This category had the highest number of responses and elicited the most information in relation to the study. Five codes were identified in this category.

The facility feeling like home was the predominant feeling of the residents studied. Five residents expressed a voice of acceptance in living in the nursing home while some expressed feelings of being happy as well as feelings of sadness. Safety issues, such as feeling safe as well as being resolved to safety were mentioned in this category.

#### Home

A feeling of the facility being home or like home was the predominant feeling. Seven of the nine participants expressed living in a nursing home was "like home" in some way.

- " . . .make it seem like home . . .it's a friendly place, it makes you feel at home . . .they're (staff) my family . . .they're all I have"

- " . . .it feels like home that's all" This participant followed up after the interview that it felt like home because she was taken care of here and the staff was like family.

- "I guess it does feel like home because when I get away from here I can't wait to get back . . .when they (family) take me away I want to get back here with my friends, I feel like this is home"

- "Sometimes (it feels like home) as long as I hear someone I'm all right" This resident liked to hear the staff voices because "I get so lonely when I don't hear them"

- ". . .as far as living here, this is my home. I had a friend . . .send me a card told me 'I was so glad to hear that you love it there and that you're home'"

- "Feels more like home . . .more like it more little bit every day . . . .I leave and I want to come back"

- "In a way it feels like home, . . .I go to bed at night like I do at home, seems strange I think sometime I'm at home in bed then I see I'm in a room with three other patients"

#### Acceptance

Participants expressed acceptance about living in a LTC facility. The respondents had a saddened or angry voice in stating these responses, and expressed a feeling of resignation in regards to living in a LTC facility. The following statements evidenced this:

- "It's the only home I'm going to have"

- "I got to be here anyhow, can't bend my legs. I wouldn't been here if I didn't get that leg broken"

- "They had to put me here. There's nothing I could do about it"

- "Well I couldn't live at home, not with the shape I'm

in. I'm not able to do anything for myself"

- "It's better than nowhere"

### Happiness

Several residents responded in a happy tone in discussing life in a nursing home.

- "It's been very beautiful, wonderful. I love it"

- "Fine. Just right. I have no problem . . .they treat me right"

### Sadness

Four participants expressed feelings of sadness in discussing their experience of living in a nursing home. Two of these were adamant that this was not home to them.

- "I feel very bummed . . .would like to be with my children all the time"

- "It's not home. I'd rather be home"

- "I would feel much better if I go back home"

- "This is one thing I'll tell you. It doesn't make a difference to me if you tell it. I don't care anything about a nursing home, not one thing. The only thing now I want is to go to my daughters a while"

### Safety Issues

Safety was discussed to note if a correlation existed between the participant feeling safe and comfortable in the facility and its contribution to the feeling of "home". A correlation was noted as all four respondents that felt safe

also felt that the LTC facility was "like home". Several participants made statements to the effect that they felt safe but did not or would not elaborate on these feelings. The participants seemed threatened by this question. Precise statements reflected this with no elaboration to the response even when the question was re-worded. The following data arose from the resident's responses about feeling safe or unsafe.

- "Oh I feel safe"
- "I feel comfortable here"
- "I feel safe" (This was stated by two participants)
- "Feel more safe"

Two participants expressed feeling safe in a more resolved manner.

- "Well you have to feel safe because you don't have any alternative . . . You take what's coming. If anything happens that's it"
- "I guess I feel safe here as I do anywhere"

#### Category 4: Relationships

Several comments were made about relationships with staff, other residents, families and friends. Reference was made by the respondents that these relationships did make a difference in living in a nursing home. There was a correlation noted between the resident's feeling that the facility was home and the frequency of visitors. Residents with families or friend visiting daily felt that the

facility was more like home. Residents who had visitors daily expressed those relationships in a more positive manner.

#### Staff

This elicited the most positive responses from participants in talking about their relationships with others. Four of the participants expressed positive responses and one expressed a negative response about the staff's personality within the facility.

- "The girls are so nice . . .they make it friendly and all. They're just so friendly, they make it feel like home they're so nice."

- "They're good to me (staff). I have nice nurses."

- "The people and staff help me, they talk to me"

- "They're very nice people and they have understanding. Everyone say 'Hi' 'Hi'"

- "Some are nice, some not so nice"

#### Residents

Relationships with other residents were also noted.

-"(my friends are) people who live here all the time and some that work here"

-"I'm friends with a lot of the other residents"

#### Family

Family relationships were expressed by several residents and stated with a feeling of love.

- "I couldn't make it without my nephew. I couldn't do it (meaning making decision on her care) without him"
- "My family is here every night. I love my kids."
- "I look forward to seeing my daughter come in. She comes just about everyday"
- "Oh, I see my son everyday. I'm proud of him."

#### Friends

Two respondents were noted to have friends visiting weekly. One expressed a feeling of gratitude while the other expressed a feeling of disappointment.

- "I love my friends. I appreciate all they do for me. They come see me at least once a week."

- "I don't see them much, when they come they don't stay long enough."

#### Confirmation

Confirmation was made by three of the participants in a follow up interview. The categories and subsequent codes were read to the participant. Several responses from each code were also read to the residents. The participants validated the analysis by nodding their heads yes or verbalizing confirmation of the findings. Statements of confirmation were noted as such:

- "Yes, that's just how it feels living here."

- "That's right. I've heard some of the others living here say that."

- "Yeah, that's it."

The researcher found a response to be consistent in length and detail whether the interview was held in the morning or the afternoon.

### Conclusion

An analysis of the research questions brought forth in this study provided unique and useful information. Each of the categories was reflective of responses that led to a feeling of the facility feeling "like home". Category 1 noted that initial placement was not comprehensible to many respondents as they were too sick to feel anything but having their basic needs met. It was noted that after the basic needs were met settling in took place the next day in most cases. Category 2 demonstrated that activities were important to the majority of the respondents and were frequently attended both in the morning and afternoon. Category 3 noted seven of the nine participants expressed that living in a nursing home was "like home". A strong relationship existed in that those feeling safe felt like the nursing home was their "home". Category 4 noted that relationships with the staff, other residents, family, and friends contributed to the facility feeling "like home".

The interview data and demographic information (see Table 1) were compared for correlations. Residents involved in the decision about LTC placement were noted to be more accepting of living in a nursing home. Neither roommates,

belongings, nor marital status had any bearing on the facility feeling like home in this study. Of interest was the lone black participant who did not feel that the facility felt like home. Geographic displacement did not have a bearing on family or friends visiting, however, family and friends visits did seem to be important in residents' feeling more like the facility was "home" and improved the quality of their life. Findings in relation to the research questions and each category and code will be discussed in detail in the final chapter.

## Chapter V

### Discussion

Phenomenological research focuses on the essence of a phenomenon as experienced by people (Polit & Hungler, 1995) For the purpose of this study the phenomenon is the "lived" experience of a female resident living in a nursing home. No definitive conclusions were drawn, but a wealth of information has now been added to nursing research regarding a female resident's perspective on living in a nursing home.

Meaning of findings in relation to research question

Research on the resident's perspective on LTC placement is very limited, so a comparison of themes noted in this study with themes from previous research will be limited. Quality of life issues, however, have been reflected in previous research studies. Quality of life is identified in a variety of ways, but is defined as life having meaning and the feelings of life as worth living. The researcher noted, in this study, that high regard for quality of life reflected a more positive sense that the facility felt "like home". Disaffiliation and disconnection represented the hallmark of homelessness in a study by Basuk, Rubin, & Lauriat (1984). Findings will be made in relation to the categories and codes identified in Chapter 4.

The initial placement code identified by the majority of respondents was being "out of it" when they were first

admitted. The residents described being "too sick" to meet even their basic needs as "being out". A study by Brooke (1989) identified four phases of adjustment a resident encounters in living in a nursing home. The first phase was from admission to six-eight weeks, characterized by feelings of displacement, vulnerability, and abandonment. It was difficult to determine from this study whether these feelings existed among participants who identified themselves as being "in and out". One participant did state " . . .when I first came I hated it. I hated the whole place and everybody in it." This would validate the feelings noted in the first phase of Brooke's study.

Settling in was not identified per se by any prior research. The study by Brooke(1989) suggested that the residents took eight months before they felt like a member of the nursing home community.

Daly (1993) recognized assertiveness (a code of control) as one of ten strategies used by women living in a nursing home to feel satisfied and happy with their quality of life. This study validated Daly's findings noted in their resident's response such as "I speak my piece when I have to speak. I let people know how I feel about things."

Solomon and Peterson (1994) also found those individuals 65 and older maintained quality of life by exerting some control over their life.

Many researchers have noted the importance of family

involvement. York & Calsyn (1977) found a large proportion of families who wanted to be involved in the resident's care. Hook, Sobal, & Oak (1982) found facilities encouraging visitors increased meaningfulness of the caregivers' visit. Solomon & Peterson (1994) also found staying connected to family and friends assisted in maintaining the resident's quality of life. Basuk, Rubin, & Lauriat (1984) concluded ". . .that the hallmark of homelessness is extreme...disconnection from supportive relationships. . ." (p. 1549). As identified earlier, this study found a correlation between the facility feeling "like home" and perception of quality of life.

Choice, in regard to nursing home placement, was noted in this study to be made by others or as being no alternative due to illness. Those residents who were involved in the decision and had a choice stated they adjusted "the next day" and felt the nursing home was "home". Johnson (1990) found that others frequently make the initial decision for LTC placement. Johnson & Werner (1982) found that 80% of those in LTC moved from the hospital with little or no opportunity to seek an alternative.

Activity involvement was noted in the research to play a significant role in the nursing home being a positive experience. Daly (1993) identified keeping active, i.e. going to activities, as a strategy women used in living in a

nursing home to feel satisfied and happy with their lives.

Spirituality takes on different meanings for members of society and can contribute to viewing one's life as meaningful (Solomon & Peterson, 1994). The present study validated this as all three participants making spiritual reference were more positive and accepting of living in a nursing home and viewed their life as having meaning.

Viewing the nursing home as "home" was the predominant feeling in this study and validated findings noted by Brooke (1989). This study found that usually a resident worked through the feeling of initial alienation and becomes a member of the nursing home community. Within eight months 93% of the residents had stabilized and called the facility home. Brooke also found that residents may ask to go "home" to the nursing home when on a family outing. Findings in the current study also support this. However, results of the current study contradict a study by Carboni (1990) which suggested the nursing home in no way represents "home" and is more characteristic of feelings of "homelessness".

Acceptance of living in a nursing home, as found in this study, was also noted in other research. Daly (1993) labeled this as acceptance, as identified by the residents deciding to make the best of the situation, even though they would have preferred to be living in their own homes. One participant, in Daly's study, stated, "Of course I'm glad to be here and get the care I need and all, but there's no

place like home". Likewise, Brooke (1989) found in phase two residents resolved or justified why they lived in a nursing home. Carboni (1990) identified this strategy not as acceptance but as "pretending". Pretending included living in the past, distancing, and surrendering. She feels a resident pretends effectively when they have convinced themselves and others that they (the resident) have accepted nursing home placement.

Some participants, in talking of the facility as home, noted happy feelings. Participants in a study by Daly (1993) viewed nursing home placement from a positive perspective and felt "glad". Sad feelings were recognized as vulnerability in Brooke's 1989 study.

Safety issues were addressed uniquely in this study. None of the literature reviewed identified safety concerns as an issue noted by LTC residents. Seven participants in this study made statements in regards to feeling safe or unsafe in living in the LTC facility. This study did note that a feeling of safety contributed to the feeling of the facility feeling like "home". Rossi & Wright (1987) described homelessness as extreme poverty among isolated people. Doolin (1986) defined homeless as those without residence, food, clothing, medical services, and social support.

The last category dealt with relationships. Numerous research findings have noted the importance of staff,

family, and other residents as enhancing the nursing home experience. Staying connected to family and friends, noted by Solomon & Peterson (1994) added meaning to the quality of one's life. Daly (1993) identified sociability as a strategy woman residents used in feeling happy and satisfied in living in a nursing home. This involved being social and interacting with others, and would include sitting in the hall, sitting near the entrance, and visiting with other residents and staff. Family interaction was also important. Brooke (1989) found phase three was characterized by relationship building, often finding the resident preferring one staff member over another or one resident over another. An important hallmark of this phase was residents' need to establish and maintain links to others.

#### Significance

The female residents' perspective on LTC placement is of significance in this study as there is currently minimal data available on this subject. The four categories experienced by these residents hold a wealth of information for the nursing profession and the residents and families as well. This study has added to limited research to provide a more in-depth look at what a woman feels as she enters and lives in a nursing home.

Recognizing and validating various meanings about living in a nursing home broadens ones perspective on how others live and feel. This contributes greatly to enhancing

one's well being as well as providing a holistic approach to care.

The responses in the four categories provide significant information to the nurse, resident, and resident's family. This opens an opportunity to explore further nursing home options and also provides questions to ask prospective facilities, i.e. What kind of activities do you provide? How often? How do you provide for a resident's safety? How do you make it feel like home? The responses in this study also provide facilities with guidelines as to what is important or of significance to the female resident in making the LTC facility seem like home.

#### Limitations

The sample population looked at the female resident only, creating an "elite bias". Another limitation was that all participants except one were white. Family members present at the interview may have represented another limitation.

Researcher bias in qualitative studies by facial expressions and/or body language may lead the participant to alter responses. The researcher attempted to guard against bias by wearing street clothes and identifying herself as a researcher. The researcher also had access to information not provided on tape. This information supported the findings noted in this study, validating the statements made

by the participants. Utilizing multidata sources guarded against the concept of "pretending". These sources included observation, daughter/family interviews, and participation in activities. The resident would not demonstrate distancing (a concept of pretending) if they refused to participate in the facility activities.

The facility in this study is known in the community to provide good care possibly providing an innate bias by its reputation. The staff also has a reputation of providing a "home-like" atmosphere within the facility by their friendliness and interaction with each other.

Only alert and oriented residents were interviewed. Their perception of living in a nursing home may be altered as they remain with some control in their lives and the ability to verbalize needs or desires.

#### Implications for Nursing

The researcher asked the participants in the study how the nursing profession could help in the transition to nursing home placement. One respondent stated, "the surroundings and people can make (it) more homelike". This may be accomplished by talking to the residents, personal recognition, and touching. Other participants stated "nurses help make it a little easier" and "friendliness of the people" makes the transition less difficult. This can broaden the nurse's understanding of the female resident's perspective of nursing home placement just by the statements

professed by the actual residents.

Geriatrics is a mushrooming practice due to advanced medical technology enabling people to live longer. The over 65 population is projected to increase proportionally by the year 2030 (Friedman & Pollack, 1996). Increased knowledge of the feelings of older people is needed to enhance the care nurses give to the geriatric client.

The categories themselves can provide numerous implications when viewed individually. The category beginning the experience provides the nurse with insight that first impressions do make a difference. It may be as obvious as caring first for the resident's medical needs and then providing emotional support. Assisting the resident to "settle in" is as important as giving the medicine and providing daily care. This can be accomplished by providing a safe, friendly environment that encourages resident's well being to be the top priority. Well-being includes physical care as well as meeting the resident's emotional needs. Allowing the resident to be in control as much as possible will foster their independence and allow them to take control over things they can, for example bath time, bed time, and meal choices.

Encouraging family involvement on the admission day and thereafter allows the resident to view the facility as one that is an extended family, not as a replacement. The nurse can offer guidance to families as to how to handle their

loved one's admission to a LTC facility. Teaching families how to handle guilty feelings about leaving a parent in a nursing home may be of great benefit. Offering support groups and having staff available 24 hours a day may help accomplish this.

If an emergency admission is not warranted nurses can encourage the resident with their families to view all available options for assisted living arrangements or nursing home placement. Nurses can also provide as much information regarding facilities as possible, encouraging unannounced tours and visits.

Category 2 involves activity involvement. As evidenced by the responses in this category, activities were a high priority and source of pleasure for these residents. Therefore it is important for nurses to foster activities geared to all residents, considering individual tastes, and religions. Another strategy is to provide a variety of activities at various times throughout the day, altering personal care needs so residents can attend the planned activities.

The facility "feeling like home" was a predominant theme noted in category 3. The nurse can recognize that several of the other categories contributed to this. Providing a safe, friendly environment and meeting the resident's spiritual, physical, and mental needs will provide a more home like atmosphere and contribute to the

resident's well being. Nurses can explore ways to make the residents area more homelike for them. This may be as simple as allowing furnishings, even a favorite picture, to be brought from home. Addressing the residents who felt they were resolved to living in the nursing home opens many opportunities for the nurse. The nurse can explore with the resident any angry or resentful feelings in regard to nursing home placement. Providing an open, honest environment may assist in dealing with unresolved issues within the family structure.

Strategies for safety issues may involve exploring with the resident what makes them feel safe and recognizing safety as a key to holistic wellness. Providing a safe mental and physical environment as much as possible for the resident is important.

Relationships between the residents, staff, family, and friends are an important implication for nursing as found in this study. Staff development activities to assist in understanding the importance of communicating with the residents therapeutically may be of benefit. Several participants commented on the friendliness of the staff and the understanding that assisted the resident to feel more at home. The nurse can also encourage relationships among residents and provide quality opportunities to enhance those relationships.

Implications for nursing are numerous as noted within

this chapter. The residents themselves are able, and willing, to direct the nurse in how to better provide a well-rounded environment for the resident.

#### Future Research

Qualitative research, due to the unstructured interview process, opens up many other topical areas for research. A field study in conjunction with a phenomenological study would elicit a wealth of information regarding clients living in a nursing home. This would provide an in-depth look at how the resident states they adapt as well as an opportunity for the researcher to view adaptation or non-adaptation processes.

Another avenue is to study personalities of the individuals. Do more optimistic people adapt to LTC placement more readily than pessimistic people? Is this because they look at the positive no matter what life hands them?

A replication of this study in another facility would provide a broader base of knowledge. Other areas of research are as follows; What is the male resident's perspective on LTC placement? What results would an "all black" study provide? What results would a longitudinal study produce? What role does the family play in the actual placement in a LTC facility? Can the LTC placement of a resident be improved by increased awareness or preplanning? Is a source such as this available? What role,

if any, does the physician play in the resident's admission to LTC? What role does the nurse play?

### Conclusion

The nursing profession can make a difference in increasing awareness and providing a more positive image for LTC placement. Often nurses are the first line of communication as families say "Where would you go?". Nurses play a unique role as providers of information and support. Clearly they can use the results of this research to make a difference for future residents of LTC facilities.

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## APPENDIX A

### GUIDE QUESTIONS

#### Demographic Questions

- Length of stay in nursing home: \_\_\_\_\_
- Age: \_\_\_\_\_
- Race: \_\_\_\_\_
- Marital Status: \_\_\_\_\_
- Involvement in decision making process for admission: \_\_\_\_\_
- Decision made over time or sudden: \_\_\_\_\_
- Roomate(s): \_\_\_\_\_
- Frequency/Type of visitors: \_\_\_\_\_
- Geographic Displacement: \_\_\_\_\_
- Furnishings from Home: \_\_\_\_\_

#### INTERVIEW GUIDE QUESTION

\* Tell me how you feel about living in a nursing home?

#### Other guide questions:

- What was it like for you when you first came here?
- Are you involved in activities? Tell me about them?
- Tell me how you feel in regards to feeling safe or unsafe?
- Does this feel like home to you? Why/Why not? How long did it take for you to feel at Home?
- How can the profession of nursing help in the transition of nursing home placement?

## APPENDIX B

### DISCLOSURE FORM

I am a graduate nursing student at Salisbury State University conducting a study on the resident's perspective on Long Term Care placement. I am seeking your assistance in conducting an interview regarding your view of living in a nursing home. You were selected to participate in this study because you are a resident in Wicomico Nursing Home.

The interview should take approximately 60 minutes of your time. **The information you give me is confidential.**

Your cooperation and participation are strictly voluntary. You may volunteer only the information you choose. Your participation is very valuable and will help me to determine how you feel about living in a LTC facility. Your participation will in no way affect the care you receive. Information you provide will be used in a formal paper, submitted for publication, and be presented in an oral defense.

Your name will not be used in any way and you may choose to stop the interview at any time.

If you have any questions about this study please contact Jane K. Insley at 410-543-0072 or Dr. Lisa Seldomridge at 410-543-6401.

Thank you for your cooperation.

Signature below is written evidence of your consent.

Name \_\_\_\_\_

Date \_\_\_\_\_



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