Generating a Model of Quality of Life for Older Nursing Home Residents in the Lebanon: A Grounded Theory Study

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ABSTRACT

The University of Manchester: PhD in the Faculty of Medical and Human Sciences
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Study title: Generating a Model of Quality of Life for Older Nursing Home Residents in the Lebanon: A Grounded Theory Study

Background: Over the past two decades, the growing number of older people in the Lebanon, the advances in medical technology, and the changing family patterns of support have combined together to increase access to long-term care facilities for older people. Lebanon, like other developing countries, still needs to define the policies and programs that will reduce the burden of an ageing population on its society and economy. Moreover, there is a need to ensure the availability of health and social services for older people and to promote the older person’s continuing participation in a socially and economically productive life in long-term care institutions. Whilst quality of life is a meaningful expression in the Lebanon, it remains a sophisticated and complex construct and it provokes considerable debate about its constituent parts. This study contributes to the debate by presenting a model of factors determining quality of life for older people residing in two Lebanese nursing homes. This grounded theory is built on the analysis of data collected in interviews with older residents, staff members and family carers with the aim of exploring the meaning of quality of life in the nursing home setting from different contexts.

Aims and Objectives: The overall aim of this study is to explore the perceptions, perspectives and meaning of quality of life for a theoretical sample of older people living in Lebanese nursing homes, care staff and family carers and to produce an explanatory theoretical model of experience using the classic approach to generating grounded theory. The research objectives were to: identify factors that older people living in nursing homes believe constitute a meaningful and good quality of life; identify the role of the staff employed by nursing homes in helping to support quality of life; and identify the meaning that families attach to quality of life and how this is constructed.

Results: Constant comparative analysis of data generated from the three groups of participants led to the emergence of three interrelated sub-core categories: “maintaining self” for older residents, “maintaining identity” for staff members, and “maintaining continuity” for family carers. Each of these sub-core categories consisted of either three or four properties/phases to explain the experience of the older resident, the staff member, and the family carer in their trajectory towards achieving and sustaining quality of life. Following a theoretical integration, the three sets of sub-core categories were conceptually connected through the linking scheme of “maintaining interrelationships”. Transcending the data, and by increasing theoretical sensitivity, the core category of “relating” emerged to explain the dynamics of quality of life. “Relating” was also found to have temporal dimensions that worked on sustaining, restoring, and creating interrelationships, processes that had the ‘fit and grab’ necessary to shed new light on the meaning of quality of life for all participants.

Conclusion: This study is one of the few that has explicitly explored quality of life in nursing homes from the perspectives of all the key actors. As such it has made an important contribution to the literature particularly in recognising the role of “relating” and “maintaining interrelationships” in enhancing quality of life in nursing homes in the Lebanon. The contribution of the substantive grounded theory emerging from this study is not solely restricted to helping interpret the everyday experience of quality of life, but also includes implications for policy and practice.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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DEDICATION

I dedicate this doctoral dissertation to the life and memory of my sister, Takouhy Gharibian that remains thriving in me for as long as I live. Our special relationship was the driving force and inspiration to continue my PhD.
I also dedicate this work to the memory of my mother, Vartouhy and my father Nazaret Gharibian, who instilled in me perseverance and a passion for learning as a lifelong occupation to explore, discover and reach new horizons.

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INTRODUCTION

Background

Lebanon is a small country with an area of 10,452 square kilometers and a population size of four million. Despite the relatively high living standard characterising Lebanese society at large, major disparities can be seen across the social spectrum (Abyad, 2001). Following World War I, a Department of Health was established in Lebanon during the French Mandate, but the establishment of a fully-developed Ministry of Health took place in 1943 in the wake of independence. The main tasks of the Ministry involved the oversight and coordination of environmental sanitation and the fight of contagious diseases. The network of 21 public hospitals built over 15 years served ‘needy’ individuals (Abyad, 1994).

Another major step forward in health and social care was taken with the establishment in 1964 of the National Social Security Fund (NSSF) after the European model of social security plans. Whilst it had a number of independent funds for retirement, end-of-service indemnities, old age benefit, maternity, sickness, and occupational indemnities, the NSSF applied the fee-for-service reimbursement system (Abyad et al., 1992). As a result, a marked rise was registered in the Lebanon about the number of private hospitals, physicians, laboratories, diagnostic and pharmaceutical activities. Thus, the NSSF offered an opportunity to all citizens to become subscribers benefiting from medical services whose costs it covered. All health professionals and institutions in the private sector were mobilised to deliver a variety of services, and the Ministry’s settlement of the medical costs relative to public patients in private hospitals expanded as well (Abyad, 1994).

Yet, the enforcement of the designed rules and policies was seriously hindered by the civil war that dragged on in Lebanon from 1975 until 1990, which led to a gradual
disintegration and dismantling of the health care system for the increasingly poverty-stricken population (Abyad et al., 1992). Whilst health coverage and old-age pension schemes varied with employers, the old-age population found itself deprived of health insurance and indemnity (Abyad, 2001). It is widely known that older people in Lebanon draw their socio-economic support from unofficial sources, such as their children and extended family members. However, the gradual decrease in family size negatively impacts upon the availability of informal and largely ‘invisible’ assistance (Abyad, 2001).

It is estimated that the old-age (over 65 years) group will make up almost 10.5 percent of the Lebanese population in 2025 (Sibai et al., 2004). At the same time, the ageing population creates a greater need for nursing services (Bou Harb, 2005) that for some people, are expected to be provided in residential care facilities. In Lebanon, an estimated 1.4 percent of its older population now lives in residential care homes (Bou Harb, 2005). The issue of quality of life bears great relevance for the residents of such homes; hence the growing emphasis on issues that determine such factors (Chemali et al., 2008).

Despite its complexity and the lack of a clear and comprehensive definition, the concept of quality of life has gained popularity in recent years due to its association with almost every aspect of daily life (Murphy et al., 2007). The concept is considerably relevant for older residents of nursing homes due to their vulnerability as a social group characterised by advancing age, and resulting higher levels of dependency (Murphy et al., 2007). Put simply, poor quality of care negatively impacts upon resident’s quality of life. The group may lack the ability or willingness to complain about poor conditions because of cognitive-communication disorders, or because of modest expectations of the quality of life offered in nursing homes (Murphy et al., 2007). Fear of additional mistreatment may also motivate resident’s compliant attitudes about poor quality care, a problem sometimes worsened by
the absence of outside support (Chahine et al., 2007). Whilst new regulations acknowledging and preserving older people’s rights, and guaranteeing a minimum of standards in nursing homes have been introduced in Lebanon (Chemali et al., 2008), further steps need to be made to ensure a good quality of life and, more to the point, how this is constructed and lived by those in old age.

Quality of life encompasses different facets of daily life; however, it revolves around key concepts such as life significance, agreeability, and purpose (Brown et al., 2004). Improving quality of life should be preceded by a definition, its causes and personal priorities together with the identification of relationships between its physical and emotional aspects and the pattern of their mutual influence (Reed, 2006). Health professionals have an inclination to restrict their perception of the quality of life solely to ‘health’ although other questions, such as finances, relationships, and living conditions could assume a similar, if not a deeper, significance (Reed, 2006). The popularity of the expression of quality of life has gradually risen and it is extensively used to involve nearly all aspects of daily living (Murphy et al., 2007). Quality of life is a useful and a common expression; it is a seemingly simple concept camouflaging the intricacies and indistinctness accompanying it (Murphy et al., 2007).

Another view explores quality of life from the professional foundations of nursing and medicine. According to Gerristen et al. (2004), only a small number of researchers have studied quality of life from the perspective of the ageing population itself, i.e. what matters to them as people. Gabriel and Bowling (2004) argue that the perception of advanced age as a period during which people get into a state of ‘regression’ and ‘helplessness’ prevails among professionals and academics, attitudes that impinge upon the production of more positive and holistic gerontological definitions of quality of life (Reed, 2006). Similarly, it
is also important to appreciate the underlying belief that a nursing home should constitute a community for all its dwellers, both the staff members and the older persons, whilst at the same time regarded as an integral part of its community (Reed, 2006).

In the course of her nursing practice, the author visited two nursing homes in Beirut, Lebanon and developed an increasing concern about the care milieu, notably relating to the feeling of powerlessness experienced by the older residents and their visiting families. The residents in need of the most support seemed to be almost voiceless and consequently unable to make choices or control over aspects of their life. Given the scarcity of previous empirical studies that address nursing home residents’ perceptions and perspectives of quality of life in Lebanon, the author came to the conclusion that much needs to be done to make the voices of older residents heard and to understand from their perspective what makes a ‘good’ quality of life, or otherwise. Consequently, a decision was taken to conduct a study exploring the perceptions, perspectives and meanings of nursing home residents about their quality of life. Lending older people a platform for their voice to be heard has been central to this study and a motivating force for the author in the conduct of the research design. It is also the first qualitative study in the Lebanon that has involved the contribution and active participation of older residents in care. The research process was underpinned throughout by the methodology of grounded theory, especially constant comparative analysis, as described initially by Glaser and Strauss (1967) and refined later by Glaser (1978).

**Rationale for Study**

Given that human beings are living longer, it is likely that there will be an increase in the proportion of the older population living with chronic illnesses and physical and cognitive disabilities. Such a population may need various levels of nursing care as provided in
nursing homes, either for short-term rehabilitation or for extended periods of time. At present, the demand for the services provided by nursing homes significantly exceeds the current supply and, as a result, the number of nursing homes in Lebanon is increasing each year due to societal demand.

One of the most significant challenges faced by the Lebanese society has been the provision of health care services to a rapidly growing, ageing portion of its population that has increased chronic illness requiring skilled services. Nursing homes are the primary formal means by which professional care is provided to these members of the population. Importantly, the quality of life provided in nursing homes is a significant issue in Lebanon as a nursing home is not only a health care institution, but it is also a place where residents live, many for the rest of their lives. This means that ensuring an optimal quality of life for older people in nursing home settings is crucially important.

There is a significant gap in our knowledge about the conditions of older people living in nursing homes in Lebanon, and the challenge for Lebanese society has been the provision of an environment that supports quality of life for residents in these settings. Policy makers, practitioners and consumer groups need to obtain a preliminary profile on the major health, social and economic problems that are encountered in such environments. Health service users have been identified as the most appropriate people to identify the strengths and limitations of health service provision (Horsburgh, 2003). Therefore, it is both a timely and necessary step to explore the meaning of quality of life from, first and foremost, the standpoint of the older residents, and second from other key stakeholders, in order to design and shape supportive programmes that aim at enhancing and personalising service improvement.
Research Aim

In an attempt to commence an evidence-based from a Middle-East perspective, the overall aim of this study is to explore the perceptions, perspectives and meaning of quality of life for a theoretical sample of older people living in Lebanese nursing homes, care staff and family carers and to produce an explanatory theoretical model of experience using the classic approach to generating grounded theory.

Research Objectives

The research objectives were to:

a. Identify factors that older residents living in nursing homes believe constitute a meaningful and good quality of life.

b. Identify the role of the staff employed by nursing homes in helping to support quality of life.

c. Identify the meaning that families attach to quality of life and how this is constructed.

Organisation of Thesis

The thesis is organised around a number of chapters, as follows:

- Chapter 1 provides a context for the thesis and provides an overview of Lebanon’s culture and healthcare system as related to older people in general and older people care in nursing homes in particular. The chapter then describes the existing nursing homes in Lebanon followed by perceptions of ageing in Lebanon and some cultural highlights related to the care of older people in Lebanon.

- A substantive literature review is presented in Chapter 2 which examines developments in the concept of quality of life, measurements of quality of life in
the absence of a clearly defined concept, models of quality of life, and the particular developments in quality of life for older people residing in nursing homes. The substantive review identifies a number of issues related to quality of life, many of which have implications for older people residing in Lebanese nursing homes.

- A discussion of the methodology utilised to underpin the research aims and objectives is provided in Chapter 3. Furthermore, the philosophical approach of grounded theory is presented together with a review of symbolic interactionism, and an argument is made for adopting the approach to grounded theory as proposed by Glaser (1978). Moreover, the chapter details the different components of the research process. Thus, it includes a comprehensive description and justification of the research process, research setting, access to the research environment, sampling, participants, data collection, data analysis, credibility of the study and ethical considerations. These procedures are reported in detail, with particular attention to rigor.

- Chapters 4, 5 and 6 report the detailed findings of the study with respect to the participating older residents, staff members, and family carers respectively. Combining data from the participants and the literature, the findings seek to articulate and explain the perceptions of older people, staff, and family carers. Participants define quality of life for older nursing home residents as follows: ‘maintaining self’ for nursing home residents, ‘maintaining identity’ for staff members, and ‘maintaining continuity’ for family carers. Passages from the full sets of transcripts, representing 39 interviews, are used to illustrate each presented model. Each of the generated models allows insights into the definition of quality of life for older residents, staff members, and family carers.
• Chapter 7 integrates the nursing home resident, the staff member, and the family carer models of quality of life, highlighting the central role of ‘maintaining interrelationships’ and ‘relating’. Four interrelated basic social processes that hold together the integrative model are explored.

• Chapter 8 discusses the findings of the study in the context of previous research and highlights the central role of ‘maintaining interrelationships’ and ‘relating’. Although the chapter recognises the strengths and limitations of the study, it also considers the policy and practice implications of the integrated model, in addition to recommendations for nursing educators, policy makers and future research and development.

• References and appendices follow; References have been listed in the American Psychological Association (5th edition) style. As such, in-text citations are listed in descending date order of publication; for cited publications with more than two authors, the first author is named and additional authors are abbreviated as ‘et al.’ References listed in the final bibliography name up to 6 authors, with any remaining authors abbreviated to ‘et al.’

Writing Conventions Used in the Thesis

Within the text of the thesis numbers from one to nine are written, with numbers 10 and above represented in their numerical form. Exceptions to this are descriptive statistical measures and sample measures (‘n’); when a number begins a sentence; and when numbers form part of a title, for example: Table 1; Chapter 5 and so on.
Direct quotes from literature or data collected within the current study are presented with double quotation marks and are italicised. Single quotation marks are used within the thesis to denote the use of phrase or colloquialisms.

At various points throughout the thesis the author will be referred to as ‘the author’, ‘researcher’, ‘I’ or by their name dependent on the context in which it is used.
CHAPTER 1

An Overview of Older Adult Care in Lebanon

*Older people are just like everyone else, except that they have been around longer* (Wenger, 2002 p. 276)

1.1 Introduction

This chapter begins with a consideration of the health needs of older people in a Lebanese context before moving on to describe care of older people and the delivery of health services to older people in the country. The chapter will then describe the existing nursing homes in Lebanon including their philosophy of care and their financial resources. This will be followed by a presentation of a notion of how do Lebanese people view ageing and some of the cultural and social highlights related to the care of older people in Lebanon.

1.2 Health Care Needs of Older People in Lebanon

Life expectancy among older people in both developed and developing countries have risen as a result of better public health care and continuous medical advances (Beaglehole and Bonita, 2004). This trend can be detected in Lebanon where significant demographic shifts have occurred over the past few decades. Whilst its 0-14 age group still constitutes a large proportion of its population, the data derived from several sources reflect a growing proportion of the ageing population. It is predicted that in the year 2025 the size of the ageing population will grow to 10.5 percent (Sibai et al., 2004) which is comparable to the European rate in the 1990s. In addition, the widening gender gap with respect to life expectancy has resulted in the predominance of Lebanese females in what is known as the phenomenon of ‘feminisation’ (Sibai et al., 2004).
The increase of Lebanon’s ageing population, and particularly the group with different chronic diseases, impels the provision of health care services on a long term basis, which in turn requires the expansion of nursing facilities and homes to satisfy these needs (Abyad, 2001). Despite the fact that a large number of Lebanese older people now enjoy good health and functional independence, some tend to develop physical and psychological conditions that threaten to undermine their physical abilities and thereby render them frail and dependent (Abyad, 2001). Healthcare providers find themselves in the face of a problematic situation having to do with the fulfillment of this population’s permanent needs (Sibai et al., 2004). Apart from their periodic health problems, older people have a potential for the development of diverse health risks that cannot be dissociated from their social and emotional considerations (Abyad, 2001).

In the past, families used to take care of older people living with impairment or frailty (Bou Harb, 2005) as the long-term institutions for older people were in the early stages of their existence and assumed the role of charities offering care to the disadvantaged and homeless. Further, with a significant increase in the size of the older population, lower fertility rates, greater geographic mobility, rapidly evolving medical technology, and reduced number of potential family caregivers, institutionalisation became a major health resource (Kinsella and Taeuber, 1992). However, in the Lebanon, the impact of institutionalisation is expected to pose a significant challenge since the traditional role of families in providing care to older people is now breaking down and new priorities are required to add to the scarce resources of Lebanon’s health and social programs.

1.3 Older Adult Care in Lebanon

The delivery of health services to older people in Lebanon is basically aimed at mitigating the effects of chronic diseases, preserving the older person’s potential for independence
and maximising quality of their life (Chemali et al., 2008). Lebanon suffers from unfavourable security and political conditions that destabilise its economy, as is the case in different Middle Eastern and other countries around the world. Under such circumstances, the social and health services offered by the government remain inadequate; therefore, non-governmental organisations (NGOs) step in and assume a supporting role by enhancing health and social benefits, advancing the understanding of gerontology, protecting the older people’s rights, and guaranteeing preventive medicine in geriatrics to preserve their independence (Dar Al-Ajaza Al-Islamia Hospital [DAIH], 2008).

The Lebanese authorities do not prioritise older adult care by devoting special attention to it in its social security and pension schemes, despite the growing proportion of the ageing population (Sibai et al., 2004). Realising the growing complexity of the challenge, the government has expanded efforts to fulfill those needs; however, the contribution of the private sector and NGOs in this respect has been more significant, particularly in the face of the government’s inability to execute several plans devised to this end owing to financial and administrative limitations (DAIH, 2008).

Health policy-making in Lebanon tends not to consider older people a focal point. A clear example of this is the absence of a universal old-age pension and the persistence of the ‘lump sum’ or ‘end-of-service indemnity’ paid to employees in the private sector (Sibai, 2000). Governmental insurance plans are not unified and the various coverage patterns are drawn from a variety of sources (Ammar et al., 2001). Civil servants and military personnel benefit from pension plans and health insurance, but people covered by the NSSF are no longer covered following their retirement, the time when this service becomes a basic need. Furthermore, the lack of any legislation about self-employed workers and casual labourers only amplifies the concern that exists (Sibai et al., 2004).
Unfortunately, private insurance costs are high and exclude individuals with pre-existing chronic or health condition, which makes participation in health insurance plans for the average citizen out-of-reach and unaffordable (Sibai et al., 2004).

The creation of the Permanent National Commission for the Elderly (PNCE) by the Lebanese government came in response to the international strategy and recommendations put forward by the World Assembly on Ageing (WAA) in an effort to meet the needs of the ageing population in the twenty-first century. The PNCE officially launched its activities on June 23, 1999 (DAIH, 2008). It plays an advisory role and acts as an implementation arm to the Ministry of Social Affairs (DAIH, 2008). The PNCE has worked hard to establish new standards for the care of the older person in all care settings, including nursing homes (DAIH, 2008). Yet, the success of this strategy is conditional on the existence of suitable instruments and schemes for the execution and evaluation of change in nursing homes. Presently, recruitment in nursing homes is conducted for the purpose of filling vacancies, while local physicians and nursing assistants, rather than professional nurses and geriatricians, serve as staff members (Hospers et al., 2007). As found in an European study, the lack of ‘quality staff’ in sufficient numbers lowers the standard of care and quality of life experienced by residents in such nursing homes (Nolan et al., 2006a).

Developed countries usually regard ageing as a priority but this is not the case in Lebanon where ‘geriatrics’ is not incorporated in the curricula of all medical and nursing schools (Chemali et al., 2008). There are only seven geriatricians in Lebanon, and there are no geriatric psychiatrists at all in the Lebanon (personal communication, July 2011). Geriatrics is a relatively new field for graduates from medical schools, and it lacks the glamour of other specialties and hence tends to be ‘unappealing’ (Chemali et al., 2008).
Currently, there are no fellowships offered in geriatrics in the country. In 2003, the Internal Medicine Department of the American University of Beirut Medical Center established a geriatric educational programme entitled ‘The integration of outpatient geriatric curriculum into outpatient ambulatory training’ targeting the needs of older adults in the community (Chemali et al., 2008). This programme includes workshops on geriatric care for faculty members and the development of a curriculum for medical trainees. Residents at the centre rotate for one month each year in the inpatient geriatric service and attend outpatient geriatric clinics. This initiative is reported here as it is the first of its kind in the Lebanon (Chemali et al., 2008).

The weakness of older adult care in Lebanon and obstacles to reform is further aggravated by a shortage of social workers in gerontology and the lack of geriatric wards in both public and private hospitals. In addition, research focuses mainly on child health, working-age adults and reproductive-age women and research grants are seldom awarded for older person studies. In the healthcare system, older patients consult with sub-specialists and their medical management can suffer from discontinuity and poor coordination due to the fact that primary care physicians do not carry out the task of care gatekeepers and coordinators (Hospers et al., 2007).

The above considerations result in the lack of policies and accurate data on the ageing population (Sibai et al., 2004). An epidemiological information gap is registered concerning Lebanon’s ageing population and the available data needs updating with further studies. The execution of the Madrid International Plan of Action on Ageing, which was approved by the second WAA held in 2002, necessitates sustained efforts and joint action among the various stakeholders including the government, the private sector, academic circles, civil society, as well as the older people themselves (Centre for Studies on Ageing...
in Lebanon and the Arab Region, 2008). Six years after the second WAA in Madrid, the Lebanese government, recognising the complex challenges and opportunities associated with population ageing, adopted the Madrid International Plan of Action on Ageing (Centre for Studies on Ageing in Lebanon and the Arab Region, 2008). The Madrid Plan gives priority to ensuring that ageing is made an integral part of the international development agenda, to advancing health and well-being into old age, and to creating enabling and supportive environments for older persons (Centre for Studies on Ageing in Lebanon and the Arab Region, 2008).

Despite these changes, the public health, economic and psycho-social implications of population change in Lebanon, and in many countries of the region, are yet to be acknowledged and addressed by policy makers and governmental and non-governmental agencies (Abyad, 2001). Only few governments in the region have implemented policies in support of ‘the old’ and programmes and actions have often been vertical in nature, disease rather than person-centred (Centre for Studies on Ageing in Lebanon and the Arab Region, 2008). Ageing has not been made an integral part of the national development agenda with little, if any, intersectoral collaboration. All of this created an urgent impetus for the initiation of a process in support of ageing, and a working group, composed of professionals involved in research, service provision and policy development, was formulated in Lebanon in December 2006 (Centre for Studies on Ageing in Lebanon and the Arab Region, 2008). The working group organised and convened the first conference in Lebanon on ‘Ageing in Lebanon: Research and Policies’ in September 2007. The conference offered an opportunity to reflect on the stock of challenges ahead and the viable approaches towards more awareness and better practices in the care of older people. Towards this end, participants in the conference strongly recommended the establishment of a ‘Centre for Studies on Ageing’ which would advocate for policy and practice tailored
for the support of older adult in Lebanon (Centre for Studies on Ageing in Lebanon and the Arab Region, 2008).

The founding members of the Centre for Studies on Ageing bring together well connected researchers and academicians from all major universities in Lebanon, geriatriicians, key officials from the Ministry of Health, Ministry of Social Affairs and the Ministry of Interior, members of the National Committee on Ageing in Lebanon, directors of older adults institutes and nursing homes and representatives of NGOs. The centre supports intersectoral collaboration and promotes exchange between researchers, policy makers, service providers and advocacy groups with the aim of strengthening evidence-to-policy and evidence-to-practice links (Centre for Studies on Ageing in Lebanon and the Arab Region, 2008).

Given the growth of the ageing population in Lebanon, especially the oldest-old, who tend to have multiple chronic illnesses, the need for intermittent or continuous long-term care services will undoubtedly grow. Arguably, this need will have to be met with increased nursing facilities and nursing homes or community-based long-term care. Many older people in Lebanon today are healthy and functionally independent (Bou Harb, 2005). However, as in other countries, some will have a high rate of physical and emotional conditions. These complex issues create a population of older people vulnerable to losing their ability to function independently and at risk of becoming frail. The nature of the needs of this population poses challenges for healthcare providers as beyond acute, episodic health problems; the older person may have multiple chronic health problems (Abyad, 2001).
1.4 Nursing Homes in Lebanon

Lebanon houses a total of 49 long-term care nursing homes that include around 4,181 residents (Centre for Studies on Ageing, 2010). Owing to the prevailing caregiving role of family members in Lebanon, the proportion of institutionalised older people remains low. It is estimated that less than two percent of older people in Lebanon are institutionalised (Centre for Studies on Ageing, 2010). These data are explained by the still relatively consistent family network, associated with a system of values that makes the nursing home a last resort both in relatives’ and older people’s eyes. Older people generally have great expectations of help from their children and one of their main fears is to end up living in a nursing home.

Nursing homes in the Lebanon are assigned to one of two categories: profit-making and private non-profit. These nursing homes are spread over the country’s five governorates with most being located in urban areas and having sectarian affiliations that often affect the admission of an older person into a nursing home (Abyad, 2001). As for financial support, it is mainly drawn from two sources. Firstly, the Ministry of Public Health regularly provides a fixed rate of 10 dollars per day, i.e. 40 percent of the expenses, for each nursing home resident. Secondly, charity and other sources of donations constitute the second source and make unsteady contributions (DAIH, 2008). Lebanese nursing homes capacity ranges between 50 and 100 residents, but comprehensive services of the rehabilitative, preventive, and curative types are operated in only three nursing homes (Abyad, 2001). Putting into effect quality control and standardised requirements in Lebanese nursing homes is hindered by the absence of financial resources, especially that public coverage of the expenses does not exceed 40 percent, an obviously small proportion (Hospers et al., 2007).
Professional and ‘round-the-clock’ care is delivered by nurses or nuns, with nurse aides offering assistance with routine daily tasks. The teams caring for nursing home residents, including physicians and nurses, are mostly not trained in geriatric care (Chemali et al., 2008). Also, nurses, and occupational, physical, and speech therapists are not specifically trained in geriatric rehabilitation (Chemali et al., 2008). The majority of nursing homes are therefore understaffed, and in the absence of a multidisciplinary team approach to care, staff often rely on volunteers to provide activities and oversee general care. These volunteers can enrich the lives of the nursing home residents and offer personalised support to each individual, although their services can be ‘intermittent’ (Chemali et al., 2008). Owing to the lack of a specific gerontological textbook on nursing in the Lebanon, the duties of registered nurses have been described to the author (personal communication, 2011) as involving physical care, medical treatment, administering medication, and keeping records. Nursing assistants, for their part, take care of feeding, bathing, positioning, transferring and elimination (personal communication, 2011). Yet, formal communication with the residents is a common feature to both registered nurses and nurse assistants who focus on promptly delivering their services.

Nursing homes deliver two types of health care services: primary health care services available to all residents, and long-term care and rehabilitation services offered to residents suffering from chronic disabling conditions. These nursing homes provide extended inpatient care for people who are not so acutely ill that require the technological and professional intensity of a hospital, but whose condition requires continuous nursing and support services (Abyad, 2001). The population is thus called ‘residents’ and not ‘patients’, especially due to its prolonged length of stay in the institution. It should be noted that the nursing home provides not only medical treatment, but also a lifestyle interventions for its
residents. Therefore, nursing home care should, in theory at least, be provided in a way that enhances, rather than diminishes, the quality of residential life.

Given that nursing homes are privately owned, there is a lack of ‘formal’ governmental care assessment bodies and nursing homes are allowed ‘free rein’ to set their own admission criteria. Moreover, neither the Ministry of Health nor any other body, defines the ‘norms for care’ concerning the residents of nursing homes, which raises questions about the compatibility between such ‘norms’ and the older people’s expectations (Hospers et al., 2007). Moreover, as far as the relationship between quality of life and residential settings is concerned, the single study that has been conducted on older patients in long-term care institutions in Lebanon has shown that there is a positive correlation between being able to keep frequent contacts with a family network and the well-being of older residents (Doumit and Nasser, 2010). Therefore, amongst the factors for the assessment of older people’s quality of life in nursing homes, a central role is played by human relations in general, and by the relationships with the staff of the nursing home in particular. A real contribution to the improvement in older people’s quality of life in residential settings could be achieved for example, by helping them to maintain their personal autonomy by the personalisation of room, having an opportunity to go out and receive friends, to cook their own meals and the maintenance of contacts with families and outside world in general (Hjaltadottir and Gustafsdottir, 2007).

As mentioned above, it is also important in nursing homes to maintain psychological well-being. The study conducted by Doumit and Nasser (2010) revealed that there is a ‘moderate level’ of able older residents, less than 15 percent, who are active in their daily lives and who have a tolerable life in the nursing home. However, the majority of older residents had mild depression measured through Geriatric Depression Scale (Yesavage et
al., 1983) with many expressing loneliness, bereavement and dependence as they moved into a nursing home. The study also revealed that a higher percentage of older residents with mobility problems also had depression and/or anxiety (Doumit and Nasser, 2010).

A nursing home is not only a health care institution; it is also a place where residents live, many for the rest of their lives. This means that ensuring an optimal quality of life for older people in nursing home settings is crucially important. So it is timely and necessary to consider ways of ensuring that the quality of care provided is at the highest level since the quality of life of residents is directly related to the quality of care provided by the nursing home. Understanding residents’ needs and how those needs can best be met is not only a unique function of nursing, it is a nurse’s social obligation.

1.5 Perceptions of Ageing in Lebanon

As stated earlier, Lebanon’s ageing population is rising at a rapid rate. However, the literature on older people and the problems they face is noticeably limited since the attention to this population is only a recent phenomenon. Research work formerly concentrated on ‘their problems’, such as seclusion, reliance, role-loss, and poor health (Centre for Studies on Ageing 2010), thus consolidating a negative description of ageing. Furthermore, sincere advocates and politicians, eager to mobilise support for frail older people, projected an image of health and financial needs which emphasised ageing as a period of dependency. Fortunately, such a negative stereotype is being challenged in light of the shift in the demographic trends and greater public understanding about the contribution of older people to society and their role in the family. In turn, the scientific community has responded by adopting a more positive view of ageing over the last decade. Both researchers and policy makers have shifted the focus from the negative characteristics
of ageing to an examination of this stage of life as a successful experience, with a view to
enhancing well-being for future generations.

Social support provided to the older individuals in Lebanon is pivotal in maintaining their
well-being and enabling them to cope with physical limitations associated with old age.
Social ties represent a major component of social support to help overcome feelings of
loneliness. Higher levels of satisfaction are expressed by older individuals who have
intimate companions. Feeling valued, needed, and having a sense of belonging,
demonstrates the potential to share positive feelings with others. Support also promotes the
older person’s willingness to preserve their health care practices and seek medical care
whenever the need arises. Moreover, Lebanon’s ageing population are updated on current
events, local and international, by seeing and listening to media reports appearing on
television, radio stations and in newspapers. The acquisition of knowledge is also made
possible through the internet and emails which also help maintain communication with
friends and family members, in addition to providing entertainment and education (Centre
for Studies on Ageing, 2010).

Involvement in interpersonal and supportive relationships with friends could be
experienced by a number of older individuals. The reception of physical care from their
children during illness serves to maintain a sense of mutual balance as it reminds them of
similar care they delivered in their youth. Being valued by one’s caregivers may reduce the
expectations of receiving tangible rewards. The support network members are expected to
offer older individuals good judgment, warmth, and a favourable survival pattern for old
age as intangible resources.

Similar to the model of activity theory put forward by Onedera and Stikle (2008),
successful ageing in the Lebanon results from an older individuals’ continued engagement
in activities and social interactions typical of middle age (Bergstrom et al., 2000). The keys to successful life vary from undertaking activities, to making an impression and receiving response. The acquisition of knowledge promotes the older persons’ contentment and meaningful existence. It has been established that participation in these educational activities is conducive to psychological and emotional comfort and to a more favourable perception of ageing (Ritchey et al., 2001).

A common trend observed in Lebanese families, as part of the wider culture of society at large, is about the shift of decision making on family and health issues, from older to younger members. Although this shift is well-intentioned, arguably the exclusion of older family members from decision making deprives them of a sense of meaningfulness and as powerful role models in the family. Consequently, the older person’s level of satisfaction and sense of mutuality and independence, are seriously compromised (Chemali et al., 2008). In the absence of formal data, a number of older individuals express the belief that they constitute a physical and financial encumbrance to their families. They respond with self-imposed seclusion and abstain from articulating their concerns to their family members, which can obstruct the treatment process and compromise the quality of life for both older individuals and their care providers (Chemali et al., 2008).

Now that a large number of older people enjoy an increased life expectancy and better health conditions in comparison with their parents, they are determined to remain active during the rest of their lives by maintaining their intellectual pursuits, social ties, and the feeling of usefulness in one’s own community. The launch of ‘The American University of Beirut University for Seniors’ is meant to help a rising number of older people to fulfill their needs and ambitions by presenting educational and cultural opportunities in a companionable setting. The programme revolves around the three main principles of
community building, peer learning and intergenerational relationships. Whilst ‘The American University of Beirut University for Seniors’ is still in its pilot stage, it will start operating officially in late 2012 (Centre for Studies on Ageing, 2010).

### 1.6 Cultural and Social Highlights

According to Lebanese cultural norms, older people earn tremendous respect through simply ageing whilst at the same time strong family ties are highly regarded. Lebanese traditions dictate that older people be considered a grace and symbol of religious faith, sound judgment, and charity. For these reasons, families usually fulfill their older relative’s health-care and physical needs on a regular basis to ensure emotional and material well-being (Abyad, 2001). Although the majority of the Lebanese population consider the decision to admit their older parents to a nursing home a ‘neglect’ of their moral obligation to ‘keep them by their side’, they are at times left with no other choice (Abyad, 2001).

In addition, women’s increasing entry to the job market, either out of personal conviction or for financial considerations, is paralleled by a decrease in their predisposition to deliver family care including parental care (Abyad, 2001). Thus, the transformation of the patterns of family life and of the health care needs of older people have markedly undermined the usually ‘dominant role’ played by families in delivering care to their older members. Consequently, the tasks performed by nursing homes and the standards of social and medical services made available to the ageing population, are acquiring an increasingly more important social dimension and attention on quality of life.

### 1.7 Summary

This chapter began with a consideration of the health needs of older people in a Lebanese
context and then described care of older people and the delivery of health services to older people in the country. The chapter then provided a description of the existing nursing homes in Lebanon followed by a presentation of perceptions of ageing in Lebanon. A discussion of cultural and social highlights related to the care of older people in Lebanon ensued. The next chapter will explore quality of life in detail and how it could be applied to a Lebanese and Middle-East context.
CHAPTER 2

Quality of Life and Nursing Home Residents: A Review of the Literature

Senior citizens are not a problem but a joy, and improving their quality of life is a genuinely noble purpose
(Milliband, 2001 p. 18)

2.1 Introduction

This chapter begins with a description of the historical picture of older adult nursing in the United Kingdom (UK) as compared to the current situation in Lebanon. Then the main studies that have contributed to an understanding of quality of life in general and quality of life for nursing home residents in particular, are presented. The purpose in presenting these studies is to place the research design in context and to identify the importance of the topic area. Consideration is given to the meaning, conceptualisation, definition, measurement and the existing models of quality of life followed by a discussion of quality of life for older people and nursing home residents, and perceptions of staff members about quality of life. A discussion of the role of family carers in sustaining family relationships and promoting the quality of life of the nursing home residents is also provided. Attention is centred upon the concept of relationship-centred care and the ‘senses framework’ which presents a set of principles that can be used as a basis for constructing a model for older people living in nursing homes, staff and family carers (Nolan et al., 2002, Davies et al., 1999, Nolan, 1997). The chapter then explores social and medical models of nursing home care practice. Finally, a description of quality of life literature in nursing homes in Lebanon is provided.
2.2 Searching the Literature

Whilst the literature addressing nursing home residents’ perceptions and perspectives of quality of life exists in Western societies (Kelley-Gillespie, 2009; Harmer and Orrell, 2008; Bowling et al., 2007; Robichaud et al., 2006; Xavier et al., 2003; Guse and Masesar, 1999; Farquhar, 1995), the same is not true for a Lebanese sample. When the keyword ‘Lebanon’ was applied in combination with other keywords such as ‘quality of life’, ‘nursing home(s)’, ‘care home(s)’, ‘residential home(s)’ to all available databases including PsychoINFO (1887-), PubMed/MEDLINE (1950-), CINAHL Plus (1937-) and Cochrane (1993-) running until 2012, only one study was identified as tackling issues related to quality of life in Lebanese nursing homes. The purpose of this study (Doumit and Nasser, 2010) was to assess quality of life in relation to well-being among Lebanese nursing home older residents. The authors attempted to assess older residents’ psychological and physical health status in relation to institutional structures, processes, and skills and a relatively high level of mild depression among older residents and a lack of mobility were found. The remainder of this chapter, therefore, is drawn from Western writings on quality of life using the results of the search terms and search engines described above.

2.3 History of Older Adult Care in the UK

Modern geriatric medicine practically started at the beginning of the 20th century with the ‘Mother’ of Geriatrics, Dr. Marjorie Warren, known as the most influential pioneering geriatrician (Barton and Mulley, 2003; McCormack and Ford, 1999; Grimley Evans, 1997). Warren created the first geriatric unit in the UK and was the pioneer of rehabilitation which was then designated as central to the care of older people in the 1940s and 1950s (Barton and Mulley, 2003). This was complemented in 1947 through the birth
of the British Geriatrics Society. Pioneers of geriatric medicine flourished and the need to create special posts to provide medical care for ‘neglected’ older people started to become necessary (Cross, 1977).

A growing concern on the care of older people was demonstrated by the increasing numbers of related published reports between 1955 and 1980. The National Health Service (NHS) responded by appointing more geriatrician consultants during the 1960s and 1970s (Barton and Mulley, 2003; Grimley Evans, 1997). However, geriatricians were still considered to have lowest status of all physicians (much as workhouse doctors had once been seen) and this ‘tarnished image’ undermined efforts to recruit trainees and students into the field (Cross, 1977). Confusion about the role of the geriatrician arose as the latter continued to share the work of the general physician in the 1970s (Barton and Mulley, 2003). According to Barton and Mulley (2003), the integration of geriatrics as a specialisation of general medicine and the revision of physician training by the Royal College of Physicians of London in 1977, resulted in successful age defined comprehensive models of care which showed improved multidisciplinary care, decreased length of stay, and reduction in patients requiring long-term care. Despite this evidence, the debate for and against the integration of geriatrics with general medicine continues to this day and remains unresolved.

In parallel, geriatric nursing in the UK also started to grow as a specialty as early as in the 1960s with the first major study on nursing older people by Norton and Exton-Smith in 1962 (McCormack and Ford, 1999). A systematic inquiry of geriatric nursing was also conducted at the Whittington Hospital to help fill the gaps in nursing knowledge related to the care of older people (Adams and McEllwraith, 1963). These studies conveyed ritualised practice based on routine rather than need and according to Brooks (2011), reports on
nursing problems, between 1955 and 1980, highlighted paucity of resources and abuses suffered by patients on geriatric wards. In this oral history study, nurses reported their experiences of obstacles to care in terms of shortages of equipment, expertise, training, lack of managerial support, and the low status accorded to the care of older people (Brooks, 2011). Testimonies reported on the emotional complexity of nursing older people as such and the daily ‘burden’ of hygiene, pressure care, and continence. Most of the participants in their study described their experience as “hard work and often soul-less” (Brooks, 2011 p. 232). Low morale seemed to prevail on geriatric wards. Similar to geriatric medicine, geriatric nursing also suffered from negative social attitudes and mirrored society’s negativity towards the care needs of older people (Adams, 2010).

In an attempt to attenuate this prevailing negativity, the Royal College of Nursing (RCN) published its guidelines on the care of older people in the hospital setting emphasising the importance of treating patients with dignity (Brooks, 2011). Also, geriatric nursing was finally integrated within nurses’ training in the UK in the mid-1970s and became a compulsory part of the nursing curriculum in 1979 (Brooks, 2011).

On the other hand, the rapid expansion of private healthcare for older people between 1979 and 1985 increased the number of private nursing home beds and by 1987 the private had overtaken the public sector as the largest provider of institutional long-stay care. The rising trend toward privatisation of health care in Britain stirred reform of the NHS, as described in the government white paper ‘Working for Patients’ (Department of Health, 1989). The white paper changed different managerial and policy aspects of older people care although it raised much debate of its ability to fulfill the promise of the government to give patients better healthcare (Kayser-Jones, 1990; Appleyard, 1989). In 1990, the NHS and
Community Care Act (Department of Health, 1990) aimed at encouraging the development of community care provision and prolonging older people stays at home (Leeson, 2004). In 1999, the UK Economic and Social Research Council funded the largest research programme on ageing in the UK. The programme brought new insights and produced knowledge on quality of life and active and healthy ageing. The question remains on the use of such evidence by policy makers (Walker, 2004). One answer might have been the Department of Health initiative for the ‘National Service Framework for Older People’ (NSF) published in 2001. The NSF for Older People was a 10-year programme of action linking health and social care services to deliver higher quality care for older adults and promoting culture change so that all older people and their carers are always treated with respect, dignity and fairness (Department of Health, 2001). The programme takes action to improve standards of care, extend access to free services, and ensure free nursing care for people in nursing homes. It also develops new intermediate services which support independence to help people avoid unnecessary hospital admissions and speed recovery and rehabilitation. At the turn of this century, the ‘Supporting People’ initiative was also put forward to help vulnerable people live independently in the community by providing a wide range of housing support services (Leeson, 2004; Department of Environment, Transport and the Regions, 2001).

The care of older people in the UK has come a long way since the days of ‘routinised geriatric care’. Older people’s health services have largely improved and presented a strongly viable example of multidisciplinary collaboration for comprehensive patient care, improved hospital environments, and rehabilitation. On the whole, the negative views of the specialty have been replaced by optimism for new research and practice horizons.
2.4 The Lebanese Context Compared to the UK

In the past few decades, rapid declines in fertility and mortality in Lebanon have set the ground for an ageing population. Projections show that people aged 65 years and over are expected to constitute 10.2 percent of the population in the next decade (Sibai, 2004). In spite of this fast-growing ageing population, care for older individuals is still playing catch-up. The available healthcare delivery does not match the corresponding healthcare needs neither on the governmental, social security, and pension plan levels nor on the level of standards of care and health professional training (Chemali et al., 2008; Hospers et al., 2007; Sibai et al., 2004; Abyad, 2001).

Healthcare delivery in Lebanon is largely dominated by the private sector and is driven by a free-market financing structure (Sibai et al., 2004). Only few services targeting older adults are covered by the Lebanese Ministry of Public Health and those include curative and high-technology and expensive services (Chemali et al., 2008; Sibai et al., 2004). Current healthcare in Lebanon neglects primary care and preventive services in particular those targeting older adults (Sibai et al., 2004).

Older people seem to be marginalised in the health policy-making process as old-age pensions or retirement plans are still lacking and largely dependent on a history of employment (Hospers et al., 2007; Sibai et al., 2004; Abyad, 2001). Tohme et al. (2011) confirm this reality reporting that 74.8 percent of older adults depend on their children’s income with only a very small share derived from pension schemes. Actually, individuals covered by the Lebanese Social Security Fund, adapted from the European model of social security schemes, lose their health insurance upon retirement and post-retirement entry into insurance coverage becomes largely difficult and unaffordable at that age. This is particularly significant to women since the majority depend upon the income and work-
related benefits of the male breadwinner, or charity institutions and distant relatives, if the option exists (Sibai et al., 2004; Abyad, 2001).

Although the Lebanese Ministry of Public Health planned specific development objectives aiming at improving the quality of primary and preventive health services, none of the objectives target older adult care in particular (Ministry of Public Health, 2007). According to Doumit and Nasser (2010), there is neither formal licensing nor surveillance procedures for nursing homes in Lebanon. Nursing homes also seem to be lacking adequate equipment with limited space and crowding due to poor funding.

Non-governmental programmes aimed at supporting family members, offering day care services, respite care, and home health care are on the rise (Sibai, 2000). In 2004, Alzheimer Association Lebanon was launched as one of the first associations targeting specific older adults’ conditions (Alzheimer Association Lebanon, 2010; Chemali et al., 2008). As mentioned in chapter 1, The American University of Beirut has also started the first University for Seniors programme in the Middle-East contributing to non-governmental efforts to empower older adults and help them maintain their independence (American University of Beirut, 2012).

The availability of specialised geriatric health professionals remains scarce in Lebanon (Hospers et al., 2007; Sibai et al., 2004). Nursing homes are still staffed on an ‘as-needs’ basis lacking specialised health professionals with gerontological training. Residents’ medical management often lacks continuity of care and coordination due to the conflicting role of family doctors who often do not play the role of gatekeepers (Hospers et al., 2007). Although the number of physicians in Lebanon is almost equal to that in developed countries, specialised geriatricians rarely exist (Hospers et al., 2007; Abyad, 2001). The shortage in trained geriatricians seriously undermines the country’s ability to assess, treat,
and rehabilitate the growing older population and leads to inappropriate care, higher costs, and poorer patient outcomes (Abyad, 2001).

Gerontology education, if any, is minimal in the medical or nursing curricula in universities in Lebanon and, indeed, specialised and formal geriatric education, is still missing (Hospers et al., 2007; Sibai et al., 2004; Abyad, 2001). The American University of Beirut, Faculty of Medicine was the only university to start a geriatric educational programme in 2003 (Chemali et al., 2008), and the School of Nursing at the American University of Beirut integrated geriatrics in the nursing curriculum only recently. Working with older people is not regarded as rewarding according to Abyad (2001). Research activities targeting older adults health is also minimal although it is definitely on the rise (Center for Studies on Aging, 2010).

2.5 Translating Western Models of Care to the Lebanese Context

Although epidemiological information in Lebanon is largely lacking (Sibai et al., 2004; Abyad, 2001) and demographics in the UK and Lebanon differ, it could be argued that the current situation in Lebanon is comparable to that in Britain during the 1970s. Clearly, there are inherent differences in the healthcare systems, financing, and demographics between Lebanon and the UK. However, a number of similarities are identifiable when one looks at the current situation in Lebanon and the related history in the UK. For example:

(1) Decreases in mortality and fertility have prepared the ground for an ageing population in Lebanon.

(2) Whilst older adults are highly respected in Lebanon they can still be viewed as a ‘burden’ to their families and attributed few rights for autonomous decision-making.

(3) Caring for older adults is given a low status and may hold negative social and ageist attitudes.
(4) Gerontology is minimally included in health professionals’ education and training in Lebanon.

(5) Reports about poor quality care for older adults are evident from few studies in Lebanese nursing homes. Nursing homes lack adequate funding and suffer from limited space and equipment as well as reduced staffing and specialty resources.

Similarities also include the current rise in the awareness of the importance of primary and rehabilitative health services for older adults. Academia and research have stimulated this awareness in both countries and facilitated a growing interest in research on ageing. Also, professional associations aimed at improving older adult care have emerged in Lebanon in line with the government’s attempt to address ageing needs with the creation of the PNCE. A major contribution is noted by international non-governmental organisations such as World Health Organisation (WHO) and United Nations Population Fund which have established several collaborative programmes addressing care needs of older adults.

However, in contrast to the UK where healthcare services for adults is significantly controlled by the government and state funding, healthcare delivery in Lebanon is largely dominated by the private sector and is driven by a free-market financing structure. This places a significant challenge in front of the Lebanese government in that standards, licensing and surveillance systems need to be put in place to ensure service equity and accountability. However, the Lebanese government has yet to take assertive measures to address this need.

In a comparison of healthcare delivery systems for older adults in Lebanon and the Netherlands, Hospers et al. (2007) recommend that Lebanon learns from the Netherlands experience particularly on the governmental level. The authors believe that the institution of older adult care programmes at the government level in the Netherlands can serve as an
example for Lebanon by targeting the needs of the ageing population and the changes in societal norms. Hospers et al. (2007) also recommend a financial model whereby healthcare for older adults is government funded. The application of such a financial model may be questionable as the Lebanese government is already faced with a multitude of fiscal and economic challenges. However, funding resources may be available from international bodies interested in the advancement of ageing studies and related healthcare reform in developing countries (Center for Studies on Ageing in Lebanon and the Arab Region, 2008). Further research is needed to provide more evidence on the transferability of Western models of geriatric care to the Lebanese healthcare system.

Recently, the Economist Intelligence Unit (2009) presented updated strategies about the provision of healthcare for ageing societies throughout the world. Those strategies are prominently in line with the UK model of geriatric care. The Economist Intelligence Unit (2009) calls for action regarding six major issues governments need to address including: (a) the financial impact of ageing on healthcare, (b) revising health professionals’ education to include a bigger part for geriatric care, (c) re-considering government vs. private funding, (d) making treatments more appropriate for the older population, (e) enabling home-based care, and (f) changing society’s mindsets about older people thus creating awareness on ageing.

The unprecedented growth of the older Lebanese population and social and economic developments in Lebanon have created new realities which have stirred the need for thoughtful healthcare reform. Lebanon needs to seriously define the policies and programmes that will address the financial burden of an ageing population and ensure the availability of social and health services for older persons. Although this is a significant
challenge, Lebanon has the opportunity to learn important lessons from previous experiences and from UK reforms and experiences.

2.6 Concept of Ageing

The classical perception of ageing as a time of decline is now challenged with the rise in the number of active and productive older people (Vaillant and Mukamal, 2001). Ageing is now seen by modern theories as growth, while role abandonment and regression are linked with pathology rather than being seen as the ‘usual’ pattern (Onedera and Stickle, 2008). Accordingly, although later phases of life can differ in terms of quality, they can still be characterised with energy and productivity whereby older people maintain their development and positive contact with their environment (Lange and Grossman, 2006). What is of considerable interest is the way in which the study of ageing has shifted, from portraying old age in terms of its losses to the notion of ‘successful ageing’ (Lupien and Wan, 2004). As Glass (2003) has argued, ageing should be seen from the position of independence, self-esteem, and a lack of suffering, instead of being restricted to the prevention of disease and disability.

Old age offers opportunities for positive change and productive functioning and should not be mistaken for illness (Walker, 2001). Researchers and practitioners in the field have admitted this existing phenomenon following a change in focus from negative signs of diseases to signs of psychological and physiological well-being. As a result, quality of life research in gerontology is placing more emphasis upon each individual’s feelings of control and coping (Walker, 2001). Whilst it may appear paradoxical, an examination of the concept of ageing should take into account the three aspects of decline, change, and development (Vaillant and Mukamal, 2001). Universally, people’s senses start to gradually weaken after the age of 20, and by age 70 they can only recognise half the smells they used...
to detect at the age of 40 (Doty et al., 1984). Similarly, vision in poor light gradually fades so that at the age of 80 very few older people manage to drive at night (Woodruff-Pak, 1997).

Yet, the expression and lived experience of ‘ageing’ connotes and denotes transformation. The same way trees change in spring and winter time, our hair goes grey, and our eyes develop crow’s feet. However, according to a fundamental truth, people’s predisposition to love and be loved is not altered over time, nor is their inclination to experience joy (Vaillant and Mukamal, 2001). The expression ‘ageing’ also connotes development and maturation. Similar to the evolution of cru wine from bitter to mature and quality wine, people at the age of 70 have developed greater patience and tolerance (Carstensen, 1992). They are more inclined to accept paradox, to value relativity, and to admit the inevitable link between the present, the past, and the future (Vaillant and Mukamal, 2001). In turn, this has implications for what could be considered successful ageing and well-being.

### 2.7 Successful Ageing and Well-being

The WHO (2002) has stressed that healthy ageing goes beyond avoidance of disease and disability. However, further agreement on what factors constitute successful ageing is surprisingly limited (Depp and Jeste, 2009). The prevailing model, advanced by Rowe and Kahn (1997), characterises successful ageing as involving freedom from disability along with high cognitive, physical, and social functioning. At the end of the 1990s, Rowe and Kahn (1998) expanded their definition to include three criteria: (a) absence of disease, disability, and risk factors like high blood pressure, smoking, or obesity; (b) maintaining physical and mental functioning; and (c) active engagement with life. This last criterion included both being connected to other persons and engaging in productive activities. To be ageing successfully one had to meet all three criteria (Strawbridge et al., 2002).
This substantive review indicates that there is no consensus in the literature about whether successful ageing should be defined objectively by others or subjectively by older adults themselves or about which components are necessary and/or sufficient (Depp and Jeste, 2009). Nevertheless, one characteristic of a good definition of successful ageing should be its use in differentiating older persons on quality of life outcomes (Lewis, 2011). Given the variations in the definitions of successful ageing, it would be useful to see what could be learned by helping older people to rate their own success at ageing and then compare the associations of these rating and quality of life outcomes with those obtained by using a definition proposed by health professionals (Strawbridge et al., 2002). However, definitions of successful ageing still place an emphasis on health and physical functioning rather than a more inclusive conceptualisation that would include well-being. The adjective *successful* has itself proven problematic because it implies a contest in which there are winners and losers; most gerontologists are not ready to call someone ‘unsuccessful’ merely because he or she is disabled or diagnosed with diabetes (Strawbridge et al., 2002).

Any successful ageing definition must be reflected in well-being to be valid, unless one wants to restrict success merely to longevity or absence of disability (Depp and Jeste, 2009; Strawbridge et al., 2002; Rowe and Kahn, 1997). It is worth noting that in a study of successful ageing conducted by Strawbridge et al. (2002), even though physical health was instrumental in older people’s perceptions of successful ageing, poor physical health did preclude participation. This is important, as most of the literature on successful ageing found that older people with a chronic illness or disability still viewed themselves as ageing successfully (Strawbridge et al., 2002). Indeed, Lewis (2011) argued that the older people’s emotional well-being and spirituality kept them from thinking negatively about their health status and being unable to engage in social and physical activities. In the study conducted by Lewis (2011) on Alaska Native Elders, the concept of physical health
encompassed numerous facets of life for the elders, such as eating a traditional diet, being as active as they are able, and abstaining from drugs and alcohol. Similarly, Brown (2005) discusses the importance of physical activity throughout life and says that it goes hand-in-hand with successful ageing:

“Exercise, one of the best tools we can give our older adults to take charge of their own health, mentally and physically.” (p. 28J)

Brown (2005) goes on to say that exercise can help ease feelings of stress, depression, and loneliness and she urges older people to take up a form of exercise, such as jogging or running. It was shown in Lewis’s (2011) study that even moderate exercise, such as staying busy in the community or engaging in subsistence activity, helps improve quality of life, both mentally and physically, of the Alaska Native Elders.

2.8 Quality of Life

2.8.1 Meanings and Conceptualisations

Over the past 20 years there has been a shift from studying the notion of well-being to quality of life (Gilhooly et al., 2005; Walker, 2001; Tester et al., 2001; Smith, 2001). This shift in discourse and research work has been prompted by different positions. First of all, medical practitioners began to admit that some diseases are not ‘cured’ by treatments and interventions and that, instead, their severe symptoms can only be alleviated (Gilhooly et al., 2005). For instance, in the case of heart diseases, a coronary artery bypass surgery can ease angina pain rather than cure the disease or guarantee the prevention of a heart attack. Consequently, patients can lead an almost ordinary life and preserve their independence. On the other hand, expressions like ‘satisfaction’ or ‘enhanced happiness’ do not have a scientific health-related connotation (Gilhooly et al., 2005) which runs contrary to an improvement in ‘quality of life’ that does have such measurement indicators (Gilhooly et al., 2005).
During the 1990s research work on quality of life broadened and over 100 definitions and more than 1000 measures of its different aspects have been proposed as a result (Cummins, 1997; Hughes and Hwang, 1996). Accordingly, these various interpretations of quality of life have impeded progress in research despite the enhancement of methodological rigor (Walker, 2005). Currently, a disagreement exists over a common perception of a theoretical framework for quality of life and the aspects that need to be taken into account to come up with an inclusive definition acceptable to adults (Halvorsrud and Kalfoss, 2007). What matters is to understand if the conceptualisation of quality of life for older adults is accepted by middle-aged younger adults (Brown et al., 2004).

According to the traditional conceptualisation of quality of life from the standpoint of adults, it involves physical health, social ties and support, milieu, financial and material conditions, and cognitive beliefs (Halvorsrud and Kalfoss, 2007). Researchers now agree that quality of life for older adults reveals a multifaceted notion comprising physical, emotional, and social realms (Buckley and McCarthy, 2009; Cooney et al., 2009; Idler et al., 2009; Kelley-Gillespie, 2009; Luleci et al., 2008; Natan, 2008; Murphy et al., 2007; Murphy, 2006; Brown et al., 2004; Bowling et al., 2003; Bowers et al., 2001). In addition, quality of life has to be examined from each person’s point of view (Walker, 2005). One of the basic challenges faced by researchers is the neglect of certain areas significant to older adults. It is suggested in this regard that little attention has been devoted to the evaluation of certain aspects such as the transition from work to retirement, taking part in group activities, changes in the social networks involving family and friends, intimacy concerns, and spiritual questions of life and death (Farquhar, 1995). It also appears that an older person’s list of priorities includes ties with family and others, independence, financial support, health, spiritual considerations, and institutional care (Brown et al., 2004).
2.8.2 Defining Quality of Life

Quality of life is a multi-level and amorphous concept, and is popular as an endpoint in the evaluation of public policy, such as the consequences of health and social care (Brown et al., 2004). Although the basic areas of quality of life pointed out by the literature refer to adults of all ages, they differ in order of priority for individuals belonging to various age groups (Bowling, 1995a, b). Nevertheless, researchers have failed to agree on a transcending theoretical framework of quality of life and a number of research frameworks have been used in the inquiry process (Walker, 2005; Brown et al., 2004). Consequently, in spite of the abundance of research on a variety of objective and subjective indicators of quality of life, there is still no consensus about a theory or a measurement tool of the quality of life (Brown et al., 2004; Walker, 2004).

Despite the broad agreement on the lack of a single definition of quality of life (Smith, 2001), there is a disinclination to equate it with hedonic happiness or *eudaimonia* (Gilhooly, 2005). This can be attributed to the increasingly extensive literature indicating that a link exists between happiness and psychological well-being on the one hand and personality traits on the other which are controlled by one’s biological make-up (Diener, 2000; Myers, 2000; Diener and Diener, 1996).

Given the conceptual confusion in the literature, it is important to explore what makes quality of life comparable or dissimilar. Here, the literature suggests that quality of life involves less subjectivity than happiness (Gilhooly, 2005). Moreover, it has increasingly been acknowledged over the past years that the assessment of quality of life depends on the individual’s personal experience (Bowling, 1997). The description of quality of life has also been narrowed down to specific areas such as health-related quality of life (Gilhooly, 2005; Walker, 2004), or it has been linked to specific diseases, hence the production of the
Diabetes Quality of Life Questionnaire (McKee et al., 2002). Since a large number of quality of life measurements involve an array of life aspects such as health, relationships, work, and milieu, it seems that the heart of the matter consists of the level of satisfaction regarding all aspects of life from each person's angle (Gilhooly, 2005), thus making it closer to *eudaimonia* than to hedonic happiness.

Blane et al. (2002) conceived quality of life in terms of need fulfillment in four fields:

1. Control, i.e. the need to feel that one is a free actor in one’s milieu;
2. Autonomy, i.e. the need to feel that one is free from unwelcome intrusion in their privacy;
3. Self-fulfillment, i.e. the need for self-actualisation;
4. Pleasure, i.e. the need to experience enjoyment.

In contrast, the World Health Organisation Quality of Life (WHOQOL) Group (1995) defined quality of life as:

“An individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept that is affected in complex ways by a person’s physical health, psychological state, level of independence, social relationships, and their relationships to salient features within the environment.” (p. 1405)

This group of investigators attributed six broad areas of quality of life as: (a) physical health; (b) psychological state; (c) levels of independence; (d) social relationships; (e) environmental features; and (f) spiritual concerns including personal beliefs. In this definition and list of attributes, quality of life suggests a subjective assessment rooted in a cultural, social, and environmental setting. Therefore, quality of life is not simply the equivalent of health conditions and, instead, it is a multifaceted notion comprising one’s perception of these and other facets of life (Kelley-Gillespie, 2009; Degenholtz et al., 2008; Padilla et al., 2004).
A contrast is at times drawn between quality of life and physical health (Kane, 2003), whereas for others it is a summary expression implying a multifaceted assessment of diverse important spheres of life, and health outcomes amongst other things (Arnold, 1991). When quality of life is used and applied in this manner, it is summed up in one score or portrayed in a set of scores that mirror various constituents or areas of quality of life. The expression health-related quality of life (HRQOL) reduces the notion of quality of life to facets of life influenced by an individual’s health status and the corresponding treatment (Drageset et al., 2009a, b; Patrick and Erickson, 1993).

Indeed, a plethora of HRQOL measures exist, with one part connected with general health-related quality of life, and another part connected with quality of life regarding a particular disease (McKee et al., 2002). To try and provide some clarity to the field, the ‘SF-36’ quality of life was introduced to decrease the number of spheres which later underwent additional reduction (McHorney et al., 1994). The SF-36 is a multi-purpose, short-form health survey with only 36 questions. It yields an 8-scale profile of functional health and well-being scores as well as psychometrically-based physical and mental health summary measures, and its different versions are often employed in quality of life measurement (Ware, 1992). The WHOQOL is a questionnaire that includes 28 questions on a variety of physical, functional, psychological, social, and satisfaction elements (Kuyken and Orley, 1999). On the other hand, the EuroQol (Dolan, 1997) condenses the HRQOL to five questions corresponding to the five domains of: mobility, self-care, routine activities, pain/disquietude, and unease/depression (Dolan, 1997).

A strict interpretation of HRQOL could be sometimes offered by health settings. The suggestion of measuring the ability to perform the activities of daily living (ADL) in the 1960s was made for the purpose of examining the impact on rehabilitation patients by
assessing quality of life without confinement to disease parameters (Katz et al., 1963). Although ADL continues to be used, the older person’s capacity to go to the bathroom, eat, move, get dressed, and bathe on their own can by no means imply having a high quality of life (Kane, 2003). In addition, oncologists equate a period of good health with quality of life (Kagawa-Singer et al., 2010; Kane, 2003); however, they have now widened the scope of assessment to include concepts such as psychological well-being and social activities as indicators of quality of life (Kelley-Gillespie, 2009; Kane, 2003). A more comprehensive notion of quality of life replaces HRQOL due to the complete change occurring in the older person’s life conditions upon their move to a nursing home (Kane, 2003).

In the context of this study, quality of life is perceived as being multifaceted and it reflects the way the older person’s subjective experience of life is shaped by their milieu, culture, and activities, as well as by the relationships they build with other people.

2.8.3 Models of Quality of Life

In the framework of the European FORUM project, Brown et al. (2004) developed a classification and a methodical review of the literature pertaining to the issue of quality of life. Bowling and Gabriel (2004) differentiate between macro-definitions, i.e. societal or objective, and micro-definitions, i.e. individual or subjective, of quality of life. Brown et al. (2004) lists income, employment, housing, educational background, and other environmental conditions in the former category, whereas general conceptions of quality of life, subjective experiences and values, and proxy or indirect indicators such as comfort, happiness and contentment in life in the latter category. Furthermore, Brown et al. (2004) indicate that quality of life models make-up a broad spectrum that involves almost everything starting from Maslow’s (1954) hierarchy of needs up to traditional models founded on psychological well-being, happiness, self-confidence, life contentment (Larson,
1978), social expectations (Calman, 1984) or the individual’s distinctive perceptions (Brown et al., 2004).

Bowling and Gabriel (2004) identify eight different models of quality of life whose application to the gerontological literature requires minor adaptation:

1. **Objective social indicators** of standard of living, health and longevity, while providing information about income, financial status, morbidity and mortality. European efforts have been lately targeted at the creation of a harmonious set of social indicators (Walker and Van Der Maesen, 2004); however, no implementation of such indicators to population subgroups has yet been achieved.

2. **Fulfillment of human needs** (Maslow, 1954), normally determined by referring to a person’s subjective contentment with the degree of need satisfaction (Bigelow et al., 1991).

3. **Subjective social indicators** of life contentment and mental well-being, self-confidence, self-worth, personal satisfaction and cheerfulness, normally calculated by applying standardised, psychometric scales and tests (Clarke et al., 2000; Suzman et al., 1992).

4. **Social capital** exemplified in personal resources, determined by indicators of social networks, backing, sharing in activities and participation in community life (Knipscheer et al., 1995; Bowling, 1994).

5. **Environmental and community resources** involving objective indicators like crime rates, housing standards, quality of services, availability of transport, as well as subjective indicators like contentment with dwelling, local facilities, transport, technological know-how, and conception of friendliness and personal security (Scharf et al., 2004; Cooper et al., 1999).
(6) Health and functioning, with an emphasis on physical and mental abilities and inabilities, as well as on general health conditions (Beaumont and Kenealy, 2004).

(7) Psychological models of factors including cognitive skills, independence, belief in one’s ability to perform a task, command, adjustment and problem management (Grundy and Bowling, 1999; Filipp and Ferring, 1998).

(8) Hermeneutic approaches underlining the person’s values, understanding and perception, normally examined with qualitative or semi-structured quantitative techniques (Gabriel and Bowling, 2004; Bowling and Windsor, 2001; WHOQOL Group, 1993).

Minimal efforts have been made to explore these models methodically or analytically despite their provision of frames for quality of models that extend over different fields ranging from gerontology, to social network mapping, health, and social impact research (Bowling and Gabriel, 2004). Policy makers and professionals, for instance, have begun to devote attention to health and social care over the past two decades at a time when practice is substantiated by facts. This interest has also produced definite HRQOL impact scales, yet less ambitious effort has been made to define and formulate a concept for a model of quality of life to be used as a foundation (Bowling and Windsor, 2001). Nevertheless, social gerontology recognises the necessity to transcend health and disease patterns of ageing and the main concerns outlined by professionals, and to take into account the older person’s outlook on quality of life, its significance to them, and the way it can be improved. As has been indicated in the review prepared by Brown et al. (2004), many valued aspects of human existence do not relate to health only, but include the environment, housing, income and freedom of expression.
In addition, academic and clinical research should depart from ‘professional centrisn’ (Stastny and Amering, 1997) and make sure that their models and measurement tools are based on the non-experts’ outlook, rather than on theoretical models exclusively. Bowling and Gabriel (2004) referred to the non-experts’ highlighting independence as a basic component of boosting the older person’s quality of life, while this concept is either dropped or not given due consideration by familiar measurement scales (Brown et al., 2004).

Fry (2000) pointed out that most models in gerontology have neglected people’s wants, hopes, aspirations, opportunities and preferences, as well as the quality of life levels individuals have become resigned to accepting, whereas surveys seldom, if ever, asked older persons about their anxieties concerning the future quality of life. It follows that the most valid approach to assessing what quality of life consists of, is to invite people to describe what quality of life means to them through the use of in-depth interviews and to balance the latter with more standardised objective and independent measurements (Mukherjee, 1989). Obviously, no single model of quality of life can be universally applicable or equally fair to all cultures. Special care is required if these models are to be transported from one culture to another, or if meaningful comparisons are to be made between cultures. Some of the key issues here include cultural differences in sense of self (Triandis, 1994), perception of others (Markus and Kitayama, 1991), cultural assumptions (Keith, 1996) and the translation of meanings (Brislin, 2000). For example, assumptions about happiness, well-being or satisfaction may not be universal, and judgments of quality of life based upon such assumptions may not be generalisable from one culture to another (Rapley, 2003). Keith (1996) suggested that one culture’s solitude may be another’s loneliness, depending on the self-construal of the individual within his or her culture.
Furthermore, Kitayama and Karasawa (1997) found that self-esteem may be perceived differently in individualistic than in collectivistic cultural settings.

The assumption that a particular dimension critical to quality of life in one culture is equally important in another culture, may also be incorrect (Kagawa-Singer et al., 2010). For example, although nearly every culture may value intelligence, the particular aspects of intelligence (speed, deliberation, consideration of alternatives) may vary widely (Keith, 1996). Failure to recognise these differences can lead to profoundly mistaken conclusions about comparative quality of life. Arguably, awareness of these cultural issues should be maintained on a number of levels, beginning with the research phase of theory development and extending through the time of its clinical application. Therefore, cross-cultural application of these quality of life models is highly significant if it can move social scientists and gerontologists towards improved knowledge and understanding of cultural similarities and differences. It is, nevertheless, also fraught with potential challenges that must be taken seriously if cross-cultural data are to contribute to realising the potential of meaningful application of the quality of life concept.

2.8.4 Measuring Quality of Life

As put forward by Farquhar (1995), measuring quality of life can be done in two ways, through either structured or non-structured instruments. The use of structured instruments, such as scales, indicates that the concept of quality of life adopted is formulated by the researcher, but the methodology followed in conducting non-structured interviews gives older people the opportunity to point out the factors behind their positive or negative perception of quality of life. Similarly, a large number of structured scales and tests have been advanced to measure quality of life (Gerritsen et al., 2007; Xavier et al., 2003). The huge variety as to their conception, construct, and content shows the diverging
interpretations of a measure of quality of life. From the available literature, it is hard to prove the validity of the measurements of quality of life owing to the lack of modes of identifying the ‘gold-standard’ that the scales are to be compared to. Moreover, the majority of scales have so far been established by professionals on the basis of their criteria and definitions of what makes quality of life (Borglin et al., 2005; Slevin et al., 1988). Conversely, the emotional perception of life is a subjective and a key factor contributing to an individual’s well-being that could be seen as meaningless by another. An older person may also seek spiritual fulfillment rather than joining a group of friends and therefore consider it a key factor contributing to quality of life (Idler et al., 2009). An examination of quality of life, in such a case, by using a structured scale that calculates the scores for the areas of ‘social life’, ‘physical health’ and ‘psychological health’, cannot measure spiritual fulfillment, the factor making this individual’s quality of life positive (Xavier et al., 2003).

Given that the use of structured measuring instruments presents problems, non-structured interview techniques can offer a clear explanation of quality of life. Correlating the scores achieved by professionals and patients, Slevin et al. (1988) inferred that a quality of life instrument has to be produced by the patients, not from doctors or nurses, if a credible method to measure quality of life for cancer patients is required. In the same vein, Calman (1984) argued that the description and measurement of quality of life is a strictly personal task. Due to the fact that the constituents of quality of life are function of each individual’s subjective preferences, relying on each interviewee’s definition is perhaps the best way to measure it (Xavier et al., 2003).

2.9 Quality of Life for Older People

Arguably, growing old denotes a shift from seeing oneself as a young and appreciated person to someone whose self-image is marked by vulnerability and incapacity, and a shift
from an esteemed to a disesteemed self (Markus and Nurius, 1986). The association between increased dissatisfaction with one’s body and ageing does not rely on uniform proof (Mckee et al., 2005). In fact, the opposite has been demonstrated by some studies whereby older people express a higher level of satisfaction with their body than younger people (Reboussin et al., 2000). Nevertheless, the older person’s satisfaction is linked to body function rather than body appearance, and the former has a close connection with well-being (Reboussin et al., 2000).

Arnold (1991) argued that the evaluation of quality of life for older people involves a number of elements, such as body function and physiological symptoms, emotional, behavioural cognitive and mental performance, social performance and support, life contentment, health perceptions, financial status, capacity to engage in leisurely pursuits, sexual performance, vigor and liveliness. Darnton-Hill (1995) underscored income as a determinant of life expectancy and quality of life for the ageing population. For Lawton (1983a, b, 1982) the older person’s well-being could be embodied in behavioural skills, one’s perception of quality of life, mental well-being and the external, objective (material) milieu. He formulated this as a four-dimensional concept of the ‘good life’ for older people (Lawton, 1983a), a concept he transformed into the more comprehensive expression ‘quality of life’ at a later stage. This model enjoys acceptance to date and has undergone testing in Europe where it effectively differentiated between the ageing populations of Sweden and Poland (Jaracz et al., 2004), hence the solidity of his theoretical framework nearly 30 years following its establishment.

Even though the definition of quality of life certainly reflects a subjective opinion and is function of one’s own perceptions, empirical data on the ageing population’s understanding of quality of life refers to good health and functional capacity, a sense of
self-worth, social involvement, friendship ties and social support, income and general socio-economic status (Breeze et al., 2001; Bowling et al., 1996). The literature also suggests that the subjective rating of one’s own psychological comfort and health plays a more pivotal role than objective financial or socio-demographic indicators in interpreting the discrepancy in rating quality of life (Gorecki et al., 2009; Bowling and Windsor, 2001).

On the other hand, Lawton (1991) identified temporal dimensions for quality of life that involve contemplating the past, holding expectations about the future, and assessing the present. Likewise, Katz and Gurland (1991) advanced a holistic concept they describe as:

“... an irreducible network of interwoven parts, encompassing the older people themselves (mind, body, and spirit), their animate and inanimate environment, their life experiences in time and space, and the functions or powers created by the interwoven parts.” (p. 341)

Their conceptual framework outlines 14 spheres of quality of life for the ageing population as follows: (a) physical performance; (b) self-maintenance; (c) routine activities; (d) social performance; (e) sexual performance and intimacy; (f) emotional well-being and suffering; (g) cognitive performance; (h) distress; (i) vigor/tiredness; (j) sleep; (k) self-worth; (l) sense of control; (m) perceived health; and (n) life contentment (Katz and Gurland, 1991). A number of these spheres were later arranged into subcategories (Stewart and King, 1994) which reinforce the notion that quality of life is a multifaceted concept but it is less obvious what facets need to be made use of in the examination of the ageing population’s well-being (Luleci et al., 2008; Kane, 2003).

Walker (2005) maintains that the older person’s quality of life derives from the interactive blend of life course factors and direct situational ones. For instance, earlier professional status and middle-age caring roles influence access to resources and health at later life stages (Evandrou and Glaser, 2004). Another study has indicated that the impact of
existing factors, such as group relationships, could be more significant than the factors at play during one’s life course, despite the connection between both (Wiggins et al., 2004). However, the interactive approaches need to be set against the context of the political economy (Walker, 2005). As this review has demonstrated, quality of life for the older person does not simply consist of personal life courses and psychological resources, but should involve the person’s range of action, the diverse restrictions and prospects existing in various social settings (Tu et al., 2006). These factors need to include financial security, community solidarity, social integration, social empowerment and spirituality (Idler et al., 2009; Walker and Van Der Maesen, 2004).

Bowling et al. (2003) argue in a mixed methods study that quality of life consists of a multifaceted set of objective and subjective spheres of life whose components influence one another. Consequently, personality traits acquire a major significance in handling the challenges confronting the ageing population. Thus, defining quality of life and measurement should involve acknowledgement of the active interaction between individual traits, conditions, and the existing social frameworks (Gilhooly, 2005). A wide range of studies have also shown that people are consistent in the domains they identify as being important for the quality of their lives (Varricchio and Ferrans, 2010; Murphy et al., 2007; Hjaltadottir and Gustafsdottir 2007; Robichaud et al., 2006; Brown et al., 2004; Bowling et al., 2003; Kane, 2003). These domains include: (a) health; (b) psychological well-being; (c) social relationships; (d) emotional well-being; (e) activities; (f) home and neighborhood; (g) financial circumstances; and spirituality and religion. The domains identified by older people in this study overlap significantly with the findings on quality of life from the general ageing literature.
2.10 Nursing Home Life in the Literature

An extensive literature review enabled Nolan et al. (2001a) to ascertain the existence of ample gerontological theory that permits an agreement about the components of a good life for older people. According to these authors, these theories should be synthesised to produce a measure of analytical generalisability. On the basis of a literature review of the existing theories and of an earlier publication by Nolan (1997), the authors formulated the concept of relationship-centred care and the ‘senses framework’ to explain this phenomenon (Nolan et al., 2002, 2001b; Davies et al., 1999; Nolan, 1997). Such a framework comprises six senses that capture major subjective and perceptual elements of care experience for residents and staff members necessary for good quality care to be delivered (Nolan et al., 2006a).

The six senses were conceptualised by Nolan et al. (2004) in the following way:

1. A sense of security, i.e. to feel safe in relationships.
2. A sense of continuity, i.e. to develop links and experience regularity.
3. A sense of belonging, i.e. to feel that one is ‘part’ of things.
4. A sense of purpose, i.e. to pursue a personally treasured objective or objectives.
5. A sense of achievement, i.e. achieve advancement towards a desired goal or goals.
6. A sense of significance, i.e. to feel that one ‘counts’.

The six senses outlines the basic principles of ‘relationship-centred care’ that infuses nursing home culture with positive attributes (Nolan et al., 2001b). This type of care acknowledges and aims at fulfilling the needs of the residents, their families and the staff members who deliver care (Owen et al., 2006). The senses framework also captures the subjective and perceptual elements of the caring relationship and mirrors interpersonal
communication and the intrapersonal experience of offering and receiving care (Nolan et al., 2004).

Intensive field testing of the senses framework and relationship centred care (Nolan et al., 2002, 2001b; Davies et al., 1999) has shown the importance of the senses in understanding the needs of older people and their care providers, and it has also demonstrated that the senses can be used as a basis for constructing a model for relationship-centred care. The delivery of the highest quality care then depends on experiencing the above mentioned senses by all those involved in caring relationships, be they the older persons, their families or staff members.

The senses were recognised as devising a method to fulfill a ‘vision’ of care incorporating ‘fundamental’ elements worthy of appreciation. Besides, the significance of the senses and their potential to enhance common understanding were approved by different stakeholder groups. By putting the senses into practice, staff participants in particular had greater ability to relate them to older individuals and their carers (Ryan et al., 2008; Nolan et al., 2006a, b; Nolan et al., 2004).

The development of the Combined Assessment of Residential Environments (CARE) profiles by Faulkner et al. (2006) was designed to explore positive events not only from the standpoint of residents in long-term care, but also from that of their relatives and staff members. The CARE profiles help practitioners to examine the frequency of positive events occurrence in nursing home contexts (Faulkner et al., 2006). Although there is a general tendency to associate quality of life in nursing homes with the absence of negative effects, the quest for favourable outcomes is receiving growing acknowledgment (Roscoe and Hyer, 2008). Faulkner and Davies (2006) define positive events in care homes as:
"... everyday occurrences experienced by residents, relatives and staff in a nursing home setting that result in a positive effect (mood) giving rise to such emotions as happiness, joy or personal satisfaction.” (p. 17)

The CARE profiles can consolidate the experiences of nursing home residents, their relatives and staff members by promoting good activities and determining potential spheres for change (Faulkner et al., 2006). The objective to be attained is to create a method to prompt the residents, their relatives and the staff members to express their views and feelings on living, working in, and visiting a nursing home, and then use their perceptions to appraise the options that best suit the home, in addition to highlighting areas for development (Faulkner and Davies, 2006).

As argued by McCormack (2004), regardless of the philosophical foundations of nursing models of care, he suggests that nurses provide humane care covering all aspects of knowledge and behaviour with the aim of reinforcing choice and partnership in decision-making relative to care. The options at the disposal of the older person seem to be frequently impeded by various factors pertaining to the setting and the prevailing attitudes. Awareness of a person’s value system is pivotal to person-centred nursing, and despite the recognition that meeting the requirements of daily nursing practice may run counter to this approach, there is an equal acknowledgment of a potential for change at the level of attitude and behaviour, thus allowing for the achievement of this philosophy (McCormack, 2004). In their capacity as facilitators of individuals’ personhood, nurses can suggest a mode to renew gerontological nursing practice. The renewal recognises in care delivery a certain dynamism that preserves independence while the individuals’ sense of autonomy seriously risks being compromised (Edvardsson et al., 2010; Winter and Artinian, 2009; McCormack, 2004).
2.11 Towards a Social Model of Nursing Home Care

The delivery of long-term care for older adults is experiencing a departure from the medical model to a socially oriented model, as exemplified in person-centred care (Rantz and Flesner, 2004) and relationship-centred care (Nolan et al., 2004) that reflect the new focus on the personhood of individuals who are recipients of continuing care services. The social approaches to care are replacing the medical model that falls short of creating a home-like atmosphere in the nursing home (Schwarz, 1996).

Person-centred care as a social model underlines normality and domesticity (Rantz and Flesner, 2004) and puts special emphasis on the ‘home’ dimension of the nursing home, thus downplaying the nursing/medical pattern of ‘care’ provision. While medical approaches seek the achievement of healing objectives related to physical and mental health, social models focus on the residents’ needs from an holistic perspective (Eales et al., 2001) which involves attention to social, psychological, and spiritual comfort, in addition to meeting physical needs (Kane et al., 1998). The social approach regards the older residents’ self-esteem, autonomy, choice, and privacy as an overriding concern (Bond et al., 1996). The older residents are considered as active community members, not mere objects of care (Phillips, 2001), hence the significance of their continued involvement in social networks, including family members, friends, and staff members.

In the framework of the medical model, staff members are involved in medical and physical care, treatment administration, and resident safety. The fulfillment of routine care tasks termed ‘bed and body work’ does not help the staff to familiarise themselves with each resident and customise care accordingly (Kane et al., 1998). By contrast, social approaches urge the staff members to become acquainted with the residents’ choices, values, and life experiences (Rantz and Flesner, 2004). Gaining personal information about
individual residents assists the staff in providing care that is in tune with their past experiences and present needs, thus resulting in a harmonious and trusting caregiving relationship (Talerico et al., 2003). Within the medical model, medical personnel have had the greatest authority. There was no reciprocity, no holistic view of the resident, and thus an empowering environment that allowed residents to focus on their abilities was not created. Rather, staff often felt that they needed to restrict residents and their actions in order to protect the residents’ safety and maintain ‘proper’ medical control (Cooney and McClintock, 2006).

The marked difference arising from a comparison of the two approaches lies in the focus placed on quality of care by the medical pattern, in contrast to the quality of life upheld by the more recent social patterns (Kane et al., 1998). Despite the emphasis on quality of life in nursing homes adopting the medical model, it is overwhelmed by safety concerns (Kane, 2003) and the technical competency of medical services (Wiener, 2003). As for the social approach that focuses on the individual resident, issues like decision-making, independence, comfort, meaningful activities, opportunity for growth, and the preservation of relationships become paramount (Lustlader, 2001). As a matter of fact, the promotion of such aspects of care has a noticeably positive impact on the residents’ quality of life, as evidenced by research findings indicating that lower incidence of depression and physical dependency is registered for these nursing home residents whose quality of life has been heightened (Gonzalez-Salvador et al., 2000).

The shift to the social care model necessitates training staff to satisfy the older residents’ preferences instead of dictating their own views on them, although certain aspects of care delivery could go beyond the scope of ancillary staff control. Kane et al. (1990) indicate that staff members might be aware of the objectives of giving a greater measure of
autonomy and control to residents, but the implementation of established care plans and safety measures limit the potential to customise care. Degenholtz et al. (1997) also refer to the challenges confronted in convincing case managers and senior staff to devise care plans more compatible with the residents’ choices and values. Therefore, the successful application of a new approach to care provision requires procedural change for all staff levels, not only the front-line nurses and nursing assistants (Cooney and McClintock, 2006).

2.12 Quality of Life for Nursing Homes Residents

Drewnowski and Evans (2001) suggest that the emphasis of nursing home care should extend beyond prolonging the lifespan of older residents, and include the steps necessary to preserve their quality of life. The successful performance of these steps necessitates primarily an understanding of the elements contributing to the quality of life of vulnerable older individuals (Sitoh et al., 2005). However, obtaining this understanding necessitates direct contact with older people themselves although, as Kane (2003) argues, this exercise poses risks as to the older person’s different perceptions of expectations. Thus, those older people who do not need long-term care are likely to have higher expectations with respect to quality of life than vulnerable individuals (Kane, 2003).

In the UK and other Western countries, the promulgation of new care standards concerning quality of life and residents’ rights occurred in the late 1980s (Kane, 2003). The care standards underline a number of elements including the preservation of personal dignity, offering individual choices, providing the residents with the opportunity to share in designing their care plans and to choose the way they pass their own time, participation in the management of the nursing home, and staff respect for every resident’s distinctness and options. Kane (2001) reported 11 unmeasured earlier aspects of quality of life, with these
aspects involving: (a) autonomy; (b) dignity; (c) privacy; (d) individuality; (e) security; (f) comfort; (g) relationship; (h) meaningful activity (i) enjoyment; (j) functional competence; and (k) spiritual well-being. These domains permit encompassing a wide range of key elements although the confines of each domain need to be determined. Furthermore, Gerristen et al. (2004) indicate that there is a lack of data proving that quality of life for nursing home residents assumes a basically different character. Consequently, the examination of the quality of life relative to nursing home residents calls for considering generational experiences and living environments (Reed, 2006).

2.13 Understanding the Quality of Life of Nursing Home Residents

As reported by Gerritsen et al. (2004), very few researchers and professionals have explored quality of life from the standpoint of older individuals, i.e. by inquiring about what matters to them. There is still a great deal of imprecision in the definition and measurement of quality of life with both researchers and practitioners frequently employing a range of health-related indicators: functional capacity, health status, psychological well-being, social support, morale, dependence, coping and adjustment without any reference to the ways in which older people in general, or specific groups of older people or service users, define their own quality of life or the value they place on the different components used by the ‘experts’ (Walker, 2001). There is a need to shift from an examination of needs to preferences, or from what the older people say they need to what they say they want, with the possibility of discounting models of quality of life built on needs in agreement with the professionals’ definition. Considering preferences implies having an older person-based perception of quality of life, and to determine the older person’s preferences implies holding conversations with them about their outlook instead of adopting models constructed by other people. This involves examining the elements regarded by nursing home residents as enhancing or preserving their quality of life (Watt
and Konnert, 2007). Although their preferences may not be satisfied due to the limited resources of the nursing home, the examination of their preferences can spark discussion and thinking about options (Reed, 2006).

Nursing home residents constitute an important group as their vulnerability makes it important to offer them assistance to preserve a high level of quality of life. Furthermore, the majority of these vulnerable residents may be incapable of articulating their desires, needs, or feelings of contentment. As the literature reveals, care providers and relatives can play a very important role in this situation by highlighting the factors contributing to quality of life for each person and the way to preserve or enhance it. Such information equips them with the instruments they may need to properly support residents in improving their quality of life. It may also constitute a conceptual foundation for the development of a course of action that can be used by the nursing home staff as a basis for their quality of life improvement policies (Gerritsen et al., 2004).

The resourcelessness of nursing home residents that touches many aspects of their lives raises the question about the manner in which they achieve a high level of quality of life (Gerritsen et al., 2004). The identification of the resources that nursing home residents still have permits an assessment of the capacities and potentials that enable them to achieve quality of life and to share in improving it. The care targets should comprise the residents’ precise and essential resources instead of limiting the emphasis to problems and impairment (Gerritsen et al., 2004). Two crucial care targets in nursing home care are comfort and affection, with comfort regarded as the cornerstone of care since the staff members prioritise its provision to the residents (Hendry and Douglas, 2003). At moments of intensive work, comfort is the overriding concern and it should be offered by any means. In addition, affection represents another fundamental care action in nursing homes
namely the importance of touch and other non-verbal means of communication (Murphy et al., 2007; Murphy et al., 2006; Gerritsen et al., 2004; Hendry and Douglas, 2003; Tester et al., 2001).

Older residents have their quality of life improved as a result of respectful treatment that preserves their dignity, freedom of choice, and the fulfillment of their wishes when they are unable to express them successfully (Kane, 2003). Nursing homes are said to improve their residents’ quality of life upon their creation of an affectionate, home-like milieu that gives them the opportunity to realise their potential for autonomy and self-guidance in the performance of their day-to-day tasks (Pearson et al., 1993).

Functional skills are associated with people’s ability to manage their capacities in full autonomy. Significant acts and ties with both the staff and family members represent major factors, even though what is seen by the residents as appreciated and meaningful acts may undergo alteration toward the end of their lives (Roscoe and Hyer, 2008). Another major constituent of the residents’ quality of life is an ability to enjoy food, whilst physical safety, security, the harmlessness of the living milieu, and the existence of good intentions on the part of their fellow residents also make up a major constituent of quality of life. Moreover, despite the mystery of spiritual comfort and its connection with mental and social well-being, it is a separate concept involving and transcending religiosity (Roscoe and Hyer, 2008).

The preservation of quality of life also depends on the satisfaction of major human needs such as love and belonging. Subsequent to joining the nursing home, the expression of love can take the form of hand holding, a hug, or a pat on the back (Hendry and Douglas, 2003). Listening to older individuals for some time may also boost their feeling of acceptance and recognition, thereby fostering their sense of belonging (Nolan et al., 2006a). The constant
presence of nurses and other care providers at nursing homes allows staff to consolidate acceptance and the feeling of love and belonging, and to meet the older person’s artistic needs (Hendry and Douglas, 2003). Moreover, a multidimensional approach to enhancing quality of life begins by promoting an interactive process between the nurse and the older resident (Hendry and Douglas, 2003).

In a report entitled ‘My Home Life: Quality of Life in Care Homes’, Owen et al. (2006) argue that the relationships developing between the residents, their relatives and the staff members affect the residents’ quality of life the most. If these relationships guide quality initiatives, it is necessary that the residents, staff and relatives be collectively committed to similar ideas, values, objectives and habitual activities. Establishing communication with an older resident is an important first step in engagement and in understanding their values, belief and opinions. According to Tester et al. (2004a) this can yield positive results even in the case of vulnerable nursing home residents living with cognitive impairment.

2.14 Perceptions of Staff Members about Quality of Life

Current evidence reveals that there is lack of consensus among healthcare professionals on what constitutes a good quality of life for older nursing home residents (Roscoe and Hyer, 2008) and the lack of studies on nurses’ views of a good quality of life make it difficult to draw conclusions in this area. Nevertheless, the role of staff members in the nursing home setting is critically important. Here, some researchers have focused specifically on nurses’ perceptions of quality care (Castle, 2008; Tafreshi et al., 2007; Luker et al., 2000; Hogston, 1995; Leino-Kilpi and Vuorenheimo, 1994) and others have focused on nurses’ perceptions of quality of life in nursing homes (Murphy et al., 2008; Murphy et al., 2006; Williams, 1998). Philp et al. (1991) found that nurses identified: a home like atmosphere, the capacity for residents to have personal belongings, the need for good clean facilities, a
philosophy of care, socialisation, a supportive atmosphere and positive staff attitudes as important quality of life indicators. Hogston (1995) also found that resources, equipment, staffing levels, skill mix, staff education, staff retention, were mediating factors of quality of life for older residents.

Roscoe and Hyer (2008) investigated which quality of life domains nursing staff in nursing homes believe are important for resident quality of life. Overall, respondents’ scores indicated a high level of importance of the following quality of life domains: (a) freedom from pain; (b) autonomy; (c) privacy; (d) dignity; (e) individuality; (f) functional competency; (g) meaningful activities; (h) food enjoyment; (i) meaningful relationships; (j) personal safety; and (k) spiritual well-being. Natan (2008) also explored the perceptions of nurses in nursing homes concerning residents’ needs. Nurses attributed greatest significance to values and personal outlook of the residents, provision of proficient physical care, skilled psychological support, social life and institutional requirements. These results highlight the critical role that staff members may play in the quality of life of nursing home residents and that they can be influential in affecting the quality of life of nursing home residents. Quality of life for nursing home residents is a function of how they are treated; thus, care providers attitudes about quality of life are critical (Zimmerman et al., 2003; Kane, 2001).

2.15 Family Involvement in the Nursing Home

The rising number of frail older people moving to nursing homes has led to increased involvement of their family carers in helping with this shift and playing a caring role in a new environment (Davies and Nolan, 2006). However, literature available in Western countries on the role and needs of family care providers in the context of long-term care is not extensive, and where literature does exist, it has mainly emphasised the experience of
the older residents and the staff members (Davies, 2001). In the case of Lebanon, no study has ever been conducted about the family caregivers of nursing home residents (Seoud et al., 2007).

The delivery of care by family members does not end once the older individual is admitted to a long-term care facility (Duncan and Morgan, 1994). It is rather a continuous process, although it takes a different direction after admission. Buckwalter et al. (1997) depicted the change in family care from the fulfillment of direct physical tasks to indirectly ensuring that ‘proper’ care is delivered by the staff. This involves interaction with the caregivers, observing their communication with the older residents, and establishing relationships with them to guarantee better care. According to Wright (2000), family members do not seek involvement in the details of practical care after admission, but they do think that the substantial information they have on their relative can help to provide optimal care. On the other hand, Hertzberg and Ekman (1996) have previously reported that staff members rarely demonstrate a keen interest in obtaining such information. Without access to this information, care staff will be unable to understand the unique preferences and needs of each single older resident (Donovan and Dupuis, 2000). For Bowers (1988), the role of the family caregiver comprises maintaining family ties, preserving the older resident’s self-esteem and hopes, and helping them maintain their mastery of the environment they live in. Kellett (1996) underscores four themes that outline the family attempts to keep a sense of attachment to their relative as follows:

(1) Engaged involvement: minimising role loss and establishing new ways of caring;

(2) Worth: making sure that the specific information on their older relative is incorporated in planning quality care;

(3) Concern: discussing the boundaries separating them from the staff members with the latter;
(4) Continuity: maintaining involvement and sharing a valuable experience with the older relative.

Although the majority of family caregivers want to be actively involved in the life and care of their older relative (Hertzberg et al., 2001), putting this interest into effect is not given due consideration in the literature. Moreover, staff members are generally reluctant to discuss the nature and degree of this involvement (Hertzberg et al., 2003). Nevertheless, studies do indicate different results in that some staff members develop ‘empathic awareness’ (Lopez, 2009; Fukahori et al., 2007; Sandberg et al., 2002). Sandberg et al. (2001) suggest that ‘keeping’ is the major process undertaken by relatives when a loved one is admitted into a nursing home and divides this process into subcategories termed ‘keeping activities’. These consist of ‘keeping in touch’ with the relatives’ care and maintaining their awareness of life outside the boundaries of the facility; ‘keeping it special’ or preserving appreciated routine activities as part of the relationship; and ‘keeping an eye’ by monitoring the care delivered to their older relatives to ascertain it is optimal from the older relatives’ standpoint (Sandberg et al., 2001).

Davies and Nolan (2006) conducted a study on self-perceived roles of family caregivers of nursing home older residents, and found out that family carers identified three basic features of their role:

1. Maintaining continuity, by helping the older individuals preserve their sense of identity. The preservation of loving family relationships and highlighting the aspects of the residents’ personality help achieve this objective.

2. Keeping an eye, by observing the delivery of care, giving the staff members feedback, and attempting to bridge gaps.
(3) Contributing to community, by communicating with fellow residents, relatives and staff, participating in social events, and ensuring a link with the outside world.

It can be inferred from the above that there is increasing evidence on the positive effect created by relative participation in the life of the nursing home residents for both relatives and older persons (Sandberg et al., 2002; Pillemer et al., 1998). At the same time, there are signs that this involvement is not always appreciated by the staff members who are inclined to hinder its translation into practice (Hertzberg et al., 2003).

The adoption of the multidimensional approach to boosting quality of life for nursing home residents implies the integration of family members in the care process. By being a source of love and understanding for the older relative and evoking valuable memories of the resident’s earlier life stages, they can contribute to promoting quality of life and quality care (Hendry and Douglas, 2003).

2.16 Quality of Life in Nursing Homes in Lebanon

Few studies on older people emerge in Lebanon (Sibai et al., 2004). Some specifically examine older people’s health through validity studies (Chahine et al., 2007; Sabbah et al., 2003) but few examine the relation between nursing homes and older people’s well-being and their quality of life (Doumit and Nasser, 2010).

It appears that some discrepancy exists between the existing conditions of care relative to nursing homes in Lebanon and the ideal models put forward in Western literature by researchers like Faulkner and Davies (2006); Faulkner et al. (2006); Nolan et al. (2006a, 2004); Owen et al. (2006); and McCormack (2004). The question about what constitutes ‘proper care’ in Lebanon that leads to resident quality of life does not stem from the physical dimension of care which is usually acceptable, but it rather lies in the routine
practice, with little interest in the older residents’ personal needs or in the concepts of choice, privacy, and dignity. The inability of the older residents to be the masters of their own life seems to be a basic problem that characterises Lebanese nursing homes.

Some nursing homes operating in Lebanon still represent classical and outdated perceptions of ageing (Chemali et al., 2008). The delivery of long-term care was initially started with a view of ensuring efficient physical care to older persons, and quite a large number received care from a limited size professional staff (Hospers et al., 2007). Physical maintenance and medical services represented a ‘top priority’ and continue to do so in some nursing homes (Doumit and Nasser, 2010). However, increased awareness of the older persons’ civil rights has instigated a reconceptualisation of nursing home care in Lebanon. This research represents a breakthrough in that it attempts to fill a major gap in the literature on the quality of life of nursing home residents in Lebanon.

As shared earlier, there is a common belief among Lebanese older people that moving to a nursing home will have an adverse impact on their existence as it could be interpreted as a break of ties with their families and a separation from a milieu that abounds in emotions and memories. It represents a turning point and is likely to be the last during their lifetime. The causes of the move vary between deterioration in physical and mental health, to a loss of independence, and the death of a partner. Some older residents enter the nursing home following a hospital stay and tend to consider the nursing home an extension of hospital care. However, nursing homes participating in this study are distinctly different. The delivery of medical, rehabilitative and nursing care is ensured by health care professionals and dedicated caregivers. At the same time, these nursing facilities attempt to create a home-like atmosphere where older people can feel comfortable, see familiar faces, and keep doing usual activities appropriate to their abilities.
2.17 Summary

Over the last two decades there has been an extensive literature exploring quality of life experiences by older nursing home residents. Researchers have struggled with the definition, conceptualisation, and measurement of quality of life. The various definitions reveal not only the complexity of the concept, but very real differences in opinion as to the nature of quality of life. Whilst adding significantly to the literature, studies have mainly focused on models of quality of life built on needs in agreement with the professionals’ definition. Moreover they have been limited in their ability to capture the dynamic nature of quality of life. There is a need to shift from an examination of needs to preferences, or from what the older people say they need to what they say they want. As will be shared in the next chapter and following a grounded theory methodology, the present study aims to add to current knowledge by exploring quality of life from the perspectives of Lebanese older residents, staff members, and family carers.
CHAPTER 3

Grounded Theory Methodology and Study Design

Generating grounded theory takes time
(Glaser, 1978 p. 19)

3.1 Introduction

This chapter encompasses an overview of the grounded theory methodology which represents the framework of the empirical component of this thesis. Such an approach allows for an inductive exploration and analysis of the research question. The chapter begins with a review of symbolic interactionism as the conceptual basis for grounded theory. Subsequently, the central tenets of the grounded theory methodology are presented, drawing primarily on Glaser and Strauss’s (1967) influential text The Discovery Of Grounded Theory: Strategies for Qualitative Research and developed further by Glaser (1978) to assimilate the notion of basic social processes within a grounded theory methodology. These two texts, elaborated upon by Strauss (1987) and Glaser (1992), form the cornerstones of the author’s approach to a substantive grounded theory on quality of life as described later in the thesis. Justification for the choice of qualitative design and grounded theory as basis of this study is provided. The chapter then presents an overview of the relevant ideas related to the theory, followed by an examination of debates surrounding methodological issues closely connected with grounded theory. Moreover, preparation for fieldwork is explored and a description of the sample, interview setting, data collection, data management, and data analysis is also provided. Finally, the trustworthiness of the study and matters related to study rigor are addressed.
3.2 Rationale for Qualitative Design

There are many reasons behind the choice of qualitative research for this study, the most important being the goal to go beyond the obvious and explore the world of the participants, to see the world through their eyes, and by this, to reach discoveries that help develop empirical knowledge (Corbin and Strauss, 2008).

Language is a basic medium for analysis in qualitative research. As a result, methodological saliency is boosted as the discourse constituting its foundation can better explore the participants’ emotions and beliefs, hence highlighting the social and cultural contexts in which human organisms react and express meaning. According to Kaplan and Maxwell (1994), qualitative methods can examine data while still protecting their textual nature. This is because the goals of qualitative research involve understanding a phenomenon from the points of view of the participants and in its particular social and institutional context. These goals largely are lost when textual data are quantified (Kaplan and Maxwell, 1994). Hence, researchers are encouraged to carry out qualitative research so they can communicate with participants on a deeper level and gain a more thorough understanding of their world and other related phenomena.

This study aims to explore meanings, understanding, perceptions and perspectives of older residents, staff members and family carers in a specific Middle-Eastern cultural context, and to be the first study to attempt this. As such, the interpretive and qualitative method is the most appropriate one (Bogdon and Biklen, 2003; Mertens, 1998; Minichiello et al., 1995). This is further illustrated in the arguments raised by Leininger (2002, p. 86) who suggested that it is “difficult to obtain findings of specific cultures and especially any full, in-depth, meaningful data with quantitative reductionistic and empirical research methods”. Patton (2002, p. 14) also argued that “qualitative methods facilitate the study of
issues in depth and detail”, while Miles and Huberman (1994, p.1) asserted that “with qualitative data one can preserve chronological flow, see precisely which events led to which consequences, and derive fruitful explanations”. Qualitative methods therefore allow the researcher to discover the patterns and meanings of a group’s life that quantitative methods would be unable to do. Moreover, qualitative research produces a ‘thickess’ and ‘richness’ of data that provide researchers with new insights about the phenomenon. For these reasons, it is believed that the qualitative approach can best fulfill the aim of this study.

3.3 Rationale for Adopting the Grounded Theory Methodology

In addition to adopting the qualitative approach, the researcher chose to employ the grounded theory method to achieve the aim of this study. Grounded theory offers procedures for the collection and interpretation of data, and for the discovery of categories and concepts that can be linked to describe processes and build theoretical frameworks (Glaser and Strauss, 1967). When the problem under study is regarded as a dynamic process, grounded theory becomes the option (Stern, 1996), as in the case of nursing home life. This methodology being hierarchical and recursive, involves data collection, different stages of coding and a continuous comparative analysis of data and recycling of previous steps necessitated by the emergent findings (Morse and Field, 1996).

Nursing research has involved the use of grounded theory since the early 1970s (Backman and Kyngas, 1999) with a focus on nursing practice and nursing education (Brandriet, 1994; Janhonen, 1992; May, 1979). The choice of this approach is mainly attributed to the fact that it allows for the formulation of mid-range theories which can have practice implications and applications (Bailey, 1997; Glaser, 1978). The grounded theory method allows the researcher to explore and examine what events mean to participants, assuming
that participants share meanings through language communication and socialisation (Chenitz and Swanson, 1986). The grounded theory approach also targets social events that are constructed of meanings which need to be understood and publicised (Chenitz and Swanson, 1986; Glaser, 1978).

According to Stern (1980), the strongest case for the use of grounded theory is to gain a fresh perspective in a familiar situation. The topic of quality of life in Lebanese nursing homes is complex and sensitive as it involves several interrelated factors, variables and concerns which are perceived differently by different parties. It is often an emotive one with many interrelated issues, variables and concerns that can be viewed from different perspectives (Bowling et al., 2003; Bowers et al., 2001). Nursing homes in Lebanon represent a salient research opportunity due to the distinct paucity of research in this field, and as a result, the paucity of published literature from a Middle-East context and very few culturally appropriate theories. Therefore, this is considered a ‘good fit’ for the use of grounded theory and it gives the researcher the opportunity to raise the question: ‘What is going on?’ whilst keeping an open mind.

The grounded theory method was also chosen for the present study as it paves the way for rigorous understanding in a field without the need of pre-existing data that reflects reality. The underlying ontological and epistemological assumptions in this research are that knowledge is not constant; rather, it is continuously emerging and transforming, while both observers and participants try to interpret it. Human organisms communicate meaning through language and activity. Through dialogue and action, understanding, experience, and emotion are created and communicated, and meaning is thus relayed from participant to observer (Charmaz, 2006). From this perspective, grounded theory represents a research tool which gives the researcher the opportunity to obtain evidenced meaning and
understanding. The present study did not aim to support a previous hypothesis, but rather to inductively construct a deep understanding of the participants’ actual lives and needs (Hunter et al., 2011a). The researcher sought to produce a theory concluded from, or rooted in, the experiences the participants’ communicated and that would allow explanation and understanding of the social process involved. The use of grounded theory allowed the researcher to develop a conceptual theory that has helped her gain a deep understanding of the major issues older residents, staff members and family carers faced in nursing homes in terms of their quality of life and the means by which they construct meaning from this exposure.

3.4 Grounded Theory: Historical Roots - Symbolic Interactionism

Grounded theory has its roots in symbolic interactionism (Strauss and Corbin 1998, 1990; Glaser and Strauss, 1967), an area of knowledge that is a subdivision of interpretivism (Charon, 2004). Theoretical traditions pertinent to the general perspective of symbolic interactionism include the ‘Philosophy of Pragmatism and Darwinian Theory’ (Charon, 2004). These major influences had a significant impact on the work of George Herbert Mead and Herbert Blumer to whom symbolic interactionism can be traced (see for example; Blumer, 1969; Mead, 1938, 1936, 1934).

George Herbert Mead is one of the founders of pragmatism, along with other prominent social theorists such as Charles Saunders Peirce and John Dewey. A key tenet of pragmatist thought is the pivotal role played by practical actions in the production of meaning, reality and truth. Mead (1934) put forth a theory adherent of philosophical materialism and rooted in human activity, primarily communicative action. From a pragmatic perspective, human action is a criterion of truth through which meaning is constructed. Human beings build their sense of self by means of shared activity, including
communicative activity. Mead’s social behaviourism is rooted in the belief that the human mind is neither a component of a transcendent realm nor a product of events which happen within the physiological structure of humans. The human mind emerges as human organisms interact with each other as well as with their social surroundings; actively participating with their social environment makes individuals aware of their capacity of significantly symbolic behaviour which is thought. Mind, according to Mead, is at the heart of the communication process. It is a linguistic activity in which an individual takes an active part. For Mead (1938), then, there is no ‘mind or thought without language’ and language:

“... is only a development and from pragmatist beginnings, Mead’s theory of the emergence of mind and the self out of the social process of significant product of social interaction.” (p. 191)

Mead defines the human mind and sense of self as products of a series of social events. Individuals take in both gestures and collective attitudes in their social environment, and they construct their reactions accordingly with other organised attitudes. Mead labels this process by the ‘Me’ and the ‘I’ whereby the former represents the social perception of self, and the latter is the response to it. Mead perceived everything pertaining to human organisms as a process that unfolds in reaction to inevitable change (Charon, 2004).

Mead’s work was further developed by one of his students, George Herbert Blumer, who coined the term symbolic interactionism to reflect its theoretical concern with meaning, language, and thought (Blumer, 1969). Symbolic interactionism focuses on interaction and on the meanings of events to the participants. Consequently, it emphasises the processes involved in human beings defining, acting, and using symbols - language - through interactions, and responses to interactions –thought- within their environments.
Mead (1934) and Blumer (1969) shared the view that the human being is an organism with a self, and that this self is an object towards which an individual directs his or her own action (self-interaction). This self also embodies processes of interaction with the environment (Blumer, 1969). In other words, the human being does not simply and passively respond to the world, but acts towards the world as an interpreter. Furthermore, the world constitutes others; therefore the human being interprets the actions of others. Thus, interpretation as meaning constitutes the self as an object whereby the self is the social product of a process manifested in social interactionism (Blumer, 1969).

It was on the basis of this premise that Blumer framed three central concepts of symbolic interactionism. According to the first concept, “human beings act toward things on the basis of the meanings that the things have for them” (Blumer, 1969, p. 2). The assumption underlying this statement is that people interpret and define the actions of others, and that their behaviour is a response to people’s actions, which rests on a process of interpretation.

The second concept underpinning symbolic interactionism is that “the meaning of things is derived from the social interaction that one has with one’s fellows” (Blumer, 1969, p. 2). Social interaction focuses on interactions between an individual and others, a process that can form and reform human behaviour in the sense that the meanings underlying it can be derived from such an interaction, that is, the outcome of interaction is a determinant of individual behaviour.

The third concept of symbolic interactionism maintains that “meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he/she encounters” (Blumer, 1969, p. 2). This meaning of things is shaped in the context of a person’s social interactions and modified by the interpretations that flow from these social interactions. What is fundamental about this world view is that it shifts the focus
away from given or static norms and values to changeable and continually readjusting processes.

It can be inferred from the above that symbolic interactionism offers a theoretical perspective on studying how individuals interpret the objects and events they encounter in their lives, and how the process of interpretation generates behaviour or action in a specific situation (Benzie, 2001). Grounded theory and its associated concepts, which are rooted in symbolic interactionism, are described in the following section.

### 3.5 What is Grounded Theory?

Grounded theory, initially developed by Glaser and Strauss (1967), comprises an interpretive qualitative research methodology. Two main paradigms distinguish grounded theory from other qualitative research methods. First, it is unencumbered by explicit expectations about what research might find, or by personal beliefs and philosophies (Pole and Lampard, 2002) and second, it helps researchers to reach discoveries independent of a priori knowledge.

Owing to its fundamental features, grounded theory is considered as a powerful tool for examining and analysing social phenomena especially when data on the situation under study is scarce (Sarantakos, 2005; Glaser and Strauss, 1967). The purpose of research that adopts a grounded theory design is to deeply understand a particular situation, especially in shared social environments which are not clearly understood as they have not been sufficiently studied (Hunter et al., 2011a). Grounded theory research does not render a group of definitive conclusions or descriptions, but rather creates a continuous conceptual theory (Birks and Mills, 2011). This theory will be recognisable to people familiar with the instance and will be modifiable to similar settings (Hunter et al., 2011a). Moreover, grounded theory is ideally suited to areas of research where there is little understanding of
the social processes at work (Hunter et al., 2011b). Grounded theory does not seek to exactly and factually describe a situation. Instead, the results are theoretically grounded conceptualisations of a basic social process following analysis, which justifies the predominance of behaviour in a key area of research. The abstract character of the analysis in time, place and people, and new data entails a modification of the analysis (Glaser and Holton, 2004; Glaser, 2001).

Throughout the research process in grounded theory, data is acquired, coded and analysed simultaneously and concurrently. The development or research problems, theoretical understanding, or literature review do not act as hindrances. On the contrary, researchers enjoy the freedom of discovering the major concerns of participants and analysing the manners in which they deal with these issues (Glaser, 1978). The essence of grounded theory is conceptualising data through coding and applying the method of continuous comparison. The data are broken down into conceptual codes by means of analysis, after which individual codes are compared and grouped into meaningful categories. In the end of the process, and in an abstract manner, the categories become built and refined enough to allow the researcher to develop substantive theories and conceptualise hypotheses based on them (Glaser, 1992; 1978). Amending relevant research with hypotheses reveals that the final product demonstrates parsimony and theoretical totality (Yee, 2001).

3.6 Grounded Theory: Roots and Divergences

In the 1960s, two sociologists Anselm Strauss and Barney Glaser developed grounded theory as an inductive approach to the development of sociological theory. Being drawn from different backgrounds each brought a quite distinct knowledge area to grounded theory. Strauss was influenced by a long tradition of qualitative research at the University of Chicago and by his study of interactionist and pragmatist writings. Glaser, on the other
hand, came under the influence of Paul Lazarsfeld, an innovator in the field of quantitative methods (Strauss and Corbin, 1998). These backgrounds came to be significant in the subsequent and complex evolution of grounded theory.

*The Discovery of Grounded Theory: Strategies for Qualitative Research* (Glaser and Strauss, 1967) was written to provide a description of the methods applied in a number of research studies concerned with matters relating to death and dying. Increasingly, other researchers began to take up and apply grounded theory in their investigations. In the late 1970s Glaser wrote *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory* for the purpose of providing practical insights into the methodological processes involved in generating grounded theory (Glaser, 1978). This work bridged gaps in the information included in his early work by detailing the advances in procedures and thought in generating grounded theory and the development of the necessary theoretical sensitivity in analysis (Keady, 1999).

In the 1990s, Strauss and Corbin introduced some fundamental modifications to grounded theory (Strauss and Corbin, 1990). They shifted the methodology away from a purely inductive stance to a ‘forced’ process of induction and deduction. This schematic concept allowed the researcher to consider all possible conditions influencing the phenomena and not only those emerging from the data. This meant that all information including the experiences, beliefs and values of the researcher and extending to international influences was to be considered legitimate data.

In response to the early work of Strauss and Corbin (1990), Glaser (1992) published a forceful response that made clear the critical differences between the original Glaser and Strauss (1967) model and the Strauss and Corbin (1990) approach to grounded theory that later followed. Glaser’s (1992) words reflected the substantial differences between the later

Glaser (1992) adopted grounded theory with a purist approach and remained fully adherent to the initial propositions. Glaser straightforwardly stated that it cannot be referred to as grounded theory anymore if changes are proposed. He firmly believed that only if the full methodological framework of his early and later publications were adopted would the work be called grounded theory (Glaser, 1999; Melia, 1996). According to Stern (1994), Glaser firmly believes in letting the theory emerge, whereas Strauss opts for a strictly prescriptive method. Both Stern (1994) and Melia (1996) suggested that Glaserian grounded theory has the potential to be directly applicable to cases in which the participants or groups had the problem under study in common and are likely to be testable. However, theory that is an adaptation of Straussian version of grounded theory, reduces the importance of the applicability of this latter (Stern, 1994). Glaser (1992) argues that at the heart of this dichotomy is the major distinction between emerging and forcing. Stern (1994) attributes this difference to the questions that each author raises concerning the data. Upon the examination of data, Strauss would stop at the level of every single word and ask, “What if?”; while Glaser considers the data itself as his major focus and asks the question, “What do we have here?” According to Stern (1994, p. 20):

“Strauss brings to bear every possible contingency that could relate to the data, whether it appears in the data or not. Glaser focuses his attention on the data to allow the data to tell their own story.”

More recently, the debate that surrounds grounded theory has shifted and it is not any longer Straussian versus Glaserian controversy (Greckhamer and Koro-Ljungberg, 2005).
Lately, the debate revolves around Charmaz’s (2006; 2003; 1994) social constructivist adaptation of grounded theory and Charmaz’s critical evaluation of the objectivity of both Glaser, the late Strauss, and his more recent co-author Juliet Corbin, and argues that they tend to have a positivist inclination. According to Charmaz (2003), grounded theory methods can be used by researchers in order to conduct constructivist studies rooted in interpretive approaches, that is, “to further their knowledge of subjective experience and to expand its representation while neither remaining external from it nor accepting objectivist assumptions and procedures.” (p. 269)

This constructivist orientation resonates with many grounded theorists who see it as adopting a position part way between positivism and post-modernism, the inference of Charmaz (2003) being that if one does not claim the constructivist position then one must be labeling oneself objectivist and positivist. Flint (2006) argues that ‘amateur researchers’ in grounded theory can find the complexity of the discussion about its essence confusing and quite frustrating. The fact that Glaser (2002) is not explicitly articulate in his epistemological perspective and criticism of Charmaz’s constructivist approach adds further to the complexity (Flint, 2006). Glaser (2002) believes that Charmaz’s version of grounded theory is a different approach to research which he labels Qualitative Data Analysis.

3.7 Locating the Study: Glaserian Grounded Theory

The author commenced the research process with an appreciation that there was limited understanding of the perspectives of older nursing home residents about their quality of life in Lebanon (Doumit and Nasser 2010). An initial reading of Glaser and Strauss (1967) convinced the author that this under-researched area was one suited to investigation using grounded theory, as theory and theory development are grounded in empirical data and in
acts of everyday social life, such as that experienced in the nursing home. To discover these processes, classic grounded theory (Glaser and Strauss, 1967) suggested that the researcher interacts with those being studied and strives to interpret their social world and meanings. Therefore, conducting interviews, transcribing text, writing, keeping and referring to theoretical memos are central to classic grounded theory, as illustrated by Hunter et al. (2011a):

“Classic grounded theory envisaged that the researcher interacts with those being studied and strives to interpret their social world.” (p. 7)

The present study has from the outset taken a path that is more in line with Glaser’s (1992; 1978) approach than that proposed by other grounded theorists. The area of interest of the study was initially very broad, targeting quality of life of older nursing home residents. Interviews were conducted with a range of nursing home residents, as well as their family caregivers and staff members. Such interaction aimed at increasing theoretical sensitivity (Glaser, 1978) and identifying a clearer direction by use of data from the field rather than from the literature. In order to increase sensitivity to critical issues, cycles of data collection and analysis followed.

Olavur Christiansen (2011) made an attempt to explain the main differences between ‘classic’ or ‘Glaserian’ Grounded theory on the one hand, and other methods which call themselves grounded theory due to their reference to the three ‘hallmarks’ of Glaserian grounded theory on the other hand. While these ‘hallmarks’ are unique to ‘Glaserian grounded theory’, Christiansen (2011) highlights the differences between Glaserian grounded theory and other versions of grounded theory as follows:

(1) Many equally justifiable interpretations of the same data?

Answer: find the core variable as the first stage of the study, and delimit to the core variable.
(2) To get through to exactly what is going on in the participant’s recurrent solution of their main concern, the researcher dissociates from his/her existing perceptions, maintains an open mind, and believes in the ‘emergence of concepts from the data’.

(3) Staying clear of descriptive interpretations in favor of abstract conceptualisations through the application of the method of constant comparison, which allows the discovery of constant patterns in the data (emergence of concepts).

It is at this level that the author agrees with Glaser’s (1992, 1978) version of grounded theory as the aim of the study is not to discover a theory rooted in preconceptions, but rather a new theory that promotes understanding and action in the field under study (Heath and Cowley, 2004). The formulated theory does not consist of a mutually constructed interpretation of data, but the outlook of older nursing home residents was raised to an abstract level of conceptualisation in an effort to identify the core pattern.

3.8 How Does Glaserian Grounded Theory Work?

The method of grounded theory (Glaser 1998; 1992; 1978) relies on two main foundations: theoretical sampling and constant comparison. Theoretical sampling entails that in the process of data collection, new data collection goals are set based on the results rendered from the preceding sample. As is the case in selective sampling, the theory emerges and the investigation gets its focus from the data collection process. Continuous comparison consists of the concomitant and concurrent coding and analysis of the collected data. Through these two processes, the researcher exercises theoretical discovery within the framework of grounded theory.

3.8.1 Stages of Coding

Three stages of coding are involved in grounded theory (Glaser, 1978); the first is open coding. During this level, the researcher examines raw data and codes them fracturing into
discrete threads of datum. These data are compiled and grouped into categories of similar phenomena. This level entails studying the data in general without applying any restrictions or using any filters. The researcher accepts all the data in the process without any exclusion, and this makes it possible for the research to detect patterns that pave the way to social processes which may be found potentially significant. In the course of this process, categories begin to gradually build and fill, and those largest categories with the richest amount of data are considered core categories (Glaser, 2001).

After the emergence of categories, the researcher moves ahead to selective coding which is the next level in the process. During this level, the researcher starts to focus on the data which is more closely related to the emerging core categories. In this sense, and in order to make it easier to conduct clearer and more focused research, interview questions are refined and recycled in order to incorporate and serve the new focus, and only the most relevant sections of the interviews are retrieved and coded. Hence, as the core categories started to surface, the interviews gradually gained a clearer and narrower focus, and the acquired data were more directly pertinent to the unfolding social process (Glaser, 1978).

As core categories become saturated, the final stage in the process of coding, theoretical coding, begins (Glaser, 1978). This saturation poses both a controversy and strength as far as grounded theory is concerned. Grounded theory builds an analytical approach through the continuous search for new categories of evidence, and this is what distinguishes it from other qualitative analysis methods which become more rigorous through several stages of confirmation (Mertens, 1998).

At a certain point in the process of data collection, saturation is established as the data becomes redundant. In this sense, a researcher continues to collect data until no new results are derived and all acquired data is already known (Selden, 2005). Theoretical coding
examines these saturated categories and provides the researcher with analytical criteria, thus helping in the establishment of conceptual links between categories (Glaser, 1992; 1978). Hence, open and selective coding involved breaking down the data and grouping them into categories based on abstract similarity; at a later stage, theoretical coding, in addition to sorting, drew conceptual relationships between the hypotheses reached through the first two stages.

The assumption that substantive coding is an essential component of data analysis within grounded theory is rarely questioned, but if the intellectual rigor stops at substantive coding, the use of grounded theory methodology by researchers becomes arguable. Glaser (1978) claims that theoretical coding, which establishes conceptual relationships between hypotheses drawn from substantive codes, allows the integration of substantive codes into a theory. A deep understanding of the social processes and human communication under study is created through theoretical coding. According to Cutcliffe (2000), theoretical coding is probably the most serious challenge to the creativity of grounded theorists. Theoretical coding paves the way to the discovery of new underlying relationships and this contributes to the potential advancement of the theory.

3.8.2 The Constant Comparative Method

The above mentioned stages of coding involve a process known as the constant comparative method. The purpose of this method, with its emphasis on the use of concepts, is to interpret, predict and search for relationships within data, as Glaser (1992) stated in this summary:

“Using constant comparison gets the analyst to the desired “conceptual power” quickly, with ease and joy. Categories emerge upon comparison and properties emerge upon more comparison. And that is all there is to it.” (p. 43)
In keeping with the constant comparative method, the build-up and increased depth of categories necessitate that the researcher initiates reflection on the data and conceptualisation, usually through the documenting of ‘memos’ which are primary in theory formulation and data testing (Glaser, 1978). The constant comparative method is designed to help the analyst remain close to the data. However, the process does not lead to a tested theory; instead, it results in the emergence of a general substantive theory based on a set of reasonably induced categories, properties and hypotheses ‘which tackle existing social problems’ (Glaser and Strauss, 1967, p.104), the validity of which is confirmed by the saturated data. The process of comparison is maintained until core categories emerge, and until only already known data is acquired (Glaser and Strauss, 1967).

Constant comparison represents the most crucial component of the grounded theory approach and differentiates between a rigorous grounded theory analysis and inductive estimation (Glaser and Strauss, 1967). The researcher has to continuously check if new patterns are detected. Constant comparison involves conducting continuous research to explore the meaning of the emerging categories by collecting additional data and analysing them (Walker and Myric, 2006). As the process develops, it allows the development of new topics and relationships. The progress of analysis paves the way for the appearance of new themes and relationships, and researchers see themselves engage in recording earlier data and reconceptualising relationships between data elements (Gasson, 2004).

3.8.3 Theoretical Sampling

Within a grounded theory study, the process of generating theory is led by data and their interpretation. As such, it is logical that the process of data collection is guided by the emerging theory. Glaser and Strauss (1967) labeled this process theoretical sampling and identified its features as follows:
“Theoretical sampling is the process of data collection for generating theory whereby the researcher jointly collects, codes, and analyses his/her data and decides what data to collect next and where to find them, in order to develop his/her theory as it emerges.” (p. 45)

Hence, the particular requirements of the theory that develops from the analysis of the data determine the decisions to be made as far as the type of data to be collected is concerned. This means that data analysis feeds the data collection and sampling processes which follow (Cutcliffe, 2000). Consequently, data collection is influenced by analytic interpretations and discoveries, and by the researcher’s theoretical sensitivity (Glaser, 1978). Thus, the early findings in the analytical process bring about additional data collection until the researcher is confidently capable of supporting the explanation and theories that meticulously rationalise the emerging ideas (Birks and Mills, 2011; Charmaz, 1983).

Theoretical sampling involves two main steps: In the first step, participants who more or less share the situation under study are targeted by the researcher. After the data from this group are examined through continuous comparison, the researcher moves on to the second step. In this step, the researcher expands the sampling until differences between participants are finally boosted. Reducing the differences at the outset makes it possible for the researcher to quickly define categories and establish their characteristics. Second, maximising guarantees that categories are thoroughly defined and that the saturation of data is factual (Glaser, 1978).

Within theoretical sampling a more focused collection is performed for the advancement and discovery of core categories i.e. the parts of the theory having the highest interpretive potential. This process goes on until the categories and properties reach a saturation level (Glaser, 1978). Constant comparative analysis is carried out using the concept-indicator model until new properties cease to arise as regards the subject under study. Therefore,
theoretical sampling allows the theory to steadily progress towards achievement (Glaser, 1992). In accordance with grounded theory, theoretical saturation is reached when the collection of additional data is no longer feasible, and when the analyst can no longer advance the properties of the category. After repeated observation of the phenomenon in data analysis whereby “the researcher becomes empirically confident that a category is saturated” (Glaser and Strauss 1967, p. 61), then theoretical saturation can be said to have occurred.

3.8.4 Theoretical Sensitivity and the Core Category

Theoretical sensitivity per se is associated with the ability to use grounded theory to arrive at a deep understanding of people’s interactions with others and to explain their meaning from the pertinent data (Strauss and Corbin, 1998; Glaser and Strauss, 1967). In Glaser’s (1978) work, acquaintance with coding families, a conceptual ability, and an analysis of the relevant literature are used as arguments to boost theoretical sensitivity. According to Glaser (1978):

“The first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible, especially logically deducted, a priori hypotheses. In this posture, the analyst is able to remain sensitive to the data by being able to record events and detect happenings without first having them filtered through and squared with pre-existing hypotheses and biases.” (p. 3)

Theoretical sensitivity corresponds to the process of understanding the stages leading to the establishment of a core category. In the search for a core category, the researcher tries to find a core variable in the data and then seeks the ‘main theme’, or problem characterising the categories in that context, i.e. the essence of what is going on in the data. Thus ‘best fit’ conceptual labels are assigned to core categories. The criteria to develop a core category were defined by Glaser (1978, p. 95) as follows:
(1) It must be central due to its relation to the largest possible number of other categories and characteristics. The criterion for centrality is a necessary condition to make it core;

(2) It must recur repeatedly in the data;

(3) A core category needs more time to saturate in comparison with other categories;

(4) Its relationship with other categories is meaningful and easy;

(5) A core category in a substantive study produces obvious and remarkable effects on formal theory;

(6) The core category brings the process to completion since it does not result in dead ends in the theory;

(7) It is utterly variable, as its recurrent connections to other categories render it an extremely dependent variable with respect to degree, dimension and type. It is readily adjustable owing to these dependent variations;

(8) A core category represents a dimension of the problem with its interpretation of itself and of its own variations; and

(9) The core category may comprise any type of theoretical code: a process, a condition, two dimensions, a consequence and many others.

As soon as the researcher’s theoretical sensitisation to the search for core categories and those that process out occurs, the discovery of ‘core’ and ‘basic social processes’ in particular is natural (Glaser, 1978). Basic social processes have temporal dimensions that move and change over time. In order to integrate a basic social process in grounded theory, the process is to have at least two elements derived from the following list: “stages, staging, phases, phasing, progressions, passages, gradation, transitions, steps, ranks, careers, ordering, trajectories, chains, sequencings, temporaling, shaping, and cycling” (Glaser, 1978, p. 74).
Stages are observable due to their sequence with one another within certain temporal boundaries. Furthermore, stages have a time dimension i.e. a noticeable beginning and an end, while the time span between these points is not necessarily set and it depends on the causes of transition from one stage to another. Stages are, for these reasons, major characteristics of basic social process and are generated characteristics of process (Keady, 1999). In the present study, the researcher brought theoretical sensitivity to the data and analysis based on shared experiences with the participants.

3.8.5 The Use of Supporting Literature

Both Glaser and Strauss acknowledge that the researcher does not tackle a certain area of research without being influenced by preconceived ideas, but they disagree about the role of the supporting literature. Discovery occupies a pivotal role as far as both researchers’ ideas are considered. Thus, when one starts exploring a field, one is predisposed to understand new meaning and, through several processes of data collection and analysis, one gradually starts to establish a focus on a core issue which involves a set of related components (Heath and Cowley, 2004). For Glaser (1978) a researcher’s earlier understanding of certain meanings should be related to the general field of the problem, and it is the researcher’s duty to broaden his/her scope of understanding by ample and avid reading in order to stay aware of and sensitised on several pertinent possibilities. Admitting that one lacks knowledge is crucial to guarantee sensitivity to data. As the emerging theory develops enough to allow the use of literature as supplementary data, reading gains focus accordingly (Hickey, 1997).

3.9 Evaluation of Grounded Theory

Glaser and Strauss (1967) noted that:

“... discovery gives us a theory that ‘fits or works’ in a substantive or formal area (though further testing, clarification, or reformulation is still necessary), since the
theory has been derived from data, not deduced from logical assumptions.” (p. 29-30)

By ‘fit’, Glaser and Strauss (1967) were alluding to the need for conceptual categories to be readily, not forcibly, applicable to and indicated by the data under study (Hunter et al., 2011a). Similarly, they described theory as ‘working’ and having ‘grab’ if it was meaningful, relevant and able to explain the behaviour under study (Hunter et al., 2011a).

Glaser and Strauss (1967 p. 237) outlined four inter-related properties for testing the practical application of grounded theory, these were that the theory must:

1. Closely fit area in which it will be applied;
2. Be readily understandable to laymen concerned with the area;
3. Be sufficiently general to be applicable to a multitude of diverse situations within the area of study, not to just a specific type of situation; and
4. Allow the user partial control over the structure and process of daily situations as they change through time.

The ‘fit and grab’ of grounded theory approach and the emphasis upon creativity are, perhaps, best summarised in the four straightforward canons outlined above (Keady, 1999).

The remainder of this chapter makes explicit the methods the author followed in the present study.

3.10 The Interview Process

Grounded theory is a qualitative methodology and as such, it relies on qualitative methods for its conduct, such as interviewing (Charmaz, 2002). At first glance, the advantages of qualitative interviewing for conducting a grounded theory analysis seem indisputable. An interviewer takes more direct control over the building of data compared to a researcher
employing other methods like ethnography or textual analysis. Lofland and Lofland (1995, 1984) suggested that the interview is a focused form of dialogue. Grounded theory methods require that researchers assume control over the processes of data collection and analysis, and accordingly, the researcher gains more and in turn these methods make the researcher more in control of their data (Glaser, 1978). A qualitative interview is a deep and open exploration of an area of life at which the interviewee is an expert who can offer insightful data (Warren, 2002). Through the interview, a researcher can acquire profound insight into the interviewee’s own perception of the world (Johnson, 2002). The researcher can thus sketch out the framework of these perceptions by identifying the topics and formulating the questions. The flexibility of interviewing makes it an adequate and emergent strategy for data collection; topics and ideas which unravel in an interview can be used as instant leads to guide the interviewer towards what to pursue afterwards (Charmaz, 2002).

Methods employed in grounded theory research require a similar level of flexibility (Birks and Mills, 2011). Besides choosing and following certain topics during interviews, researchers using grounded theory methods analyse collected data, establish a certain focus, and go back to the field to collect yet more focused data in the process answering analytic questions and bridging conceptual gaps. The flexible and emergent nature of interviews and the control they give the researcher are an ideal fit for grounded theory techniques for improving the level of analytical accuracy of the resulting analysis (Charmaz, 2006). The difference between grounded theory interviewing and in-depth interviewing is that in the former, the research process develops as grounded theorists limit the range of the interview by making the questions more focused so that the resultant data would to be more directly relevant to theoretical frameworks (Charmaz, 2002).
The questions framed by a grounded theory interviewer should identify and discover processes (Charmaz, 2006, 2002). The interviewer starts with the participant’s story and fills it out by trying to situate it within a basic social process. The main grounded theory question leading a study is: ‘What is happening here?’ (Glaser, 1978). In this case, the ‘happening’ corresponds to the experience or substantive area handled in the research.

The first question may be sufficient for the first interview if story telling is obstructed. Sympathetic ‘uh huhs’ or simple comments and questions may encourage the participant to carry on narrating a story if he/she is able and willing to identify with it. In the present study questions were carefully chosen and slowly asked to the participants to stimulate their reflections. Grounded theory researchers use in-depth interviewing to discover rather than interrogate (Charmaz, 1991). Questions are expected to tackle the themes of the research study and simultaneously fit the participant’s experience. Questions should also be general enough to include a wide scope of experiences, and they should be focused enough to obtain and explore the particular experience of each participant (Charmaz, 2006).

The interview should encourage the interviewees to communicate their views, rather than mirror those of the interviewer. This is an essential aspect of the process of conducting qualitative research during which the researcher fulfils the task of exploring the interviewees’ subjective interpretation and meaning of events within the global setting of the area under study. Yet, good conversational skills are required on the part of the interviewer. Field and Morse (1985) suggest that this involves: to use sensitive questions; to avoid being judgmental; to remain vigilant about addressing and sequencing the questions; and to hold the interview in a setting that is familiar and comfortable to the interviewee, which could be the nursing home. An additional advantage can be gained
from holding an interview at the nursing home. Indeed, visiting the older persons in their domestic environment helps to construct a more complete and realistic picture of their daily life.

An interview situation also allows the researcher to identify nonverbal cues such as the tone of voice, eye contact, hand gestures, and others. Those cues are experienced during the interview, but do not appear in transcriptions or when other qualitative methods are employed. Polgar and Thomas (1991) suggest that interviewers use different means of recording interview data which range from written summary notes of the interview to an actual video or audio taping of the interview. With a tape recorded interview, the transcription can be open to independent scrutiny and, more importantly, to verification from the subject; a sequence of events that can assist in determining the validity of an emerging theory. For these reasons, the author decided to seek permission to tape record interviews, while also taking field notes during and following the interviews, an essential addition to conducting grounded theory research (Glaser, 1978). These field notes include a code number and a pseudonym for each participant, the interviewees’ responses, observation of non-verbal communication (e.g., facial expressions, grimaces), the interviewer’s reflections and ideas, and any other relevant information that could not be recorded by the recording device. In addition, the potential for recall bias was reduced with the taping of all the interviews and ensured a detailed and accurate record of the interview content (Strauss and Corbin, 1994).

The interviews were held in private meeting rooms or offices approved by the nurse unit administrators and managers. At the beginning of each interview, the participant was greeted and thanked for his/her attendance. The study and the study consent form (Appendix 1) were reviewed, and written consent was obtained for taping of the interviews.
and the use of the data from the interviews. The author’s role as a researcher was explained by informing participants about her affiliation with the University of Manchester and the American University of Beirut, and that this research was part of the requirements for a doctoral degree.

During the interview process, the participants were encouraged to ask questions regarding the study, and to describe their own experience and meaning of quality of life by gesturing with head nods and making the sound ‘uh-humm’. Moreover, participants were further prompted by comments such as ‘Please elaborate’, ‘Can you give me an example?’, ‘Can you please clarify what you mean by that term?’ A non-intrusive stance was assumed, so whenever the participant’s responses appeared not to address the purpose of the study, no attempt was made to interrupt the participant’s story. Instead, at the conclusion of their story, they were asked to make clarifications. This approach has contributed to facilitating the emergent nature of the study.

3.11 Data Collection
The author recruited participants with the help of a social worker who served as an access point to the residents, staff members, and family caregivers in nursing home A, and with the help of the nurse manager in nursing home B. The data were collected from in-depth interviews that started with the following question: What do you understand by the expression ‘quality of life’? The participants were encouraged to tell their stories at their own pace and to use their own words. Once participants completed their stories, open-ended probes were used as needed to ensure information was obtained about quality of life. Participants were encouraged to provide added detail and vignettes to illustrate their points. The interview was open and not leading in order to allow elicitation of aspects that might be peculiar to Lebanese culture. The probes that were used were based on studies of
predictors of quality of life as regards older people residing in nursing homes. The grand
tour question and probes for staff members and family caregivers were similar to those
asked to the older persons, with an emphasis on their role in helping to support the quality
of life of their older relative, an issue that is just beginning to be explored in the literature
(Davies and Nolan, 2006).

All the interviews were carried out by the researcher in Arabic, specifically in colloquial
Lebanese (the participants’ mother tongue), and were conducted in a private location such
as a vacant dining room, a resident’s room, a physiotherapy room, the nurses’ room, or the
social worker’s office at the nursing home. Interviews were tape-recorded and lasted
between 35 and 60 minutes. The potential for recall bias was reduced with the taping of all
the interviews and ensured a detailed and accurate record of the interview content (Strauss
and Corbin, 1994; 1990). The author spent some time monitoring life in the nursing home
to improve her understanding of the participants’ account. For the older residents,
interviews and conversations provided opportunities for them to reflect on their lives,
speaking of significant issues both in the past and present.

The interviews commenced at the end of October, 2009 and were completed in March
2010. A total of 39 interviews were carried out, with 20 interviews conducted with older
people, 11 interviews conducted with staff members, and eight interviews conducted with
family caregivers.

3.12 Data Analysis

The approach to data analysis in grounded theory was described in some detail earlier in
the chapter, and the author followed it using a Glaserian approach, and focusing on data
rather than formulaic technique. Transcription in particular was always completed
following each interview and prior to the next one, in addition to conducting a preliminary
analysis with the aim of starting the identification of key aspects. The author analysed the
data manually and did not use any qualitative data management/analysis software so as to
absorb herself in the experience of analysing qualitative data. The audio taped interviews
were transcribed and translated into English by a nurse holding a Master’s in Nursing and
fluent in both languages. The researcher listened to the recordings again, checked the
transcriptions thoroughly word by word, and edited them when necessary. Having grown
up as a speaker of Arabic and English, the researcher checked the translations for accuracy.
They were also checked again by a colleague who is proficient in both languages. The
involvement of two proof readers in the transcription and translation process ensured
greater data reliability (Lincoln and Guba, 1985). Any items having translation problems
of meaning, rather than wording, were discussed with other colleagues to clarify meaning.

Each interview was read completely at first, and then line by line. Holistic reading allowed
the identification of main statements on the participant’s experience. This provided the
researcher with an opportunity to interact with details embedded in the data and thereby to
grasp the underlying meaning of these data. Theoretical sensitivity was further enhanced
by the coding process which results from interaction with the data transcripts. The
researcher then read the interview transcripts again and independently wrote remarks in the
margins to facilitate the identification of coding categories. The key ideas were translated
into more abstract concepts. Then the author developed a set of tentative coding categories
and pinpointed examples of respondents’ statements indicative of these categories. The
purpose was to identify the most prominent ideas and themes that frequently emerged from
the detailed scrutiny of the interview data. Moreover, in line with constant comparisons,
early interviews were analysed and their data compared to those obtained in subsequent
interviews.
By implementing the grounded theory approach, the author relied on the conceptual power of the constant comparative method to help guide and shape the analysis of each interview. Theoretical memos were kept by the author following each interview and their use helped to shape the process of data analysis, particularly in the search for basic social processes and their role in explaining relationships in the data.

3.12.1 Coding Procedures

Coding procedures helped to identify, relate, and develop categories that had relevance to the older residents, family caregivers and staff. Proven theoretical relevance was achieved when any significant category or property met the following criterion: the category or the property was repeatedly present when different incidents were compared in the interviews. In other words, the categories and properties earned their status of a category or a property through their repeated presence in the actual participant data. During the coding procedures, the two analytic procedures of making comparisons and asking questions were used. In this study, coding was done within the transcribed interview on the right hand margin of the transcript. The codes represented what was going on in the data. Regardless of the type of coding done, asking questions about the data was crucial and part of specifying the conditions in which the codes appeared.

The coding process in the present study comprised substantive and theoretical coding, with the former involving both open and selective coding. A line-by-line analysis of data was carried out in open coding (Glaser, 1978; Glaser and Strauss 1967). Each happening, incident, idea, or event was given a label or conceptual reference that reflected what was indicated in the data. Similar ideas, incidents, and happenings were then compared and grouped under a common property. Properties which pertained to the same phenomenon were then grouped under a category that stood for the group of properties. The category
was given a name or label that was more abstract than the properties under it (Glaser, 1992). Categories represented the actual actions described by the participants.

The next step in the coding procedure was to identify the relationships between the categories. This step involved examining the relationships between categories and properties of indicators for the quality of life in terms of contexts, actions, interactions, and consequences. The recurrent patterns within the data derived from previous steps were identified. As the categories began to fill, those that were most dense became known as core categories (Glaser, 2001). The next step in the coding process was theoretical coding. Here the data were put back together in different ways in order to re-categorise the data and to link them to the different categories and their properties. Finally, themes were presented and abstracted from the data as derived from previous steps. The researcher used excerpts from interviews and field notes in order to illustrate and validate the emerging categories and themes. An example of data analysis is included in Appendix 2.

3.12.2 Memo Writing

Glaser’s specific definition of memos indicates that they comprise “the theorising write-up of ideas about codes and their relationships as they strike the analyst while coding” (Glaser, 1978, p. 83). Writing memos allows the researcher to take the time to pause, think, and exercise self-reflection. The researcher kept writing memos throughout the process of core category generation. Glaser invoked the idea of theoretical pacing to ensure that coding proceeded at a rate that allowed sufficient time for the fundamental activity of memo writing. He also emphasised that while writing memos, recognising proper pacing means that “if you are finished before you are finished, then you are really finished” (Glaser, 1978, p. 24). Charmaz (2006) also argued that writing memos is a function of the researcher’s readiness and can be started at any point in time when analytical and insightful
ideas occur during the research process. Memos are a liberating component of classic grounded theory as they allow researchers to write down any and all ideas they have concerning their data (Birks and Mills, 2011). This creates a fund of memos that when properly stored allows the memos to be re-worked and sorted in preparation for theory development (Hunter et al., 2011b).

The central importance of memo writing to generating a grounded theory was first suggested by Glaser in his work *Theoretical Sensitivity* (Glaser, 1978). It is a procedure devised to explain an event or a concept and to expand on that event or concept. Memo writing can assist the researcher in establishing categories and core categories while conducting data analysis. Memos are the researcher’s thoughts, questions and observations. They vary greatly in length and detail, the key element being that they capture the researcher’s thoughts on the data at that time (Hunter et al., 2011b). Glaser (1978) advocated that the researcher raise the conceptual level of those ideas towards developing theory. Memo writing was undertaken during this study as a means of emphasising the researcher’s thinking about a particular point or issue, and as a means of bringing related information together.

Therefore, theoretical memos reflect the researcher’s thinking in relation to the raw data. They also include the researcher’s ideas and insights during the research process, even though any ideas or insights are considered provisional until they are confirmed by comparing incidents, one after the other, in the actual interview data. Writing theoretical memos assisted the researcher in tracing the development of a category and its properties, as well as in determining the relationship between categories. Furthermore, theoretical memos assisted in the identification of unrelated categories that could be discarded.
Memos also helped the researcher to move from providing a descriptive to a conceptual account of what went on in the data.

### 3.13 Data Management

The sources of data included audio taping, field notes, written transcripts and their translations, and the signed consent forms. All the data were kept either in a locked drawer or in password protected files accessible only to the researcher. The nurse who transcribed and translated the audio-taped interviews was the only person other than the researcher who had access to the interviews. Audio-files of interviews were stored in a locked cabinet and will be destroyed following the completion of research. The researcher alone managed the data and conducted the analysis including data coding and categorisation. Immediately after the interviews, field notes and audio taped interviews in the Arabic language were transcribed first into Arabic. The researcher immersed herself deeply in the transcriptions and read them several times. All electronic data files were password protected. The participants' interviews were coded and a code log with identifiers was kept in a separate password protected file. Furthermore, pseudonyms were used for the participants while codes were used for the recorded interviews, field notes, transcripts, and translations. Codes, pseudonyms, and telephone numbers were recorded in a separate notebook and kept in a separate locked drawer different from the one containing field notes and transcripts.

### 3.14 Preparations for Conducting the Study

Once the methodology and method had been decided upon, the next stage of the study involved its operationalisation which was achieved through the following stages:
3.14.1 Gaining the Support of Key Personnel (directors of institutions, geriatricians, and nurse managers)

As an initial step, the researcher made an approach to the directors of the two nursing homes in Beirut to discuss their preliminary thoughts about the proposed study and its research design. Fortunately, this approach received an enthusiastic response and meetings were held between the researcher and each of the directors of the nursing homes and the geriatricians in charge who also expressed support for the study. The researcher, who is a nurse educator, pays frequent visits with her students to these nursing homes within the context of her practice to implement educational programs. Consequently, permission to conduct the study in these nursing homes was granted and a facility liaison was appointed by the administrators to serve as an access point to the residents, staff and family carers in the nursing home. A meeting was arranged with each of the nursing unit managers in the nursing homes. At this meeting, the researcher asked for assistance with some practical issues such as the best days and times to interview the residents, nurses, and family caregivers, the times when rooms for interviewing were available, and a schedule of the unit activities. After setting the time frames with the nursing managers, the researcher made herself available during these days and times for possible interviews. Conducting an interview was always left to the discretion of the residents, staff members and family carers.

In addition, the nurse managers took the researcher on a tour of the premises and introduced her to the staff available on those particular shifts. At the same time, each of the nurse managers briefly informed the residents, staff members and family carers about the study and mentioned the researcher’s name through their usual routes of communication.
3.14.2 Designing the Semi-Structured Interview Guide and the Consent Form

The semi-structured interview guides for the older residents, staff members and family carers were developed on the basis of a preliminary literature review of the factors that influence the quality of life of nursing home residents. Each question derived from the literature was considered tentative until the participants made sure that it was relevant to their experience and understanding of ‘quality of life’. The questions were prepared in accordance with Patton’s (1990) and Kaufman’s (1994) suggestions and sequence of interviewing an older person. The interview usually starts with an initial part, an introduction, with questions pertinent to the interviewee’s life experiences and daily activities. The second part involves a more focused approach with general and specific questions about core issues. The interviewer repeated some of the main questions using different wording at several points during the interview in order to get as comprehensive an answer as possible.

The stimulus question for the residents in the study was: ‘How do you describe quality of life? In-depth interviewing was used with questions specifically designed to delve into the interviewer’s theme and match the participant’s experience. The questions were also designed to incorporate a broad spectrum of experiences, yet they were also sufficiently focused to more particularly explore each participant’s specific experience (Charmaz, 2006). This dual purpose was exemplified by questions such as: ‘What do you understand by the term quality of life?’; ‘What kind of things does the expression quality of life make you think of?’; and ‘What do you like most about being in this nursing home?’ The interview guides are presented in Appendix 3.

In accordance with the grounded theory approach (Heath and Cowley, 2004), the primary purpose of the literature review was to facilitate the phrasing of questions to be used in the
interview guide. The information and the stories the participants shared with the interviewer became the primary basis for any modifications of the questions in the initial interview guide. Those questions were used tentatively, until the incoming data released by the participants sharpened the focus of the questions and the study (Glaser, 1992). Emerging concepts were added to the interview guide because the incoming information supplied by the participants determined what information was sought next.

The interview guides were translated into Arabic by a professional translator, and then they were translated back into English in order to ensure the clarity and appropriateness of the questions. The interviewer used a first draft of the interview guide with two residents, one staff member and one family carer. Accordingly, some questions were reformulated based on the result of this pilot test.

Consent forms were designed for the older residents, staff members and family carers according to the requirements of the American University of Beirut, and were translated into Arabic and then approved by the Institutional Review Board at the American University of Beirut. Since the researcher is a faculty member at the Hariri School of Nursing at the American University of Beirut, and since the research was conducted at the American University of Beirut, it logically followed that the American University of Beirut’s consent form should be adopted. The Institutional Review Board’s approval of the proposal was granted on the understanding that the consent form be that of the American University of Beirut. It was thus incumbent upon the researcher to use these forms. These consent forms have been used to obtain the approval of the participants in the research study.

3.14.3 Gaining Ethical Permission to Conduct the Study

(1) The University of Manchester
The research ethics application was submitted to the research ethics committee of the School of Nursing, Midwifery and Social Work to be considered in the committee’s meeting of May 27, 2009. However, obtaining ethical permission from the University of Manchester was a protracted process. The ethics committee reviewed the ethics application and an unfavourable decision was granted because of certain queries raised by the committee. The committee’s queries were answered by the author and some clarifications and amendments were made to the study as requested by the research ethics committee, and the application was submitted again to be considered in the meeting of July 29, 2009. After a negotiated process, University of Manchester ethical permission to conduct the study was eventually given and full ethical approval was granted on October 28, 2009. Consequently, data collection commenced in October 2009. The ethical approval letter is contained in Appendix 4.

(2) The American University of Beirut

The complete research proposal was submitted to the Institutional Review Board at the American University of Beirut, where the study was conducted. The Institutional Review Board reviewed in an expedited manner the study proposal, the English and Arabic interview guides (for older resident, staff member and family carer), the English and Arabic consent forms (for older resident, staff member and family carer). They recommended that since the proposal targets a vulnerable population that may be suffering from dementia, a witness be present during the process of informed consent. The signatures of both the witness and the older person should be secured prior to participation. Accordingly, the informed consent forms were modified and were submitted for further consideration by the Institutional Review Board. Following the review of the submitted letter indicating
that a witness would attend the process of getting informed consents from the older residents, approval for the study proposal was granted on June 9, 2009. The ethical approval letter is contained in Appendix 5.

3.15 Sample and Setting

The sample recruited for the present study included older people residing in two nursing homes in Lebanon, staff members and family carers. The two nursing homes represent large nursing homes for older people located in Beirut where both cognitively intact and older people with dementia reside.

The inclusion criteria for older residents comprised:

1. Being of an age equal to or over 65;
2. Living in a nursing home for more than six months;
3. Speaking Arabic; and
4. Being able and willing to consent to and engage in the research study.

As 23-74 percent of Lebanese nursing home residents have dementia (Chahine et al., 2007; Bcherraoui, 2006, unpublished data), this population were deemed suitable for participation based on Whalley’s (1992) suggestion that a person with dementia is able to give consent to participate in a research study if he/she understands what is being asked and feels free to refuse. In addition, it is easier to discuss the issue of competence to make such a decision with people undergoing the early experience of dementia, than with those in the later stages when competence is considered more elusive (Gilhooly, 1984). Gilhooly (1992) claims that a diagnosis of dementia should not automatically disqualify a person from taking part in a study, especially if they wish to do so, on the condition that these participants would not have any traits which are related to the exclusion criteria of the study. People in an early stage of dementia may welcome the opportunity to discuss their
experiences at the nursing home (Cotrell and Schulz, 1993). Furthermore, people with
dementia can make their voice heard by indicating choices while their voice is vitally
important to capture; they can still make a contribution.

In the present study dementia is defined as a group of symptoms, an accompanying
disease, manifested in memory loss, disorientation, changes in mood or personality, as well
as in difficulties with abstract thinking, task performance, and language use. It is a
progressive illness that impairs social and occupational functioning (American Psychiatric
Association, 1994). The DSM-IV (American Psychiatric Association, 1994) defines the
criteria for dementia as being:

(1) Development of cognitive deficits:

   a) The person cannot recall new or previously learned information.

   b) Memory problems must be present.

(2) One or more of the following:

   a) Apraxia: Impaired motor activities due to damage to motor cortex (e.g., the
      person cannot use a key).

   b) Aphasia: Language disturbance (e.g., cannot find words or put sentences
      together).

   c) Agnosia: Failure to recognise or identify objects (e.g., the person may see
      something but cannot label it or tell what it is used for).

(3) Disturbed executive functioning: Planning, organising, sequencing, and abstracting
    problems due to frontal lobe damage.

In the two nursing homes where the study was conducted, the geriatricians diagnose
dementia by taking into consideration the DSM-IV (American Psychiatric Association,
1994) criteria while communicating with the older resident.
The decision on whether participants would be approached to take part in the study was made in consultation with the geriatrician in charge of the case, the family caregiver, the director of the nursing home, and the nurse manager. Unfortunately, Lebanon lacks mental capacity legislation and does not have the kind of trained advocates that one might expect to see in the UK. Therefore, in order to facilitate the older persons’ participation, the researcher was guided by:

1. The clinician’s judgment that the person is competent to participate;
2. Involvement of the family in the decision making process, i.e. the family has to agree that the older person will take part in the study;
3. The researcher’s own assessment; and
4. The experience of the supervisory team in undertaking research in this field.

The exclusion criterion for older residents was:
Mental or physical illness having an unfavourable impact on the person’s ability to take part in the research project; for example older residents with dementia who are severely agitated or very distressed, and are unable to give informed consent.

A nursing care provider or a staff member is defined in this study as a registered nurse, a licensed practical nurse, or a certified nursing assistant who has been employed in a nursing home for at least six months. The licensed practical nurses and the certified nursing assistants provide much of the hands-on care that residents receive.

The inclusion criteria for the staff were:

1. Being a permanent paid staff of the nursing home;
2. Being employed at the nursing home for at least six months;
3. Caring for residents as the main focus of their work;
4. Provision of direct care to the residents participating in the study; and
5. Reflection of the typical skill-mix in the nursing home.
In this study, a ‘family caregiver’ is defined as the individual in the resident’s family who most frequently visits him/her as identified by the staff members who have initially contacted family caregivers on the behalf of the researcher. Afterwards, a meeting took place between the researcher and family caregivers interested in taking part in this study. During this meeting, these caregivers were provided with additional details about the study, and their informed consent was obtained after they were reminded that they can choose to withdraw from the study at any point. After explaining the purpose of the research study and its duration, the researcher also reassured the family caregivers of the confidentiality regarding all the data acquired throughout the study.

A family caregiver is understood to be sufficiently involved with a resident if:

1. The person provided personal care to the resident before the latter was admitted into the nursing home, and if this person visits the nursing home regularly at intervals of not more than eight weeks;
2. The person is a first degree relative and visits the nursing home regularly at intervals of not more than eight weeks, and if this is the person the nursing home staff liaise with on the older resident’s health status;
3. The person is a relative, former neighbour or friend of the resident and visits the nursing home regularly at intervals of not more than eight weeks; and
4. The person is not a staff member but participates in the physical care of the resident (assistance with dressing, personal hygiene, feeding).

The inclusion criteria for the family caregivers comprised:

1. Consenting relatives or close friends of residents who on average visit the nursing home at least once every two months (preference was given to first degree relatives);
2. Aged 18 and over; and
(3) Arabic speaking.

Two nursing homes were purposefully sampled to take part in the study and were chosen on the basis of their geographic accessibility, size, and willingness of their administrations to take part in the research.

Nursing home A was selected because it has a community reputation for ‘admitting complex cases.’ It includes four sections for older people, for men and women separately, with a total population of 258 residents. The beds are always permanently occupied by patients. Nursing services are provided by 57 nurses of whom one third are registered nurses, whereas the others comprise practical nurses, nursing assistants, and a team of social workers and ergo therapists. The main objective of this long-term care institution is to ensure health, medical and nursing care, and social services to older people living with fraility and dementia.

Nursing home B provides traditional care and has a 70-bed capacity. It is a non-profit organisation and seeks the provision of comprehensive health and social services to its older residents. The home provides medical care, nursing care, social and recreational care, rehabilitation, rest, and security. The activities of nursing home B are carried out by a multi-disciplinary team of health care professionals including 40 full-time staff members, two medical doctors, and three part-time staff members. All residents are visited twice daily by the geriatrician, and a comprehensive geriatric assessment is conducted as a weekly follow-up. The necessary treatments are administered to those needing them while the follow-up on prescribed treatments is ensured by the nursing staff on a 24-hour basis. Nursing home B is affiliated with ‘Assistance Publique – Hopitaux de Paris.’ Both nursing homes house older people with and without dementia.
3.15.1 Sample Characteristics of the Older Residents

A total of 20 older residents were interviewed in nursing home A and nursing home B and the participant demographics are shown in Table 1. As can be seen from this Table, the sample comprised 11 women and nine men, aged between 65-91 years with a mean age of 73.7 years. Four older residents lived alone before admission whereas 16 others lived with their families.

Three of the older residents who lived alone before admission had never married, five other older residents were widowed, three were divorced and nine were still married. Admission into the nursing home had been voluntary for all older residents. Most of the older residents had chronic health problems such as hypertension, diabetes mellitus and heart failure, yet they were all able to self-care. As Table 1 also reveals, the main reasons for admission were failing physical health and family members’ anticipated inability to provide care at home. The residents were all lucid, able to participate in a conversation and to express views on their living circumstances, as well as to reflect on their life story. They had lived in the nursing home for a period of 10 months to nine years. In the two participating nursing homes all residents’ rooms have two or more beds, two or more dressers, and various medical equipment as needed by the residents, including over-the-bed tables, walkers and wheelchairs. Call buttons are located at the bedside for each of the residents. A bathroom with accessible fixtures is located within each room. On each wing is a nursing station that serves as the centre of the staff activity.

3.15.2 Sample Characteristics of the Staff Members

A total of 11 staff members were interviewed in nursing home A and nursing home B. The data gathered represents participant’s age, gender, job title, qualifications and number of years of work experience in the nursing home. The majority of participants were registered
<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Nursing Home</th>
<th>Gender</th>
<th>Age in years</th>
<th>Marital Status</th>
<th>Education</th>
<th>Previous Occupation</th>
<th>Date of Interview</th>
<th>Date of Admission to Institution</th>
<th>Reason for Admission</th>
<th>No. of Children</th>
<th>Visitors</th>
<th>Location of the Interview</th>
<th>Duration of the Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>A</td>
<td>F</td>
<td>&gt;70</td>
<td>M</td>
<td>Illiterate</td>
<td>Housewife</td>
<td>Oct. 28, 09</td>
<td>July, 2006</td>
<td>Social &amp; Financial</td>
<td>4</td>
<td>Children</td>
<td>Nurses' Room</td>
<td>50 minutes</td>
</tr>
<tr>
<td>R2</td>
<td>A</td>
<td>F</td>
<td>81</td>
<td>M</td>
<td>Illiterate</td>
<td>Housewife</td>
<td>Oct. 28, 09</td>
<td>Sept. 2008</td>
<td>Social &amp; Financial</td>
<td>—</td>
<td>Sons &amp; daughters of sisters</td>
<td>Nurses' Room</td>
<td>40 minutes</td>
</tr>
<tr>
<td>R3</td>
<td>A</td>
<td>M</td>
<td>74</td>
<td>M</td>
<td>Elementary</td>
<td>Sells vegetables</td>
<td>Nov. 4, 09</td>
<td>6 years ago</td>
<td>Doesn’t have a place to live</td>
<td>3</td>
<td>Children</td>
<td>Nurses' Room</td>
<td>60 minutes</td>
</tr>
<tr>
<td>R4</td>
<td>A</td>
<td>M</td>
<td>65</td>
<td>M</td>
<td>Elementary</td>
<td>Skilled laborer</td>
<td>Nov. 4, 09</td>
<td>8 years ago</td>
<td>Doesn’t have a place to live</td>
<td>6</td>
<td>Children</td>
<td>Patient's Room</td>
<td>40 minutes</td>
</tr>
<tr>
<td>R5</td>
<td>A</td>
<td>M</td>
<td>65</td>
<td>D</td>
<td>Elementary</td>
<td>Waiter</td>
<td>Nov. 12, 09</td>
<td>2 years ago</td>
<td>Social &amp; Financial</td>
<td>—</td>
<td>Brother/Neighbour</td>
<td>Patient's Room</td>
<td>40 minutes</td>
</tr>
<tr>
<td>R6</td>
<td>A</td>
<td>M</td>
<td>66</td>
<td>D</td>
<td>Illiterate</td>
<td>Sells vegetables</td>
<td>Nov. 12, 09</td>
<td>2 years ago</td>
<td>Family unable to provide care</td>
<td>—</td>
<td>Sister &amp; Niece</td>
<td>Patient's Room</td>
<td>40 minutes</td>
</tr>
<tr>
<td>R7</td>
<td>A</td>
<td>F</td>
<td>85</td>
<td>W</td>
<td>Illiterate</td>
<td>Housewife</td>
<td>Nov. 19, 09</td>
<td>1 year ago</td>
<td>Family unable to provide care</td>
<td>—</td>
<td>Nephew</td>
<td>Nurses' Room</td>
<td>55 minutes</td>
</tr>
<tr>
<td>R8</td>
<td>A</td>
<td>F</td>
<td>72</td>
<td>D</td>
<td>Illiterate</td>
<td>Housewife</td>
<td>Nov. 19, 09</td>
<td>13 years ago</td>
<td>Family unable to provide care</td>
<td>3</td>
<td>Children</td>
<td>Nurses' Room</td>
<td>50 minutes</td>
</tr>
<tr>
<td>R9</td>
<td>A</td>
<td>F</td>
<td>&gt;80</td>
<td>S</td>
<td>Illiterate</td>
<td>Housewife</td>
<td>Nov. 26, 09</td>
<td>10 months ago</td>
<td>Family unable to provide care</td>
<td>—</td>
<td>—</td>
<td>Nurses' Room</td>
<td>40 minutes</td>
</tr>
<tr>
<td>R10</td>
<td>A</td>
<td>F</td>
<td>75</td>
<td>M</td>
<td>Elementary</td>
<td>Housewife</td>
<td>Nov. 26, 09</td>
<td>1 year ago</td>
<td>Family unable to provide care</td>
<td>3</td>
<td>Children</td>
<td>Nurses' Room</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Participant Code</td>
<td>Nursing Home</td>
<td>Gender</td>
<td>Age in years</td>
<td>Marital Status</td>
<td>Education</td>
<td>Previous Occupation</td>
<td>Date of Interview</td>
<td>Date of Admission to Institution</td>
<td>Reason for Admission</td>
<td>No. of Children</td>
<td>Visitors</td>
<td>Location of the Interview</td>
<td>Duration of the Interview</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------</td>
<td>--------</td>
<td>--------------</td>
<td>----------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>------------------</td>
<td>-------------------------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>----------</td>
<td>---------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>R11</td>
<td>B</td>
<td>F</td>
<td>80</td>
<td>M</td>
<td>Secondary</td>
<td>Housewife</td>
<td>Feb. 19, 10</td>
<td>4 years</td>
<td>Family unable to provide care</td>
<td>1</td>
<td>Son 2x/week</td>
<td>Patient's Room</td>
<td>60 minutes</td>
</tr>
<tr>
<td>R12</td>
<td>B</td>
<td>F</td>
<td>90</td>
<td>M</td>
<td>Secondary</td>
<td>Housewife</td>
<td>Feb. 19, 10</td>
<td>9 years</td>
<td>Family unable to provide care</td>
<td>1</td>
<td>Brother 2x/week</td>
<td>Patient's Room</td>
<td>60 minutes</td>
</tr>
<tr>
<td>R13</td>
<td>B</td>
<td>M</td>
<td>82</td>
<td>W</td>
<td>Secondary</td>
<td>Skilled laborer</td>
<td>Feb. 23, 10</td>
<td>4 years</td>
<td>Family unable to provide care</td>
<td>—</td>
<td>Brother 2x/week</td>
<td>Salon</td>
<td>60 minutes</td>
</tr>
<tr>
<td>R14</td>
<td>B</td>
<td>M</td>
<td>91</td>
<td>S</td>
<td>University</td>
<td>Accountant</td>
<td>Feb. 23, 10</td>
<td>1.5 years</td>
<td>No family</td>
<td>—</td>
<td>Cousins once/2wk</td>
<td>Salon</td>
<td>60 minutes</td>
</tr>
<tr>
<td>R15</td>
<td>B</td>
<td>M</td>
<td>70</td>
<td>M</td>
<td>Elementary</td>
<td>Business man</td>
<td>Feb. 23, 10</td>
<td>5 years</td>
<td>Paralised</td>
<td>2</td>
<td>Brother &amp; cousins</td>
<td>Physiotherapy Room</td>
<td>60 minutes</td>
</tr>
<tr>
<td>R16</td>
<td>B</td>
<td>M</td>
<td>75</td>
<td>W</td>
<td>Illiterate</td>
<td>Laborer</td>
<td>Feb. 25, 10</td>
<td>1 year</td>
<td>No family</td>
<td>3</td>
<td>Son once/week</td>
<td>Physiotherapy Room</td>
<td>35 minutes</td>
</tr>
<tr>
<td>R17</td>
<td>B</td>
<td>M</td>
<td>91</td>
<td>W</td>
<td>Secondary</td>
<td>Business man</td>
<td>Feb. 25, 10</td>
<td>9 years</td>
<td>No family</td>
<td>—</td>
<td>Brother &amp; sister 2x/week</td>
<td>Patient's Room</td>
<td>90 minutes</td>
</tr>
<tr>
<td>R18</td>
<td>B</td>
<td>F</td>
<td>80</td>
<td>W</td>
<td>Elementary</td>
<td>Tailor</td>
<td>Feb. 26, 10</td>
<td>8 years</td>
<td>Family unable to provide care</td>
<td>1</td>
<td>Daughter once/wk</td>
<td>Lobby</td>
<td>35 minutes</td>
</tr>
<tr>
<td>R19</td>
<td>B</td>
<td>F</td>
<td>83</td>
<td>S</td>
<td>Elementary</td>
<td>Tailor</td>
<td>Feb. 26, 10</td>
<td>4 years</td>
<td>Family unable to provide care</td>
<td>—</td>
<td>Neice once/wk</td>
<td>Patient's Room</td>
<td>50 minutes</td>
</tr>
<tr>
<td>R20</td>
<td>B</td>
<td>F</td>
<td>89</td>
<td>M</td>
<td>Elementary</td>
<td>Housewife</td>
<td>Feb. 26, 10</td>
<td>3 years</td>
<td>Family unable to provide care</td>
<td>4</td>
<td>Children once/wk</td>
<td>Physiotherapy Room</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

**Marital Status:**

- M = Married
- D = Divorced
- S = Single
- W = Widowed
nurses (RN) (n=8), two of whom were nurse managers, while three of the participants were health care assistants and are called licensed practical nurses in Lebanon. Eight of the participants were female and three were male, with a 23-50 age range and with clinical experience varying between one and a half and 14 years. Table 2 provides summary data on the staff characteristics.

3.15.3 Sample Characteristics of the Family Carers

Study participants in this phase of the study were all family carers who had relatives in one of the two participating nursing homes. The eight participating family carers, whose ages ranged from 32 to 70 years, consisted of three sisters, two daughters, one son, one niece, and one nephew. While all had cared for their older relative prior to admission to the nursing home, they were family carers in the nursing home context for a period of time extending from between one to six years. For three of the participants (nephew, niece, and sister), the older person had been co-resident prior to admission to the nursing home. The interviews were conducted mostly in the nursing home facility and focused on their experience as family carers and their involvement in the care of their older relative in the nursing home context. The participants were interested in communicating with the researcher and were able to share their experience with her. The key characteristics of family carers who took part in the interviews are shown in Table 3.

3.16 Human Subject Consideration

Because the delivery of care to humans is the subject matter of nursing, the protection of their rights, and particularly those of the older people, was a primary concern in this study. Data collection involved interviewing older people admitted to nursing home A, nursing home B, staff members employed in these nursing homes and family carers.
<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Nursing Home</th>
<th>Education/Training</th>
<th>Age</th>
<th>Gender</th>
<th>No. of Years of Service at the Institution</th>
<th>Date of the Interview</th>
<th>Location of the Interview</th>
<th>Duration of the Interview (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>A</td>
<td>RN</td>
<td>33</td>
<td>F</td>
<td>8</td>
<td>Jan. 7, 2010</td>
<td>Nurses Room</td>
<td>45</td>
</tr>
<tr>
<td>S2</td>
<td>A</td>
<td>RN</td>
<td>30</td>
<td>F</td>
<td>14</td>
<td>Jan. 7, 2010</td>
<td>Nurses Room</td>
<td>45</td>
</tr>
<tr>
<td>S3</td>
<td>A</td>
<td>LPN</td>
<td>25</td>
<td>F</td>
<td>4</td>
<td>Jan. 7, 2010</td>
<td>Nurses Room</td>
<td>45</td>
</tr>
<tr>
<td>S4</td>
<td>A</td>
<td>RN, Nurse Manager</td>
<td>32</td>
<td>M</td>
<td>12</td>
<td>Jan. 12, 2010</td>
<td>Nurses Room</td>
<td>60</td>
</tr>
<tr>
<td>S5</td>
<td>A</td>
<td>LPN</td>
<td>23</td>
<td>M</td>
<td>3</td>
<td>Jan. 12, 2010</td>
<td>Nurses Room</td>
<td>45</td>
</tr>
<tr>
<td>S6</td>
<td>A</td>
<td>RN</td>
<td>29</td>
<td>M</td>
<td>2</td>
<td>Jan. 12, 2010</td>
<td>Nurses Room</td>
<td>45</td>
</tr>
<tr>
<td>S7</td>
<td>B</td>
<td>RN, Nurse Manager</td>
<td>49</td>
<td>F</td>
<td>6</td>
<td>March 3, 2010</td>
<td>Nurse Manager's Office</td>
<td>60</td>
</tr>
<tr>
<td>S8</td>
<td>B</td>
<td>LPN</td>
<td>50</td>
<td>F</td>
<td>11</td>
<td>March 3, 2010</td>
<td>Nurse Manager's Office</td>
<td>60</td>
</tr>
<tr>
<td>S9</td>
<td>B</td>
<td>RN</td>
<td>23</td>
<td>F</td>
<td>3</td>
<td>March 3, 2010</td>
<td>Nurse Manager's Office</td>
<td>45</td>
</tr>
<tr>
<td>S10</td>
<td>B</td>
<td>RN</td>
<td>27</td>
<td>F</td>
<td>6</td>
<td>March 5, 2010</td>
<td>Nurse Manager's Office</td>
<td>50</td>
</tr>
<tr>
<td>S11</td>
<td>B</td>
<td>RN</td>
<td>29</td>
<td>F</td>
<td>1 ½</td>
<td>March 5, 2010</td>
<td>Nurse Manager's Office</td>
<td>50</td>
</tr>
</tbody>
</table>
### Table 3: Family Carers’ Demographics

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Nursing Home</th>
<th>Gender</th>
<th>Age</th>
<th>Date of Interview</th>
<th>Relationship to Resident</th>
<th>Time since Admission</th>
<th>Co-resident prior to Admission</th>
<th>Frequency of visits</th>
<th>Location of the interview</th>
<th>Duration of the interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>A</td>
<td>M</td>
<td>50</td>
<td>Jan. 19, 10</td>
<td>Nephew</td>
<td>1 year</td>
<td>Yes</td>
<td>every day</td>
<td>Social worker's office</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F2</td>
<td>A</td>
<td>F</td>
<td>39</td>
<td>Jan. 19, 10</td>
<td>Niece</td>
<td>6 years</td>
<td>Yes</td>
<td>every day</td>
<td>Social worker's office</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F3</td>
<td>A</td>
<td>F</td>
<td>32</td>
<td>Jan. 26, 10</td>
<td>Daughter</td>
<td>2 years</td>
<td>No</td>
<td>once every 2 days</td>
<td>Social worker's office</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F4</td>
<td>A</td>
<td>F</td>
<td>60</td>
<td>Jan. 26, 10</td>
<td>Sister</td>
<td>1 year</td>
<td>No</td>
<td>once /week</td>
<td>Social worker's office</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F5</td>
<td>A</td>
<td>F</td>
<td>70</td>
<td>Jan. 26, 10</td>
<td>Sister</td>
<td>3 years</td>
<td>Yes</td>
<td>every day</td>
<td>Social worker's office</td>
<td>40 minutes</td>
</tr>
<tr>
<td>F6</td>
<td>B</td>
<td>F</td>
<td>57</td>
<td>Mar. 10, 10</td>
<td>Daughter</td>
<td>1 ½ years</td>
<td>No</td>
<td>every 3 days</td>
<td>Nurse manager's office</td>
<td>45 minutes</td>
</tr>
<tr>
<td>F7</td>
<td>B</td>
<td>M</td>
<td>50</td>
<td>Mar. 20, 10</td>
<td>Son</td>
<td>4 years</td>
<td>No</td>
<td>every 4 days</td>
<td>Nurse manager's office</td>
<td>50 minutes</td>
</tr>
<tr>
<td>F8</td>
<td>B</td>
<td>F</td>
<td>65</td>
<td>Mar. 25, 10</td>
<td>Sister</td>
<td>5 years</td>
<td>No</td>
<td>every week</td>
<td>Nurse manager's office</td>
<td>50 minutes</td>
</tr>
</tbody>
</table>
Special attention was given to the choice of the time and place to conduct the interviews whereby the participants were willing and felt comfortable at the nursing home. They were given sufficient time to read the consent form, ask questions, and sign the form prior to the start of the interview. Older residents, staff members and family carers were informed of the voluntary nature of participation so that they could withdraw from the study at any time without having the care delivered to them affected. Those who agreed to participate were asked to sign a consent form and were assured of strict confidentiality. These data were anonymised due to the adoption of a code to identify each participant and pseudonyms were used for qualitative quotes. The researcher took all the steps necessary to maintain confidentiality and anonymity, such as keeping all transcripts and other data files locked and separated from personal identifiers. No personal identifiers were used for either the participants or the researcher on data collection forms or audio taping. It was made clear that the interviewer or the participants could discontinue the interview whenever the participants wished or the interviewer deemed it necessary due to their discomfort, fatigue, or distress. Fortunately, disruptions did not occur during the conduct of the study. The participants were also given the freedom to stop the tape at any time. The only reported instance had to do with one staff member’s request to stop the tape to relate information which she did not feel comfortable about having recorded this way.

3.17 Credibility of the Study

Chiovitti and Piran (2003) devised the following eight research methods that can render a more rigorous grounded theory methodology:

1. Give the participants the opportunity to direct the inquiry process;
2. Compare the emerging theoretical construction with the participants’ meanings of the phenomenon for verification;
3. Use the participants’ exact words in the theory;
(4) Express the researcher’s personal perceptions and views about the explored phenomenon;

(5) Indicate the criteria established in the researcher’s mind;

(6) Explain the manner of and reasons behind the selection of participants in the study;

(7) Define the scope of the research as regards sampling, setting, and the level of theory generated; and

(8) Explain the relationship between the literature and each category emerging in the theory.

In this section, the steps made to ensure the fulfillment of the above mentioned criteria are described in detail. The participants were mainly asked open-ended questions during the interviews which were exploratory in nature. For the sake of adhering to the grounded theory methodology, participants were asked general open-ended questions, thus limiting the impact of previous theoretical constructs of the quality of life on participants (Glaser, 1978). Moreover, the data acquired from the interviews were used to narrow the scope of the focus of the research questions and other related questions, and this is in line with grounded theory methodology (Glaser, 1978). This is the reason behind asking the following research question and general questions at the initial stage of the study. The research question was ‘What are the perceptions, perspectives and the meaning of quality of life for a theoretical sample of older people living in Lebanese nursing homes, their care staff and family carers?’ The three following general questions were also asked at the beginning of the study, in order to explore the research question with the participants: (a) ‘How would you describe quality of life?’; (b) ‘What do you understand by the term quality of life?’; (c) ‘What kind of things does the expression quality of life make you think of?’ These general questions effectively elicited thorough and dense descriptions of the quality of life.
The first interviews with five of the participants made it possible for a tentative preliminary model to emerge. Accordingly, the interview guide was amended with additional questions based on the data acquired from the participants; these questions were found to be effective in identifying the content areas discussed and in validating the emerging theory.

The data acquired from the interviews with the participants made its way into the emerging theory when continuous comparisons of these data unraveled a repetitive presence of specific content topics. In the present study, the continuous comparison of data analysis was established through regularly comparing new data with previously acquired information (Carpenter Rinaldi, 1995). This allowed the discovery of topics that were regularly present in the interviews with the participants and directly pertinent to their experiences. Two standard questions were asked in order to analyse the transcribed interview data: ‘What is happening in the data?’ and ‘What action does each particular happening, incident, event or idea represent?’ (Glaser, 1978). These two questions aimed to detect categories, relationships between and within categories, and a central phenomenon or core category around which all the other categories revolved. Through the continuous comparison of data, the researcher identified and built categories that needed additional refinement and development. Moreover, the researcher became able to establish a better focus for the inquiry process and to enhance the credibility of this research study by using the actual data elicited from the participants in order to make modifications in the interview guide and the content areas of the emerging theory. Another factor that added to the credibility of this study is the use of the participants’ own language during all levels of coding in the construction of grounded theory (Glaser, 1978). Each relationship and action was validated with excerpts from the interview data.
The implementation of the grounded theory methodology entails delineating and specifying the criteria used when tackling the transcribed interview (Glaser 1978). In the present study, the criteria that influenced the thinking of the researcher were specified as a result of the delineation of the standard questions consistently asked during the interview and appearing in the transcribed interview data during analysis. These questions were, (a) ‘What is happening in the data?’; (b) ‘What does the action in the data represent?’; (c) ‘Is the conceptual label or code part of the participant’s vocabulary?; (d) ‘In what context is the code/action used?’ (e) ‘Is the code related to another code?’; (f) ‘Is the code encompassed by a broader code?’; and (g) ‘Are there codes that reflect similar patterns?’ (Chiovitti and Piran, 2003). These questions were used in the identification, development, and refinement of all codes. They helped to control the researcher’s potential for biased interpretation by ensuring that any category of the quality of life that emerged from the analysis was verified in the actual data. In addition, these questions were helpful in making the researcher’s thinking visible, thus enhancing the confirmability of the findings by another.

By developing a theory that applies grounded theory methodology, Glaser (1978) highlighted the importance of explaining the bases on which study participants were selected. The information supplied by previous participants (theoretical sampling) defines the number of participants recruited to the study. In the present study, convenience sampling was initially applied (Strauss, 1987), because no information from participants was present to suggest what further data should be explored and analysed. This meant that any participant who fit the eligibility profile took part in the study. Afterwards, participants were selected until data reached the stage of theoretical saturation.
3.18 Summary

This chapter has addressed the key tenets of symbolic interactionism as they inform the methodology applied in this study. The basic canons of the grounded theory methodology and the design and the method of the study were introduced. The chapter has also engaged with the ensuing schism in grounded theory with Strauss preferring a rigid conditional matrix as a more transparent process of generating grounded theory, whereas Glaser developed further the concept of theoretical sensitivity and continued to place a basic trust in the creativity of analyst. The methodological differences between the Glaserian/classic, Straussian and the constructivist approach of Charmaz to grounded theory were discussed. The Glaserian approach appealed to the author as she saw in it the greatest opportunity to meet the objective of the study. The chapter also provided a thorough description of the interview process, recruitment, sample selection, data collection, data analysis, and data management. Chapters four to six will now present the findings of this study. Each chapter introduces a core category, categories, and related properties as they have emerged from the data analysis.
CHAPTER 4

Results: Nursing Home Residents

*What I like about living here is my independence. I can go for a walk anytime I want.*

(Interview: R14)

4.1 Introduction

Using Glaser’s (1978) approach to grounded theory, as outlined in the preceding chapter, this chapter will describe the emergence of the concepts, categories, their supporting properties and the core category on a model of quality of life that emerged from the experience of 20 older residents in two nursing homes in the Lebanon. After discussing the categories and their properties that emerged from the data the chapter will provide an overview of the emergent and generated theory. The six categories that emerged from the data were: (a) maintaining good health; (b) ensuring physical safety; (c) relationships; (d) meaningful activities; (e) continuity of personhood; and (f) spiritual well-being, each being evidenced by its supporting properties. The properties associated with each of the six categories will be described, as well as outlining the conditions necessary to facilitate movement between the categories and the core category, which was identified as ‘maintaining self’. Illustrative quotations from participants are included throughout the chapter, as well as extracts from the author’s theoretical memo book.

4.2 Category 1: Maintaining Good Health

Through constant comparative analysis of the data (Glaser, 1978) from older residents the first category of ‘maintaining good health’ emerged. During the ongoing process of analysis, participants mentioned having and maintaining good health as a prerequisite for a good quality of life. This category had four supporting properties: experiencing health and comfort, independence in daily life, being active, and sense of well-being. Older residents
who did not report having a long-standing illness or disability were more likely to mention the contribution of good health to their quality of life than those who had a chronic illness or disability. Similarly, those with no or a slight difficulty with physical functioning and with the performance of the activities of daily living were more likely to mention their health as bringing quality to their lives. Thus, according to data, the majority of the residents attach paramount importance to good health in retaining their independence and in shaping their perception of a good quality of life.

4.2.1 Property: Experiencing Health and Comfort

According to the older residents being healthy and comfortable constituted the most important factor determining quality of life. Moreover, being healthy involved absence of disease and disability, maintenance of high physical and cognitive function, and sustained engagement in meaningful activities. The following three excerpts represent an illustration of this finding:

“I am happy when I am healthy and physically independent. This is quality of life. I don’t want to be dependent on anybody.”

(Interview: R6)

“So as it is said, glory to my God the greatest. He is right. Mind and health and comfort are the most important things in life.”

(Interview: R3)

“I can tell you that health comes in the first place before anything else. This is true a 100 percent and even 500 percent. Health is the most important thing. What is left to lose after my health? What do I need money for? What would I need life for if I am not healthy? I weep over myself my dear. God deprived me of my health. If I still had my strength they wouldn’t have brought me here. I feel embarrassed to ask or anything or any help. When someone loses his health, he loses everything, he loses his life.”

(Interview: R15)

Attempting to make a theoretical connection between these similar experiences led the author to place the following entry in her theoretical memo book:
“Being comfortable and healthy appears to be central to retaining the independence of these older residents and their perceptions of a good quality of life. Good health appears to be essential to their continued enjoyment of life. Being unable to participate in specific social and other activities due to ill-health took quality away from their lives, especially those who have great difficulties with activities of daily living.”

(Theoretical memo book entry: 23.3.2010)

For the majority of older people, the enjoyment of good health and comfort made them express their gratitude to God. They carried on with the discussion of health against the backdrop of offering their thanks to God. Older residents thought it was important to hold on to the health they still enjoyed and were very thankful for keeping healthy, as can be seen in the words of some of the participants:

“My health? Thank God. I am losing some weight, but I am healthy and comfortable. What can I do? Thank God.”

(Interview: R4)

“We should thank God because I did four surgeries and I am doing very well now. There are many residents in this institution who are worse than me.”

(Interview: R17)

“Thousands of thanks to God. Thanks God. We are blessed by God. All we need is God’s mercy.”

(Interview: R5)

Participants also perceived health and comfort to be relative to the health of others and were thankful for what they could do for themselves:

“Well, I am living in this institution and I am healthy and comfortable. Thank God. It’s okay. I don’t need anybody. I am able to get around and I am all right. I could be a lot worse.”

(Interview: R3)

Evoking the past and the achievements associated with it had an invigorating effect on some residents. They referred to a life of independence and hard work they had previously lived, but the loss of both created a vacuum and uncertainty about a future that would be
partially determined by others, including the consultation of a physician, a nurse, a physiotherapist or a social worker:

“I spent my life sewing for people and then I had this stroke thing. Now I am sitting here and feeling bored.”

(Interview: R18)

“I used to work at home, clean, wash, do the laundry, cook, visit my neighbours, and they used to visit me in return. I had a small garden in front of my house and I used to plant it with different kinds of vegetables. So at any time I could pick my stuff from the garden and make a delicious bowl of salad, fry some potatoes and eat.”

(Interview: R7)

“I used to play tennis at the American University of Beirut. I played tennis all my life. At first I played football but then I broke my leg, so I started playing tennis. I spent all my time playing tennis. We used to meet people there, to have guest teams to play with and meet during cocktails. Well, really, I used to have a beautiful life!”

(Interview: R14)

It is evident from these accounts that there was significant diversity in perceptions of health and comfort and the importance attached to good health. As older residents’ physical functioning declined, they defined health in terms of their abilities rather than absence of illness and many judged their health in relation to others. These accounts also revealed that health and comfort mattered for quality of life and that disease-related disability impacted on health, but it was also evident that perceptions of health and comfort changed with increasing physical disability.

4.2.2 Property: Independence in Daily Life

Having and retaining independence in daily life was mentioned as an essential feature of a good quality of life, particularly being able to do things for oneself. Older residents said that the loss of their independence impaired their quality of life. A number of participants said they appreciated their independence and underscored their ability to maintain it. They expressed their determination to fight boredom and the monotony of confinement to indoor
life by mobility, and they also wanted to retain their ability to do things for themselves. Avoidance of dependence on others was a commonly-held value. Attaching considerable weight to independence was attributed by participants with going outdoors, enjoying life, and avoiding dependence on others.

Four participants reported that they lacked energy or were in poor health, which had left them unable to do things for themselves. The inability to go out for a walk for example, aroused feelings of frustration. Independence entailed the capacity to be active and take part in a life situation without the need of assistance from another person. All the participants emphasised the indispensability of independence for having a good quality of life, whereas they found it hard to accept dependence. One woman who had been used to doing all activities of daily living independently and who was being treated for a hip displacement stated:

“I was going out of the bathroom when I fell and broke my hip. I also have arthritis, so I am unable to walk without my walker. I try to do some exercises to walk back and forth. If I just recover from this and be able to take care of myself, I won’t ask for more. I thank God because there are many people who are worse than me.”

(Interview: R12)

When asked about the most important determinant of a good quality of life, one of the older residents answered:

“Having the ability to move without help.”

(Interview: R9)

For the older residents, being independent in daily life meant being able to do what they wanted to do, being able to take care of themselves and not having to rely on others for personal care. For older residents to be independent also meant having some autonomy, capacity for self-direction and being able to make choices. What increased their independence was feeling in control and having some degree of freedom:
“Having good quality of life means you are independent; you can take care of yourself, you can go out whenever you want, and you can make decisions...”

(Interview: R8)

As the transcription and analysis progressed, the author jotted down the following substantive areas for subsequent comparative analysis in her theoretical memo book (entry dated: 19.2.2010):

_in future interviews compare and contrast the:_

(1) Emerging sense of independence for having a good quality of life;

(2) Impact of poor health and immobility on quality of life.

In the subsequent interviews it became apparent that older residents who were used to independence in their daily life were apprehensive of experiencing chronic disability that would make them heavily dependent, making their quality of life poorer, with the most upsetting thoughts described as follows:

“I do eat by myself. I wash and get dressed alone too. This is very important for my quality of life, very, very important, especially the bathroom privilege issue despite the fact that my shoulders hurt me. I had several surgeries for them and they hardly function, but I do my best and I am afraid to lose my independence one day.”

(Interview: R19)

On the other hand, the most dependent persons who needed a great deal of help with daily activities, including personal care, strove to accept their situation. Older residents who spoke most about acceptance were also those who were most disabled. Part of the process of acceptance was acknowledging that life would not revert to normal and that there was no alternative but to ‘get on with it’. One of the older persons who had paraplegia and was confined to a wheelchair said:

“My quality of life now consists of adjusting to my current conditions. Sometimes when I have thoughts about my past life I feel upset, but then I accept reality and God’s will. I say to myself that I have no other choice than accepting my situation as it is.”

(Interview: R15)
He also focused on the positive. He concentrated on what he could do rather than focusing on what he could not:

“As long as God gives me the mind and the ability to read I am fine.”

(Interview: R15)

The ability to do something meaningful reassured participants about being an active and independent person who has ‘something to give’ to people around him/her. The older resident felt that he/she is a human being capable of managing his/her own life rather than becoming a burden to others. Therefore, the maintenance of independence in daily life was a key issue for older people as the data suggests that participants disliked depending on others for help. Dependence on others for help with intimate personal activities, such as going to the toilet was, at times repugnant. However, acknowledging that they needed help was a precursor to accepting dependency and, as such, threatened self-esteem and personhood. Poor health and immobility posed the most serious threat to the older resident’s independence in daily life.

4.2.3 Property: Performing Activities

During the series of interviews and constantly comparing the data, similarities in the attitude of older persons towards activity became apparent. Being able to actively share in various areas of life generated unanimous endorsement by all the participants whereas the restrictions to their activity compromised their life satisfaction. In their meanings attached to quality of life, participants underscored the importance of performing activity to the extent that its absence seriously undermined quality of life.

The ability to move and walk was often mentioned as a major precondition for important activities, such as personal care. The activities regarded as important in the present study were frequently related to personal functional limitations or disabilities. As the interviews progressed, the author was able to test out this observation on the next interview in the
study (participant: R15). During this interview, an older resident who had a car accident causing paraplegia and mobility limitations explained:

“Well I wish God blessed me with the ability to get out of this chair so I can walk again and do something useful to me, my family and the community, but I can’t anymore.”

(Interview: R15)

The ability to perform activities related to personal care was seen as being of fundamental importance by all participants. Nevertheless, activities not connected with personal needs, for instance going out of the rooms, was also seen to be important in being able to carry out and perform activities.

4.2.4 Property: Sense of Well-Being

Well-being was mentioned by all participants when describing quality of life. The participants emphasised the importance of their positive outlook in influencing quality of life in terms of having a positive disposition (happy/satisfied person), feeling they had a role in life, and having good memories of the past. A few older residents also ‘felt lucky’ in this context, suggesting a more fatalistic view of life. Several older residents also said that they valued their independence emphasising that they were still ‘fit enough’ to retain this ability, as one respondent stated:

“Having my health and having a sense of well-being; this is quality of life. Well they both give you the freedom to do what you want. You are not dependent on anyone.”

(Interview: R1)
well-being was achieved upon their participation in a large number of activities, whilst for others it resulted from relaxation:

“Of course I enjoy the day we go on a trip! They take us in a bus to visit touristic sites. They also take us to restaurants, and I enjoy it very much.”

(Interview: R13)

“I prefer to sit here alone and read a newspaper or watch television. I love to be alone and to sit alone with my thoughts.”

(Interview: R14)

Older residents saw their sense of well-being undermined by pain as a result of the loss of control over their bodies and social lives. They were inclined to focus their attention on the body whose unpredictability and defenselessness permanently disturbed them. However, their masked frailty and suffering might remain ‘hidden’ from other people and might not be subject to quantification. Specifically, pain raised doubts about the older person’s positive sense of well-being:

“When I do not have this pain in my legs, I have good quality of life.”

(Interview: R18)

Another factor that compromised the older person’s sense of well-being was fatigue, which when suffered for a long period of time, deprived the body and mind of the power to make plans, play roles and lead a normal life:

“The quality of my life is poor. I am exhausted all the time, even when I wash and dress. Sometimes I don’t even want to go to the bathroom. It takes so much time and effort to transfer from my wheelchair to the toilet and back.”

(Interview: R19)

Reflecting upon these interactions shortly after the interview, the author entered the following note in her theoretical memo book:

“The desire to maintain or improve the current level of independence and health is fundamental to maintaining a sense of well-being. This involves doing what they could do for themselves, remaining mobile and trying to retain their sense of well-being. Admission to nursing home does not result in an instant loss of one’s independence. When efforts are made to maintain the resident’s independence
and health, the gains are enormous and quality of life is enhanced. Good health and having a sense of well-being are associated with the number of face-to-face contacts and social ties the older person has. Conversely, decreased functional ability affects the amount of social interaction experienced by the older resident.”

(Theoretical memo book entry: 23.2.2010)

Diet also contributed to the enhancement of well-being as well:

“I eat everything. Thank God I don’t have diabetes or hypertension or anything. I can eat all kinds of food. I have no restrictions.”

(Interview: R16)

A sense of well-being was also experienced by older residents who were engaged in physical exercise. The two participating nursing homes had private physiotherapists who provided regular exercise classes which in turn helped in maintaining muscle strength and mobility for the older resident.

Having a sense of self and identity was also key to an older resident’s well-being. Being in pain, being fatigued or having a disability have the potential to threaten a resident’s sense of self because they may lead to role changes, dependency on others, isolation and lack of opportunity to express things that are important to the individual:

“In the past I used to run a business and then I had this stroke thing, you know, so it has kept me down; I had to give the business up in the end. I was really sorry about that. It really affected me.”

(Interview: R17)

Experiencing an enhanced sense of well-being was promoted through spending time in personally meaningful and enjoyable ways, socialising and sharing, undertaking physical activity/exercise and learning. Residents experiencing a sense of well-being felt that more of their needs were being met and appeared to experience greater sense of control and autonomy.

The category of maintaining good health was accomplished by the properties of experiencing health and comfort, independence of daily life, performing activities, and sense of well-being as illustrated in figure 1.
4.2.5 Theoretical Reflections

Upon analysing the first series of interviews the author ‘worked on the data’ so that the underlying processes and strategies utilised by the older residents in maintaining a good quality of life emerged. Armed with this knowledge, the author returned to the data and started to read and re-read all the interview transcripts (Interviews R1-R20), beginning the time-consuming process of listening again to the audiotapes of each interview and consulting her theoretical memo fund. Frequent listening to the audiotapes, especially during transcription, helped to capture the powerful statements of the subjects that led to the development of the codes. Whilst undertaking this exercise, the author concentrated her attention on a theoretical memo (dated 23.2.2010) which concerned the term ‘having sense of well-being’ as the potential name of a possible component of having a good quality of life. The author attempted to assimilate data emerging from the study under this heading. This was articulated most clearly during the 19th and 20th interviews in the study:

“I was used to being independent in my life in all activities of daily living, and now I am being treated for this fracture of my hip. If I recover from this and can take care of myself, then I shall be satisfied, I will have a sense of well-being. It is important not to have to trouble others, and to be able to carry out the responsibilities I can, because I would find it very difficult to be dependent.”

(Interview: R19)

“Yes, of course I have a sense of well-being; I am satisfied with my life; otherwise I wouldn’t be reasonable, because when you have lived for such a
Accordingly, having a sense of well-being emerged as an antecedent condition of having a good quality of life. Although the things that generated a sense of well-being varied with each of the older residents, this sense of well-being was associated with quality of life that comprised the resident’s perception of themselves and others; outlook on life; and a general sense of well-being. The ability to lead an ordinary life without suffering from pain, whilst gaining recognition and understanding, also contributed towards the resident’s well-being. Older residents who were able to make deliberate choices, to do physical exercise, to perform activities, and to be socially interactive had their sense of well-being validated. Quality of life could be seen to start with maintaining good health. The first supporting process of the emerging model therefore was named ‘having a sense of well-being’. Once this first supporting process was identified from the data, the author returned to her theoretical memo fund and interview transcripts to begin the task of discovering the next supporting process(es) of quality of life.

### 4.3 Category 2: Ensuring Physical Safety

It was found that experiencing safety emanated from being in an environment that could meet needs of treatments, diagnosis, support, and in which participants knew what was going on. The category ensuring physical safety had three properties: being safe, being cared for, basic functional care needs. The quest for safety and for assistance upon need constituted the primary reason behind the older people’s move to a nursing home. However, older residents also mentioned that they felt secure when certain human needs such as love and belonging were met. Meeting those needs helped to maintain and sustain their quality of life.
4.3.1 Property: Being Safe

The lack of assistance and the resulting feeling of helplessness experienced by staying at home made the move to the nursing home unavoidable for older residents:

“At home I have no body to take care of me although I had my freedom, and I don’t think it’s safe for somebody at my age to live alone at home. Here too, there is freedom but the rules are a bit strict and I am not used to this. I have been single for fifty years. Imagine this. Living alone and then coming to this place is hard for me, but I said to myself it’s better than being alone, it’s safer here.”

(Interview: R14)

“Here it is safe. Safety is very good, very very good. It’s very important. Living in this nursing home offers me an advantage.”

(Interview: R1)

The older residents experienced some level of anxiety and fear about dealing with unpredictable illnesses or sudden incidents. If help was not provided immediately when they asked for it, they were dominated by a feeling of insecurity. As a result, the ready accessibility to medical care and staff improved the residents’ feelings of security.

Fear of ‘being ill’ or acquiring another ‘illness’ was an important consideration for participants. Therefore, speedy access to a medical doctor or medical resources brought about a feeling of safety and security to the older residents during their stay in the nursing home. In Lebanon, physicians represent the authority of medicine and the hope of recovery and some of the residents mentioned that the doctor’s visit made them feel secure and helped them to alleviate any discomfort:

“I haven’t seen the doctor yet today. Yesterday I missed him. He comes and visits me every day. When I see him today I will tell him about my pain. I am sure he will give me some medication to take the pain away.”

(Interview: R7)

“… so that guy who was bathing me went to the supervisor and told her that I had a small mass on my tummy. So the next morning they sent me a doctor.”

(Interview: R17)
“Everyone likes to receive good care, otherwise we wouldn’t have come here. Right? We don’t come here just to eat and drink; we come here for care my dear. It’s true that it is a home for older people. You can call it a shelter, but actually it’s much better than your own house. We have medications, infusions, or anything we need. We see the doctor. The nurses come and take our blood pressure; they respond to all our needs. That’s why I am here.”

(Interview: R2)

Attempting to make a theoretical connection between these similar experiences led the author to place the following entry in her theoretical memo book:

“It is an important aspect of residents’ lives to feel safe in the nursing home; this must be accomplished not just with safety issues in the environment but also with dependable and individualised care. One of the important aspects of quality of life for the residents appears to be feeling safe and secure in the nursing home.”

(Theoretical memo book entry: 25.2.2010)

From this theoretical memo book entry, the author extrapolated the words ‘feel safe’ to describe this experience upon the older resident’s admission and on-going adjustment to the nursing home. Therefore ‘being safe’ was considered the next supporting process of the emerging model.

4.3.2 Property: Being Cared for

‘Being cared for’ represented to the older residents a response to their need for individualised and reliable care. The friendly attitudes of the nurses and the fact that they were dependable mattered a great deal, which made participants feel certain that they would be by their side in case of illness or pain. The description participants gave of ‘good care’ referred to the provider as someone who ‘really liked his/her work’ and ‘really cared about the older residents’. For residents, the technical details of care, such as passing food trays, making beds, assisting with bathing and personal care, occupied a secondary position in comparison with the indicators of personalised affection and friendship they perceived in the care given to them. In their assessment of the quality of care, they referred to their relationships with the nurses and underlined the degree of closeness to their caregivers.
They used key expressions such as affection, motivation, and genuine friendship to describe their experience in these relationships:

“Here I have a lot of friends. All of the girls (nurses) are my friends. The lady who brought me here a while ago is a very good friend. She is so sweet. I love her. She helps me a lot. If you could only see! You know, if I had a sister she wouldn’t have treated me the way she does.”

(Interview: R19)

Communication with the nursing staff and the monitoring of their verbal and non-verbal language allowed the older residents to make a judgement about the personal attributes of their care provider. The residents expected to receive care, kindheartedness, warmth, tenderness, and an expression of concern from their caregivers. Some of them stated that being treated with consideration made them feel warm and valued:

“They take very good care of us. May God bless all the nurses and the doctors, and may the Almighty keep them safe. They keep checking on us as you can see. I am happy. Currently it’s better than home.”

(Interview: R20)

But one resident reported the negative experiences she had in the nursing home by emphasising the importance of displaying a caring attitude by the nursing staff:

“They (the nurses) are very good at providing physical care, but they do not cater well to emotional side of things…”

(Interview: R8)

Patience, the exhibition of attention and love, and keeping a good temperament and pleasant behaviour during the delivery of care and while satisfying their needs, represented the older residents’ expectations from staff members.

4.3.3 Property: Basic Functional Care Needs

From the older residents’ perspective, their main functional care needs comprised nutrition, personal hygiene and exercise. As the name of this property suggests, it has to do with the fulfillment of their main physical functions. The question of food appeared in participant’s list of priorities, and mealtimes were the ‘bright parts of the days’ in the everyday routine
of the nursing home, hence their focus and lengthy comments on food. It is, perhaps, no wonder that food enjoyment is one of the factors contributing to their quality of life:

“Food is very good. They prepare all kinds of food and it’s so tasty. Yesterday we ate fish. I eat everything. Thank God I don’t have diabetes or hypertension or anything. I can eat all kinds of food. I have no restrictions.”

(Interview: R16)

The personal hygiene of the nursing home residents was maintained through the performance of the daily tasks of bathing and grooming. Yet, different levels of assistance were needed to help the older residents with diminished physical or psychological functions carry out these tasks. The level of assistance needed in bathing and grooming depended on the physical and psychological condition of the older residents. Those who were independent, or with mild dependence needs, did not require any help in the shower, whereas for others, little assistance was needed while taking off and putting on clothes. However, some of the sample were totally dependent on others for help. Regardless of the degree of assistance needed by the older residents, the issue of taking a bath was a point of concern and consequently it elicited frequent comments from them:

“No, I can’t get out of the wheelchair at all. There is a guy who helps me. He puts me in bed when I want to sleep. We have special chairs for the bathroom and for bathing. Whenever I need to sit on such a chair, the employees help me. They also help me in dressing because every time I raise my arms I feel the pain, so they help me as much as they can.”

(Interview: R19)

The changes in bodily function called for nursing care that the older persons expected to be given in the form of support and encouragement. However, physical care often involved intimacy, i.e. touching, handling or examining genitals. It also included offering assistance with incontinence pads, going to the toilet, washing, dressing and undressing. The inability to control parts of the body indicated the need, to varying degrees, for nursing care of the physical type. Nurses with a listening ear as well as a helpful and respectful attitude were deemed to deliver ‘positive care’. In other words, care was delivered to them whenever
they needed it, nurses responded to their calls, the treatment they got was humane and they felt they were in safe hands and their experience of the nursing care was positive:

“You know I have been bedridden for too long. They bathe me, they put diapers for me, they feed me, they take very good care of me and I accept all this because there is no other solution. There is no body at home who can take care of me.”

(Interview: R10)

Taking a walk was the kind of exercise often performed by the residents with the ability to move. The safety and length of the corridors and the hallways outside the nursing home encouraged the residents to go on a walk. Some reported doing walking exercises and stressed their importance, even those who were wheelchair-bound:

“As soon as I have my coffee at 3:00 p.m., I go outside to breathe fresh air. I walk (sitting in wheelchair) there and I smoke a cigarette.”

(Interview: R15)

The residents cherished every opportunity they had to go outside to enjoy a breath of fresh air. Maintaining optimal levels of physical activity might minimise the loss of physical capabilities and retain a resident’s quality of life. Walking was still the major exercise activity for the independent and wheelchair-bound older residents in the nursing home.

In summary, the category of ensuring physical safety was accomplished by the properties of being safe, being cared for, and basic functional care needs as illustrated in figure 2.

4.4 Category 3: Maintaining Relationships

The category of maintaining relationships was most commonly identified by the older residents as bringing quality to their life with those participants who had (or were) experiencing a married relationship most likely to share this. The participants who were not too frail also placed great importance on maintaining relationships, whilst those suffering from increasing frailty considered their physical comfort a priority. Questions about important experiences in the nursing home, as well as quality of life, prompted every
Figure 2

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<tr>
<th>Properties</th>
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<td>• Experiencing health and comfort</td>
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<td>• Performing activities</td>
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<td>• Sense of well-being</td>
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<td>• Being safe</td>
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resident to discuss socio-psychological aspects of quality of life at length. They particularly explained how their life was given meaning by relationships, establishing a link with their feelings of self-worth and identity. They discussed three types of relationships that mattered to them: relationships with staff, relationships with family, and relationships with other residents. The nexus of their discussion on quality of life in the nursing home seemed to be their relationships with the staff members.

4.4.1 Property: Relationships with Staff

The older residents stated that staff members were generally kind and helpful. They emphasised how hard they worked and that ‘nothing was too much trouble’ for them. Knowing the nurses by name formed the basis for a relationship and for trusting the care. For the residents, reciprocity proved the existence of good relationships, and consequently of good quality of life. Their discussion of reciprocity was frequently done alongside sharing past personal identities. A nurse might share with the resident details about her life outside the sphere of work. The resident might, in turn, uncover personal details from his or her past. ‘Good’ nurses were portrayed as attending to these identities while delivering
care. Thus, they acknowledged the residents’ selves apart from the ones linked to old age, illness, and disability. When residents shared stories about important aspects of their lives with staff, this helped the nurses identify meaningful activities or to personalise care routines. One of the residents noted:

“There is this nurse. Her name is X. She is very good. I like her a lot. She sees me not just as an old lady who needs nursing care all the time.”

(Interview: R10)

“They take good care of us. May God bless the director, the nurses and the doctors. May the Almighty keep them safe. They always watch over us and keep checking on us. As you can see, we are like a family and I am very happy in this nursing home.”

(Interview: R1)

Answering a question about her relationships with the staff, one resident said:

“My relationship with the staff? It is very good. The director here is so sweet. God bless her! She makes sure that everyone in the institution is satisfied. I am so thankful to her, so thankful. I always pray for her, I love her so much.”

(Interview: R11)

The nursing home residents appreciated the opportunities to chat with the staff members, and expressed satisfaction at hearing the staff disclose personal information in contrast to the care-related information usually exchanged. It was an indicator of establishing a ‘special’ relationship with their caregivers:

“The personnel are all good. We love them. I love this environment. I like to know everything about their lives.”

(Interview: R2)

“I know that I am comfortable in here and that the employees are so sweet. They love me and they treat me as if I were their mother or their grandmother. They are very gentle when they’re handling me. Well, I am thankful to all.”

(Interview: R7)

The staff members were observed interacting with the older residents during the author’s visits. Two factors appeared to impinge on building resident-staff relationships, the first being the shortage of staff and, therefore, the lack of time the employed staff can spend with residents; and the second factor being the continuity of care.
This was recognised by the author in a theoretical memo made shortly after the interview:

“Lack of time the staff members had to converse with residents and lack of continuity of care are representing a problem in forming meaningful relationships with staff. Older residents enjoy showing their picture albums to staff and tell them about themselves and their family. They value the development of personal and responsive relationships with staff. Developing confidence in staff appears to be based on their past experience and contributes towards the development of trusting relationship. Stories shared by residents with staff made a major contribution towards the development of personal relationships. Such stories helped the staff better to know the resident and understand their biography and this supported them in creating personalised care routines appropriate to each resident.”

(Theoretical memo book entry: 7.3.2010)

Staff continuity facilitated the establishment of relationships between the older residents and their care providers since it presented greater opportunity for chatting and exchanging information and paved the way for the development of reciprocal relationships. One of the residents complained about the transfer of staff she knew to other units. When asked about the reason behind the transfer of staff members from one unit to the other, it was mentioned that the reason was because the other unit was ‘understaffed’. This disruption constituted a hindrance to the development of relationships with nurses. An older resident described a special relationship she had with one of the staff members:

“There is this pretty young girl... she comes in when she is on duty, washes me, she puts me to bed and then she asks me if I want anything else. She is really good. I like seeing this girl when she comes in here.”

(Interview: R2)

“They are very good not only at providing physical care but they do care about our emotional state as well. They provide care in a very caring way. Nothing is too much trouble for them.”

(Interview: R3)

On the other hand, one older resident was unhappy about the staff cold and unfriendly attitude, despite their efficiency. Dislike for the staff seemed to be motivated by either their conduct or their general approach to work. She reported that certain staff members delivered care with an uncaring spirit, which created a feeling of being a nuisance on the part of the older resident whenever she wanted to ask for help:
“She is very good at providing physical care but she does not care about the emotional side of things... She just gives me my medications and disappears.”

(Interview: R18)

From the author’s theoretical sensitivity to the data, and as intimated in the theoretical memo book (entry dated: 7.3.2010), the author considered that developing positive relationships could possibly represent a supporting process of the emerging model explaining the journey towards a ‘good’ quality of life in the nursing home.

4.4.2 Property: Relationships with Other Residents

Forging relationships with fellow residents was another factor seen by the residents as promoting their quality of life. Some displayed a pleasant and tolerant attitude towards other residents, thus creating a strong sense of collegiality amongst them. Residents not only enjoyed each other’s company, but they also behaved like friends and met regularly near the rooms, in the living room and in the garden. Physical nearness paved the way for interaction and subsequently for the formation of relationships, mainly with residents that they often see, share meals with, and with those living in neighbouring rooms:

“Yes, I enjoy going on picnics with other residents. I enjoy having them around. They sing, clap and dance. We listen to the radio all the road. Almost every Thursday they take us on a picnic, but Ramadan (the Holy Month) is coming so they might not take us...”

(Interview: R4)

“The life that I am living here is a normal life. We really live together with the other residents as one family, so I don’t feel that a stranger at all. We are like brothers and sisters.”

(Interview: R13)

One female resident, who enjoyed networking with other residents, helped them if they needed any help:

“I stay with the residents who have no family to check on them. I don’t leave their side and spend some time with them. Take for example the lady who is sitting in front of us. In the afternoon someone comes to sit with her. I keep her company at other times so she doesn’t get bored. I want to bring her comfort. I am the type of
person who goes to the residents’ rooms to check on them and see how they are doing. I kiss them, tell them stories. Even the men. They do enjoy it a lot.”

(Interview: R11)

On the other hand, one resident refused to mingle with his fellow residents, not because he is a ‘loner’, but because he regarded himself as ‘different’. He deliberately distanced himself from the others. The reasons behind his perceived aloofness could be his belonging to a higher social class and the resulting feeling of superiority, or his realisation of having different interests:

“I prefer to sit alone. All the residents have come from villages. They don’t have any ideas, so I feel limited. I cannot share my thoughts and ideas with them. What makes me unhappy is that there is no one I can talk to.”

(Interview: R14)

Another key relationship was the one developing between the older residents and their roommates. This relationship could be either positive or negative. Positive relationships seemed to evolve when the roommates provided companionship or opportunities for help. Occasionally, however, roommates did not get on. One of the older residents was irritated by another resident with dementia and she was afraid of her. There was an instance when she was attacked and hit:

“...Everyone is good, but there is that woman whom I had a conflict with. She is sick. Her bed is next to the window. I asked her to open the window to have some fresh air. You know it’s a closed room and we are seven inside. They change the diapers and the smell fills the room. It’s not right!!... She refused to open it and started teasing me, so I decided to tell the doctor...You can’t imagine how much that woman hates me. Well, they should either transfer her or me. I can’t take it anymore.”

(Interview: R7)

According to data therefore, residents often developed relationships with other residents in the nursing home although this did not necessarily imply friendship or intimacy and a shared environment did not necessarily imply shared interests. However, older residents
described the significance of their social relationships, with the majority of residents indicating that it was important to engage in social relationships with fellow residents.

**4.4.3 Property: Relationships with Family**

Family and community connections also counted in the life of the nursing home residents. Visits paid by family members and friends were highly appreciated as they helped maintain family ties and kept the older person in touch with what was happening at home and in the community. As a result, connection with the family and community played a role in maintaining well-being. Relationships with the family provided companionship and people to do things with (going out, going on holidays), in addition to preventing loneliness, and promoting psychological well-being. Older residents referred to the importance of having a family in general, one with whom they have forged a good, close, supportive, and loving relationship. They attached weight to having someone ‘to make life bearable’, to ‘know there is someone there willing to help me’ or ‘look after me.’ For some, such things instilled confidence. The importance of being surrounded by a family when one’s health deteriorates and when one feels vulnerable was also illustrated by a number of respondents, with one example shared below:

“*Yes my children come and visit me frequently especially if I get sick or something. They bring me medications and everything I need. They take me to spend some time with them on holidays when they are not working. Thanks God they all love me and I know they will take very good care of me if I need their help.*”

(Interview: R8)

Coming into contact with sons and daughters, be it face-to-face or by telephone, was significant to the majority of the older residents as it brought them delight, assistance and security. Contact with grandchildren was frequently mentioned as important, and intergenerational interaction enabled residents to play a reciprocal role, and to experience the much needed feelings of usefulness and esteem. Widows in particular valued the
company and emotional support their children and relatives lent them. Other participants derived enjoyment from spending time with their families and seeing them lead happy lives:

“Quality of life. Well, it means to be around those you love. Your children and grandchildren. They visit me almost every week. I have three grandchildren, one boy and two girls. They are so lovely. The three of them go to school.”

(Interview: R8)

“Yes, thank God. My two daughters are married and they have children. They live in the States. Two years ago my elder daughter came here. She has two children, a girl and a boy. I saw them and I was so happy to see them.”

(Interview: R15)

“I like when we go on picnics. My nephews are the bus drivers. When they ask me if I am happy, I answer by saying I am happy because I am with them.”

(Interview: R7)

Attempting to make a theoretical connection between these similar experiences the author placed the following entry in her theoretical memo book:

“These kinds of relationships made the older persons realise that others cared about them and were always ready to offer assistance whenever they faced a problem.”

(Theoretical memo book entry: 25.2.2010)

Few of the older residents rarely had visitors, although one participant said that he had nobody left ‘belonging to him’. He accepted this as a feature of ageing or a sign that he had lived too long. For another resident, families related to him lived too far to make frequent visits, whilst another had sons and daughters living overseas:

“I feel cut off, you know, from all my friends. All the people here are very nice; they are very good but they are all strangers to me. My son and my daughter live in the United States and maybe they come and visit me once every six months.”

(Interview: R3)

These findings also support the explanatory power of developing positive relationships. Lebanese culture and traditions treasure the bonds of affection linking all the family members. The repeated visits made by the family had a reassuring effect on the older
persons by showing them that they are not forgotten and that they continue to be held in great esteem by their beloved ones:

“Thank God, my children come to visit me every Thursday and Sunday. I feel so happy to see them. I am relieved that they are fine. I like to see them healthy.”

(Interview: R4)

“Yes, my daughter has a girl and a boy. They come to visit me frequently. They are so lovable. I live for them. The boy is sixteen and the girl is twenty-one years old. She is studying business at the university.”

(Interview: R16)

“My son has two baby girls. They go to school and they are also scouts. Whenever they have the chance, they come and visit me. They are twelve and nine. I feel so happy when they come. I open my closet. There is a drawer full of accessories. All are stylish and fashionable: necklaces and make-up, all the colours you want. Then we sit and sing together. I teach them songs and tell them stories about things I used to do when I was a scout leader.”

(Interview: R11)

From the above findings, development of positive relationships between staff, other residents and family members seemed to be one of the most significant factors to have an impact on a resident’s quality of life. By establishing good relationships with staff, other residents, and family, the older residents felt they could gain better support from them all. It appeared important that participants developed social interaction within the nursing home. The visits paid by friends and family allowed the residents to maintain connection with the outside people who cared about them, thus making them have a wonderful time.

For these older residents, a good relationship inferred a good standard of care. Their personal relationship with staff encouraged them to help within their care. Moreover, relationships were enhanced for residents if staff were reliable, empathic and consistent in their approach. Developing confidence in staff was based on their past experience and contributed towards the development of trusting relationships. Hence, by transcending the data, developing positive relationships within the nursing home became the next supporting process of the emerging model.
In summary, the category of maintaining relationships was accomplished by developing positive relationships with staff, other residents and with family as illustrated in figure 3.

**Figure 3**

![Diagram showing properties and categories]

### 4.5 Category 4: Meaningful Activities

The significance of certain activities for the older residents came from their reliance on values and beliefs linked with their past roles, interests and routines. Equally significant were the activities that fulfilled their psychological needs. The more the activities contributed to reinforcing a sense of self, the greater their meaningfulness for the residents. Other factors included delight and a sense of belonging.

Participants stressed the importance of ‘keeping busy’ as one of the components of psychological well-being. This issue surfaced when residents drew a connection between the value of meaningful activities and their quality of life, including mutual activities such as...
as helping fellow residents. It was discovered that meaningful activities had the following properties: social and recreational activities, activities for special occasions, and individual activities.

4.5.1 Property: Social and Recreational Activities

Most of the residents had stated that organised social events and outings were of value, since they represented occasions on which the residents received additional attention. Ambulatory residents underlined the importance of ‘getting out’ of the facility, such as going for a walk, visiting friends or family, and taking day trips. By engaging in these activities, the older residents had the opportunity to mingle with people outside the facility and keep informed about what is going on. The more physically able residents had an edge over their less able compatriots in that they could leave the facility if they wished to do so. Facilities were expected to guarantee the safety of the residents, and particularly those experiencing confusion and inclined to ‘wander’. Facilities were equipped with a mechanism that prevents residents who are a concern from leaving the facility unnoticed. Both of the participating nursing homes visited by the author had a keypad system whose operation was restricted to the staff. Both nursing homes also organised trips for older residents to places of interest, sometimes allowing them to share in the decision about the trip destination. However, unfortunately, both facilities lacked a specialised transport system thus preventing some residents from going on trips due to the inability to accommodate their special needs or wheelchair.

The list of the older residents’ favourite activities varied and included coffee breaks, mealtimes, musical events, trips and outings, exercise and preparing vegetables for cooking. Outdoor activities proved to be particularly enjoyable to the older residents, especially when the outings connected them with people and places reminiscent of their
past life. This provided a sense of history and emphasized continuity that in turn contributed to self-identity and self-worth. They saw their life course as one in which present and past were connected through common themes:

“I like to go out. Every once in a while, they take us out, and this makes me happy. We went to Sidon and other places. My niece takes me sometimes for three days, and then she drives me back here. Recently, she took me to Tripoli where I used to go a lot when I was younger. In Tripoli they sell fish. I love fish and I eat a lot of it.”

(Interview: R6)

“Activities like movies are very important. They bring us movies to watch. They organise all kinds of activities for us. They take us to different places and restaurants. Wow! What can I tell you? Gifts and very nice stuff. Of course we go to distant places as well. They took us to Barouk last month.”

(Interview: R5)

The residents pointed out the importance of social and recreational activities in a closed environment whereby they stayed in the institution all day long. In addition to creating the opportunity for socialisation amongst the residents, such activities also toned down the feeling of ‘nothing-to-do’ and enhanced their quality of life. Furthermore, resident’s self-esteem and self-worth were enhanced when their opinion was taken regarding the timing, duration and destination of the trips.

4.5.2 Property: Activities for Special Occasions

The older residents expressed enthusiasm for activities done in the nursing home for the purpose of celebrating national events, birthdays, holidays or other occasions such as Mothers’ Day:

“The staff organised a very nice party for us on the occasion of Mothers’ Day. A group of nursing students came and gave a very nice show. They distributed small gifts to all of us. They brought a big and very delicious cake. Everyone had a piece. Well, it was fantastic.”

(Interview: R9)

In the Lebanese culture Mothers’ Day is very significant and the older nursing home residents expect to celebrate it every year on March 21st. At the American University of
Beirut, nursing students within the Community Health Nursing course are required to organise a special event on that day for nursing home residents. These celebrations bring about a holiday atmosphere characteristic of family life, and strengthen the bond between the older residents and the nursing home. They introduce a dynamic and joyful mood rendering the nursing home a community with ‘an atmosphere of life’. The holiday food, decorations and rituals also make up major components of the celebrations held by the older residents.

4.5.3 Property: Individual Activities

According to the older residents, individually targeted activities served not only to bring a meaningful content to their time, but also to assert their ability as individual persons to do the things they enjoyed. Engaging in meaningful activities that were individualised were seen as being very productive. Some residents also gave care to other residents, which they regarded as meaningful activity:

“There is a lady here who is always sad. I always talk to her and try to support her. When I have money I give her some.”

(Interview: R6)

“I stay with the residents who have no family to check on them. I don’t leave their side and spend some time with them. Take for example the lady who is sitting in front of us. In the afternoon someone comes to sit with her. I keep her company at other times so she doesn’t get bored. I want to bring her comfort. I am the type of person who goes to the residents’ rooms to check on them and see how they are doing. I kiss them, tell them stories.”

(Interview: R11)

In other cases, the older residents appreciated having open spaces within the nursing home allowing them to exercise:

“I do sports alone. They only helped me twice and then I started exercising by myself. Every day at 5:00 p.m., I go down to the garden and exercise. I move my arms, legs and neck. I am a fast learner, you know. You just have to do the thing once in front of me, and I’ll learn it quickly. The doctor told me that I have a great will to walk. If it wasn’t for the exercises, I would have been paralysed by now. Every time I am in bed, I start moving myself and I exercise.”

(Interview: R17)
“I walk down the hallway, but they don’t allow me to go to the garden alone. They worry that I might fall, so I only go downstairs and walk. The hallway is quite long, so I can walk back and forth two to three times every day.”

(Interview: R13)

Some residents had identified a range of favourite activities that included playing cards, reading, watching television, going for a walk, knitting, crocheting, sewing, spending time alone and recollecting the past. Individual activities like spending time alone to gather one’s thoughts also fostered a sense of well-being:

“If I can’t read or watch television or play cards, I can still sit by myself. I have my memories, my past. I can remember everything. Not my mother-in-law, of course (she smiles). So many things.”

(Interview: R11)

“I prefer to sit here alone. I love to be alone, sit alone with my thoughts and ideas and remember the good old days.”

(Interview: R14)

Interesting activities tended to be meaningful to the older residents since they allowed them to learn new things and to keep in touch. Besides being pleasant and cognitively stimulating, these activities helped them to relax and pass the time productively. As soon as the older residents were given encouragement to do something they wanted to do, their self-esteem increased. The performance of activities they like made them feel good about themselves:

“They take us to the garden downstairs to do sports. After that, they teach us how to play cards and do other handicrafts, using beads for example. I didn’t know this stuff before. I learned doing it in here and I feel so good about it.”

(Interview: R1)

“Activities like exercises? Yes, they do these activities for us. There is a specialist who comes and teaches us exercises. I try to participate as much as I can and I do feel good about it.”

(Interview: R2)

For older residents, what mattered was that the activities were tailored to meet their interests and capabilities, and that they were integrated into the daily life of the nursing
home. Those who participated in activities often demonstrated personal interest in the activity and seemed to prefer activities structured into small groups of like-minded people. It was important, therefore, that the activity organisers become familiar with the residents’ interests and capacities. The participants described how meaningful activities could create feelings of being able to share in and make a contribution to one’s own life and others.

This was recognised by the author in a theoretical memo made shortly after the above interviews:

“It seems that older residents enjoy helping fellow residents they believe are more disabled than they themselves. These activities make them feel useful and fulfill their time in a meaningful way which helps to improve their quality of life. Activities even if very simple remain vital for these older residents. The goal of the activity is to communicate with the resident and to make some connection that can enhance the personhood of the individual and bring out the best in that person.”

(Theoretical memo book entry: 28.10.2009)

In contrast, one of the older residents stated that he did not participate in the activities offered because he was not interested in large group activities, and he felt he was at a mental level superior to the others:

“Activities in here! Well, I have a mentality that is different from the others’, totally different. I talk differently, that’s why I don’t participate in the activities. You can’t find anyone to talk to in a proper way. They are all uneducated and some are even illiterate.”

(Interview: R14)

The participation of nursing home residents in meaningful activities made the benefits they reap overshadow those of any one activity in and of itself. The participants in these activities felt a sense of belonging to the nursing home community. They could also build friendships and get a sense of achievement and self-esteem that could have been otherwise overshadowed by loneliness and depression. Meaningful activities helped the older residents maintain interest in life, keep busy and active, and mingle with other people.
In summary, involvement in meaningful activities was achieved by the properties social and recreational activities, activities for special occasions, and individual activities as illustrated in figure 4.

**Figure 4**

<table>
<thead>
<tr>
<th>Properties</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>• Experiencing health and comfort</td>
<td>Maintaining good health</td>
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<tr>
<td>• Independence of daily life</td>
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<tr>
<td>• Performing activities</td>
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<tr>
<td>• Sense of well-being</td>
<td></td>
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<tr>
<td>• Being safe</td>
<td>Ensuring physical safety</td>
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<td>• Being cared for</td>
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<tr>
<td>• Relationship with staff</td>
<td>Maintaining relationships</td>
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<td>• Relationship with residents</td>
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<td>• Relationship with family</td>
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<td>Meaningful activities</td>
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<td>• Activities for special occasions</td>
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<td>• Individual activities</td>
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### 4.6 Category 5: Continuity of Personhood

The possibility of continuity of personhood was reported as a category contributing to quality of life. This category emerged through data from older people and had four properties: autonomy, privacy, avoidance of being a burden, and self-esteem.
4.6.1 Property: Autonomy

During their stay in the nursing home, the older residents might see their individuality compromised and swept over by helplessness. This could be related to the fulfillment of the nursing homes routines. For example, some residents expressed their powerlessness in relation to the menus and meal schedules that were set at fixed times: breakfast was at seven in the morning, lunch at noon and dinner at five thirty in the afternoon. One of the residents complained about his lack of control over the meals:

“I told the Director that people have a snack at five o’clock. You want us to have dinner at five!! This is not acceptable.”

(Interview: R17)

To overcome this obstacle, this resident got a refrigerator from home and put it in his room so he could eat again at night.

“Thank God I got a refrigerator and I can eat whenever I want to.”

(Interview: R17)

The lack of control and choice was a problem emphasised by the older residents. The routines of nursing home life at times made residents feel powerless with a need expressed by participants to gain a sense of control over their situation.

4.6.2 Property: Privacy

There were a small number of private rooms in each of the nursing homes participating in this study, so the majority of the residents shared a room and bathroom with other residents. The curtain between the beds was the only physical boundary that could distinguish one resident’s space from the next. During the day however, most curtains were opened to easily observe the residents, thus disturbing the residents’ privacy at this time. Conflicts could easily occur between the residents because of the lack of privacy. Closing or opening the windows or the doors as well as using the bathroom were issues over which the residents most commonly argued:
“When I wake up in the morning I feel annoyed because I have people with me in the room. I feel distressed because I am used to being alone in the room. This one wants to close the window while that one wants to close the door. I need privacy, but I don’t have enough money to live on my own.”

(Interview: R18)

An older resident had a room of his own and enjoyed a measure of privacy and control not available to residents living in multiple occupancy rooms. Having a private room gave him choices. He could choose to join other residents or to retreat to his room if he wanted to be alone. Having a door meant that he could shut out the rest of the world if that was what he chose to do. He could choose to turn up his radio if he wished:

“I have a very nice little room with a comfortable bed. I have privacy. Sometimes I like to sit alone in my room and think, or lie on my bed or do whatever I like. Whenever I want to speak and mix with people I go out and do it.”

(Interview: R12)

Privacy refers not only to having a private room and bath, but also to experiencing a sense of privacy that is, being able to be alone when one wishes, to be together in private with others when one wishes, and to be in control of information about oneself like this older resident said during the interview:

“When my children come to visit me I don’t have a private place to sit with them; so usually we go down to the garden so I can have some private conversation with my family.”

(Interview: R16)

Having privacy could be considered a ‘human right’, but in an institution like a nursing home, with a limited number of private rooms, it was hard to have a private area for each resident. Some personal items can be symbols of personal identification, but the area for the residents is limited. On this matter, some residents may feel that their privacy has been compromised.

Having the feeling of privacy was therefore identified by the residents to be an important care need.
4.6.3 Property: Avoidance of Being a Burden

The older residents maintained a positive attitude toward the caregivers in general and abstained from causing them trouble while displaying empathy for their situation. This was expressed most frequently in connection with the staff. Both men and women found it hard to face the issue of dependence. Being a useful person and benefiting others, rather than depending on them and becoming a burden on them, was emphasised by all. A male older resident confined to the wheelchair preferred to stay alone in his room instead of being carried in order to go on a trip. Dependence on others for help was repugnant to him. He explained his feelings in the following statements:

“*I enjoy the activities, especially the trips. But personally I don’t like to go. I prefer to stay alone because I hate to bother people. Lift him up. Put him down, up, down, down, up. People have to carry me and keep taking me up and down. I don’t want to bother people. I feel bad about myself. I feel fed up and tired when I see them carrying me.*”

(Interview: R15)

An older person, who was fully reliant on the staff members for mobility and experienced little sense of independence, was experiencing the ‘burden of being a burden’ so heavily that she preferred death:

“*My children come to take me out. I ask them to leave me here. I am satisfied with my life. Believe me, I am fed up with life. Nothing means much to me. I wish I could die.*”

(Interview: R10)

A female resident suffering from intense pain because of hip replacement after she had been an active and independent person always ready to help people around her, made the following comment:

“*Well, we have to spend our days. All that I ask God for is to pick up the pace. It’s enough. What is the purpose of living? I can no longer give anything, and I am causing trouble to so many people who have to take care of me.*”

(Interview: R12)
The nursing home residents could see their self and identity compromised as a result of their growing need for help and care on a daily basis. Poor health and the need for care had a direct effect on the body and on the identity as a result, hence the threat posed to the interpersonal aspects of self, identity and dignity. Increasing dependency threatened self-esteem and personhood. Moreover, the need for help and care seemed to endanger relational dignity in particular. Older residents saw themselves as being a burden on staff or family when they were dependent on others for activities of daily living thus revealing a low self-esteem.

4.6.4 Property: Self-Esteem

Self-esteem was described as a feeling experienced by an individual having dignity and hope while keeping active and independent. As one interviewee who was taking care of herself said:

“I do care for myself. I change my linen and my own diaper. I tidy the room and prepare something simple to eat. This way I do not think that someone in a white coat comes to do this and that for me. I rather think that I share in the delivery of care.”

(Interview: R11)

Self-esteem arose from the feelings that an individual experienced about himself or herself at a given time, as well as feelings acknowledging human dignity, respect, independence and potential for self-determination. Being an active individual with one’s own responsibility was also very important for self-esteem, so that the apparent reactions of others influenced this perception.

Acknowledging the residents’ value was central to their self-esteem. Staff drawing on the residents’ life experience and expertise in some way conveyed the message that they still had something ‘to offer’ and were valued. Occasionally, the residents were targeted to be involved in the running of the facility, as part of the organisational philosophy of care.
Residents who were not given formal opportunities to help, created ways to help and derived great satisfaction from being able to contribute. This could be helping out a roommate or another resident with greater disabilities than they have, or ‘fetching and carrying’ for someone in a wheelchair. During interviews these residents proudly described how they ‘helped out’ in such instances:

“A woman brought her husband in here. He is completely dependent. I feed him and take care of him all the time. Sometimes I get him stuff. When my sister gives me something I give it to him. He is poor and I am happy about doing that. If someone is in need I help him.”

(Interview: R6)

“Well madam, I am a sociable person, whether you put me in the living room or in the garden I provide assistance. This means that I help others. They send for me when they need someone to speak.”

(Interview: R17)

Attempting to make a theoretical connection between these similar experiences led the author to place the following entry in her theoretical memo book:

“This property ‘self-esteem’ depicts how important it is to the older residents for their individuality to be acknowledged by the staff and for their needs to be met on a personal basis. Being personal included paying attention to the small details of care that is delivered by considerate and compassionate staff.”

(Theoretical memo book entry: 25.2.2010)

Self-esteem also included hope, a major factor influencing the feeling of life satisfaction, which in turn influenced quality of life. Hope bears relevance to the older resident’s life, and a future remains a future, no matter how long it is:

“I just hope that this pain will go away, and that I will be able to walk to the bathroom by myself, and this is it.”

(Interview: R7)

For older residents, physical appearance was closely connected with self-expression and positive self-esteem. Residents who could not afford buying their own clothes wore clothes provided by the nursing home. Other residents liked to wear their own clothes and tended to have strong opinions as to what they wanted to wear and were equally concerned that
their clothes were cared for properly. These residents also enjoyed having their hair or nails done:

“I like to dress up by putting on nice clothes and wearing my jewelry. When I wake up every morning, I get dressed and go to the nurses’ station to greet them. They feel happy when they see me all dressed up, and so do I. This obviously makes the quality of my life better.”

(Interview: R11)

As the data were constantly compared, it was noticed that participants repeatedly described how good care involving empathic reciprocity contributed to maintaining the person ‘they were’, and helped them and their family to preserve their everyday life pattern. Examples of such aspects of everyday life included being addressed and acknowledged as a valuable and competent person that people know and respect, and being provided with opportunities to do likable things and make decisions about when to get up from bed, what to eat and who to spend time with. Maintaining positive self-esteem also included living in a familiar and flexible environment, spending time with family members, and being given options and opportunity to build and maintain relationships.

Showing care and loving-kindness, having warmth and affection, and feeling and exhibiting concern to others described the expectations the older residents had of the nursing staff. Some participants stated that someone showing consideration for them made them feel warm and valued and this improved their self-esteem:

“Everybody is good in here, thank God. The doctor is a very nice person. Even the director here is very nice to me. The girls (nurses), everyone is good. They all treat us with respect and I feel very good about it.”

(Interview: R2)

The positive attitudes of the staff members, including showing respect and caring for the residents were stressed as important by the older residents. The caring attitudes of the staff also provided the older residents with considerable emotional support. They liked to be listened to, valued, respected and loved. This suggested that the respectful and caring
attitude of the staff was one of the major factors that improved the self-esteem which in turn had a positive impact on the quality of life of the older residents:

“The nurses, may God protect them, are all polite and caring. They respect me.”

(Interview: R5)

“In here they are all good. Thank God, they all have very good manners...I am comfortable in here and the employees are so sweet. They love me and they treat me as if I were their mother or grandmother. Well I am thankful to all.”

(Interview: R7)

Having positive self-esteem was one of the essential determinants of quality of life of the older resident and therefore it was considered as one of the supporting processes of the emerging model.

Continuity of personhood or maintenance of self in the nursing home depended on whether the residents were empowered or disempowered. Those who felt empowered realised that they could shape their day and have the potential to make choices. Residents who felt disempowered were constrained by the rules and routine. They lost their individuality among the multitude, which negatively affected their sense of self and personal identity.

Personalising the residents’ life experience in the facility, making it a home away from home depended to large extent on the willingness of staff.

In summary continuity of personhood was accomplished by the properties autonomy, privacy, avoidance of being a burden, and self-esteem, as illustrated in figure 5.

4.7 Category 6: Spiritual Well-Being

Christianity and Islam are the primary religions followed by the people in Lebanon. Spirituality is a broad concept that captures an individual’s sense of peace, purpose, and connection to others, as well as beliefs about meaning of life. Most of the older residents expressed their spirituality in their religious practices which involved mainly praying.
Religious and spiritual beliefs helped older residents combat perceptions of helplessness. For many older residents, religion and prayer emerged during the interviews as coping mechanism linked to solace and hope. One of the residents commented:

“Spirituality or religion helps you to deal with your difficulties and problems.”

(Interview: R5)
For many residents, spirituality and religion were a source of comfort, well-being, security, meaning, sense of belonging, purpose and strength. Reading the Bible or Qur’an and talking to God were strategies used to cope with daily hassles and stresses. Spiritual well-being had two properties: faith and presence.

4.7.1 Property: Faith

Observance of their faith was another way in which older residents expressed their individuality. Many residents spoke about the strength and comfort they derived from their faith. Opportunities to attend mass were particularly important to these residents. In one participating facility, residents had an opportunity to attend mass on Sundays, which they valued highly. However, some residents reported that they had less opportunity to attend mass than they would have liked. Residents who were unable to attend mass had the opportunity to meet for a prayer service. Some residents described an intimate relationship with God, with consistent daily communication and expressions of love:

“When you truly put your faith in God and let him direct you in your life you will be able to face any difficulties you find yourself going through. I have confidence that his almighty can guide me. Thank God, I am a strong believer and I love praying. I love to be honest and tell the truth all the time and this is very important for my quality of life.”

(Interview: R9)

“Yes I pray every day. I have a Bible, it’s always beside my bed, once I have dinner I come back to my room and I read the Bible, I pray before I sleep, I pray a lot. Prayer is an important part of my life.”

(Interview: R17)

Faith, a category of spirituality, guided decision making and problem solving. Faith was important to each participant for his/her quality of life in different ways. Beliefs, religion, and a relationship with God were the subcategories of faith. Beliefs consisted of moral and ethical principles, convictions adopted by the older residents. Religion was an important part of faith development for most residents.
4.7.2 Property: Presence

The property ‘presence’ indicates the presence of God, others, and the nursing home community. Presence is not necessarily just the physical aspect of ‘being with’ someone, although that is what is commonly understood. There is a deeper presence on a spiritual plane, it is transcendent going beyond the separate egoistic self into an interconnected wholeness. In this type of presence there is an intimate connection, love and acceptance. The majority of older residents formed close friendships within the nursing home with other residents:

“I wake up at three or four in the morning, I pray, I thank his almighty using my rosary, then I turn the television on so I can hear some verses from the holy book “Qur’an”. This is the most important thing for me in this life; the holy book. We live and die and we only take with us what we learn from the holy book, his Almighty’s words. We should be loyal to ourselves first and then to our friends. I am not selfish. If I have one bite of food I cannot swallow it if I don’t share it with my friends here. No one should think selfishly, we should think of others.”

(Interview: R1)

Older residents reported that God played a central role in providing the strength to deal with daily challenges. Their spirituality was seen as a source of emotional support, a positive influence on health, and contributing to life satisfaction. Religious beliefs acted to buffer feelings of helplessness. Older residents characterised their beliefs as giving them a sense of hope, purpose, and control, with prayer providing a vehicle for emotional expression. For several older residents interviewed, spirituality and religion were important determinants of quality of life. All subjects stated that spirituality had become more important as they aged and provided a sense of comfort and strength. Prayer and reading the Bible or the Qur’an were the two spiritual practices engaged in most frequently. Spiritual beliefs helped them to accept suffering from chronic illnesses and maintain hope for a better life. Therefore, approaches that promote appropriate and regular times for religious practice within the nursing home should be encouraged.
In summary spiritual well-being was maintained by the two properties faith and presence as illustrated in figure 6.

**Figure 6**

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<table>
<thead>
<tr>
<th>Properties</th>
<th>Category</th>
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<tbody>
<tr>
<td>- Experiencing health and comfort</td>
<td>Maintaining good health</td>
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<tr>
<td>- Independence of daily life</td>
<td></td>
</tr>
<tr>
<td>- Performing activities</td>
<td></td>
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<tr>
<td>- Sense of well-being</td>
<td></td>
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<tr>
<td>- Being safe</td>
<td>Ensuring physical safety</td>
</tr>
<tr>
<td>- Being cared for</td>
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</tr>
<tr>
<td>- Basic functional care needs</td>
<td></td>
</tr>
<tr>
<td>- Relationship with staff</td>
<td>Maintaining relationships</td>
</tr>
<tr>
<td>- Relationship with residents</td>
<td></td>
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<tr>
<td>- Relationship with family</td>
<td></td>
</tr>
<tr>
<td>- Social &amp; recreational activities</td>
<td>Meaningful activities</td>
</tr>
<tr>
<td>- Activities for special occasions</td>
<td></td>
</tr>
<tr>
<td>- Individual activities</td>
<td></td>
</tr>
<tr>
<td>- Autonomy</td>
<td>Continuity of personhood</td>
</tr>
<tr>
<td>- Privacy</td>
<td></td>
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<tr>
<td>- Avoidance of being a burden</td>
<td></td>
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<tr>
<td>- Self-esteem</td>
<td></td>
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<tr>
<td>- Faith</td>
<td>Spiritual well-being</td>
</tr>
<tr>
<td>- Presence</td>
<td></td>
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</tbody>
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4.8 Maintaining Self: Developing the Core Category:

The author attempted to transcend the data in order to establish the core category that linked these properties and categories. She was prompted by her awareness of the fact that every one of the above mentioned categories, their supporting properties, and the supporting processes identified met the ‘fit and grab’ requirement necessary to put forward a substantive grounded theory.

The following observations made her realise that the witnessed scene involves older residents who permanently seek to preserve their sense of self:

(1) Older residents sought to maintain the lifestyle that predated their admission to the nursing home.

(2) Older residents expressed satisfaction with the similarities between the nursing home experiences and the preceding ones.

(3) The ability to carry out significant tasks greatly mattered to the older residents.

(4) The recognition of the older residents as persons, as well as their ability to maintain their pervious experiences and to express their identity assume paramount importance to them.

(5) Having personal space, the preservation of one’s physical appearance, and wearing one’s own clothes also mattered to the older resident.

(6) The two factors of keeping a handsome physical appearance and leading a busy social life proved to be instrumental in sustaining the self of the older residents as they ensured the continuity of earlier life themes.

(7) The cultivation and preservation of personal relationships also played a major role in the older residents’ existence.
The author’s theoretical sensitivity to the data represented another tool she used in her interpretation of the older residents’ perception of quality of life.

In considering the data it was possible to identify a link between the older residents’ attempt to ‘maintain self’ on the one hand, and their striving to protect their health and functional well-being, maintaining their personal safety, forging new ties, participating in purposeful activities, ensuring the continuity of personhood and spiritual comfort on the other hand. Such insight gave rise to the core category of ‘maintaining self’ which constitutes the foundation of quality of life for the older residents.

Therefore ‘maintaining self’ was considered the core category and principal psycho-social process at this moment in the study and prior to theoretical integration of the emergent models (Glaser, 1978). The older residents shared the belief that ‘maintaining self’ brings about life satisfaction. In their attempt to improve their quality of life, the older residents engaged in social processes and activities revolving around the key variable of ‘maintaining self’. This core category stood for a conceptualisation of the relationships between the identified categories, their properties and the supporting processes. The four supportive processes that gave meaning to the core category emerged from the data, from the author’s theoretical memos and from the author’s theoretical sensitivity to the data. An heuristic outlining older residents’ perceptions and meaning of quality of life as expressed through the process of maintaining self and its categories and their properties is illustrated in Figure 7.
Figure 7: Maintaining Self: An Heuristic Outlining Older Residents’ Perceptions of Quality of Life

Properties
- Experiencing health and comfort
  - Independence of daily life
  - Performing activities
  - Sense of well-being
- Being safe
  - Being cared for
  - Basic functional care needs
- Relationship with staff
  - Relationship with residents
  - Relationship with family
- Social & recreational activities
  - Activities for special occasions
  - Individual activities
- Autonomy
  - Privacy
  - Avoidance of being a burden
  - Self-esteem
- Faith
  - Presence

Categories
- Maintaining good health
- Ensuring physical safety
- Maintaining relationships
- Meaningful activities
- Continuity of personhood
- Spiritual well-being

Supporting Processes
- Being safe
- Relationships
- Positive self-esteem
- Sense of well-being

Core Category
- Nurse’s positive attributes
- Knowing the older resident
- Flexibility
- Multidisciplinary resources

Maintaining Self
Facilitating Conditions

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4.9 Facilitating Conditions to the Process of ‘Maintaining Self’

It was evident from the older residents’ accounts that their capacity to ‘maintain self’ was influenced by conditions that facilitated the process of ‘maintaining self’. The identified conditions were: the presence of positive attributes in the nurses including competent nursing practices; knowing the older person; flexibility in the ethos of care; and resources both human and physical. These facilitating conditions are shown in figure 7. They were identified as factors which helped older residents develop a sense of themselves and determine whether or not ‘maintaining self’ materialised. If one of the facilitating conditions is missing, then the model is exposed to over-balance and risks collapsing. The facilitating conditions can be seen as the ‘constants’ necessary in an older person’s life to determine their overall quality of life.

4.10 Summary

This chapter has described the findings of the first series of interviews with the older residents that comprised the study, highlighting in particular the dynamic processes of conducting a grounded theory study. Working within a grounded theory approach, using constant comparison, the author constructed a model of quality of life for older residents with the supporting processes being named as: (a) sense of well-being; (b) being safe; (c) relationships; and (d) positive self-esteem. This model was generated through the author’s theoretical sensitivity to the data. A description of the concepts, categories, and their properties that emerged from the data was offered from a theoretical perspective. Finally, the discovery of the core category of ‘maintaining self’ was introduced, its relevance to the lives of the older residents briefly was considered, and the conditions facilitating the process of maintaining self were introduced.
CHAPTER 5

Results: Staff Members

*We always encourage our residents to get involved in stimulating activities*

(Interview: S5)

5.1 Introduction

In this chapter the author describes the meaning of quality of life as perceived by the staff members in the two Lebanese nursing homes that comprise the study sample. Using the grounded theory approach outlined in Chapter 3, this chapter will describe the development of the supporting processes of a model of quality of life developed from the staff members’ perspective. The emergent theory involved interviews with 11 staff members with different years of experience working in a nursing home environment. A brief outline of the categories and their properties will be presented from a theoretical perspective. The five main categories that emerged from the data were: (a) respecting the older person; (b) creating a home-like environment; (c) providing quality care; (d) fostering well-being; and (e) encouraging meaningful activities, each being evidenced by its supporting properties. Illustrative quotations from the participants are included throughout the chapter, as well as extracts from the author’s theoretical memo book.

5.2 Category 1: Respecting the Older Person

The culture of Lebanon emphasises the concept of respecting older people and they, in turn, expect to be respectfully treated. In Lebanese society, older people are looked upon as a source of spiritual blessing and models of religious faith, wisdom, and love. At each of the encounters, staff members working in the participating nursing homes showed great respect towards the older residents. Respecting represented the staff members’ general method of interaction. From constant comparison of the data, staff members accomplished
respecting the older person through the properties: showing concern; including the older person in decision making; consulting the older person to identify their preferences; and protecting the continuity of the older person’s self. Each of these properties appertaining to the category of ‘respecting the older person’ is presented.

5.2.1 Property: Showing Concern

As seen in the data, acknowledging the older person’s concern or distress was one strategy staff members used in respecting the older person. Nurses reported that what the older person says is important as is acknowledgement, as illustrated in the following quotations:

“You can’t just carry out your duties with an older person and then leave. You have to listen to their concerns, their complaints, to let them tell you about things that bother them. You have to sit and listen to what they have to say. When you give them your attention they feel that they are somebody, that they are a person who is worthy enough to be listened to.”

(Interview: S9)

“I think from the time they are admitted to the nursing home you have to make them feel that they are respected, they are an individual, and that you just want to help them.”

(Interview: S2)

Attempting to make a theoretical connection between these similar experiences led the author to place the following entry in her theoretical memo book:

“By acknowledging and listening to what the older resident has to say nurses appear to respect the resident and this shapes the context of their day-to-day caring and nursing interventions.”

(Theoretical memo book entry: 7.1.2010)

Acknowledging the older person’s concern or distress also involved making them feel empowered. The staff attitude to residents was a factor in determining whether residents felt empowered or powerless in the nursing home:

“We always ensure safety in the nursing home, but I think empowering starts right from the minute the resident is admitted to the nursing home, even for somebody who has very little control. There are small ways you can empower them by giving them choices. For example, you can give them a choice between wearing their own
clothes or wearing those provided by the institution. I think that is empowering them because it gives them a choice.”

(Interview: S9)

“We always try to help the older residents experience success at an activity. We focus on identifying and promoting the residents’ strengths. If you can find a strength and get them going at that, then they can succeed and accomplish things.”

(Interview: S9)

The ability to make residents feel empowered and respond to their concerns related to how well the staff members knew the residents as individuals and showed interest in them as people. They believed that viewing residents as ‘patients’ may result in a focus on physical rather than emotional care, and considered a departure from this perspective to be a key to good quality of life for residents. Accordingly, care staff spent time getting to know the residents and were willing to meet their individual needs. In addition to showing concern to the older resident, the staff members used alternate forms of interaction such as nonverbal active listening, therapeutic touch and observing individual responses of the older resident. These techniques facilitated development of a trusting relationship and demonstrated an empathic understanding of the older resident which directed the staff member to act upon their concern.

5.2.2 Property: Involvement in Decision Making

Involving the older person in decision making was another key strategy that staff members used in respecting the older person. They identified the involvement of older residents in decision making as an important aspect of quality of life, and some described ways in which they are involved. Care staff also suggested that residents’ opinions about care are sought and their care was based on their opinion as the following examples reveal:

“Yes, of course I take their opinion into consideration. One hundred percent. For example I ask them in the morning what they like to wear and I let them choose, especially if they are able to move and walk, I let them walk to the closet and choose whatever they want to wear.”

(Interview: S7)
“Many older residents desperately want to be involved in the decisions that affect them, both on a daily basis and at a wider level. We try as much as possible to make sure that everyone has the opportunity for their voice to be heard. This is greatly appreciated by the residents and contributes positively to their quality of life.”

(Interview: S8)

After completing the series of interviews and constantly comparing experiences, differences in the attitude of the nurses regarding involving the older person in decision making were noted. Staff participants who had worked in the nursing home for a long period of time felt that they have gained familiarity with the residents’ likes and dislikes and could, therefore, make appropriate choices for them:

“Since the residents are here every day and we are here every day, we know them very well, we know what they want and what they don’t like.”

(Interview: S10)

In order to create opportunities for shared decision-making, staff members needed to see this action as a priority and as an integral component of their work. For some of the staff members, maximising the extent to which the older residents were enabled and empowered to exercise decision-making was increasingly accepted as essential for the quality of life of the older resident. Furthermore, staff thought that the extent to which residents were able to exercise decision-making and control had a direct influence on the relationships they developed within the nursing home, with staff and with each other. The continuing importance of maintaining personal control in day-to-day activities as far as possible was also emphasised by some of the participants. As frail older residents, particularly those with any degree of cognitive impairment, may find it difficult to express their wishes, they could be considered more at risk if care routines became inflexible and failed to respond to individual needs and preferences:

“…for example older residents with some cognitive impairment may not be able to decide what they want or what they wish, through our daily contact with them and our relationship with them, we try to know what they need or what they want and devise their care plan accordingly.”

(Interview: S5)
The most positive experiences were described when older residents were able to work in partnership with staff, confident that their views and opinions would be taken into account:

“Each resident has their own individual care plan and it is drawn by one of the staff members. We try as much as possible to involve the older resident in devising the care plan taking into consideration their likes and dislikes, and this helps in establishing a trusting relationship between the resident and the nurse.”

(Interview: S5)

“There is this resident, he does not go to bed until around ten. I can give him a choice; why not? He has his own television in his room and he can watch it for as long as he wants. There is the other resident who likes to stay in bed to nine o’clock in the morning. He is his own boss kind of thing now.”

(Interview: S7)

All the participants interviewed were very much aware of the importance of involving the resident in decision making on their quality of life and were aware that rigid policies and inflexible rules were likely to have repercussions for effective partnership working and shared decision-making. Care staff also believed that a philosophy of care should be based on resident inclusion in decision making and maximising resident capacity, facilitating choice and keeping residents involved. It was evident that there was a real desire to improve care practices and that increased flexibility was required to enhance the quality of life of residents.

5.2.3 Property: Identifying Preferences

One of the ways in which staff members accomplished respecting the older person was by consulting the older person to identify their preferences. Staff emphasised the importance of making choice during the day such as choices about the time residents are woken up, have breakfast, go back to bed, have meals and what they do during the day. It was also evident from the data that choice can only be facilitated when there is flexibility in care giving routines:

“If I go in and they say look, I don’t want to get up, I say fine ‘I’ll come back to you in an hour.’”

(Interview: S5)
“I think the big quality of life issue is that they still have their human rights that they had when they were living in their home. When the older resident says that ‘no, I don’t want to eat dinner at five o’clock’ that should be respected, rather than fitting into our routine.”

(Interview: S5)

Some staff respondents suggested that choice about when to go back to bed was only possible when staffing levels in the evening allowed it or if residents could return to bed without staff help:

“They can stay up as long as they want; we don’t have a problem with that. The television room is separate from the bedroom, so they can sit there and watch television without bothering others of course, and if they are able to go to bed without any help. Of course the evening staff should be aware that someone is staying up for a while so they check on them frequently and make sure they go back to their room when they are done.”

(Interview: S7)

Providing the older person with choices meant helping them take action and regain control over their own daily living activities, as the following statements demonstrate:

“Freedom, freedom, freedom is the most important thing for a good quality of life. An older person should be able to express their opinion as much as they want. They should be able to ask for everything they want. We usually tell them that “your opinion is highly valued and important to us.”

(Interview: S8)

“Those who are able to do their own personal hygiene, I let them do it themselves. If they are able to scrub their bodies on their own I just help as needed. For those who like to use a lot of water during their bath, I give them the freedom to do so. This is just a simple example of how I let them do things the way they want or the way they feel comfortable.”

(Interview: S8)

Thus, not only is adequate staffing necessary for providing choices to the older residents, but it is ‘a must’ for successful delivery of care.

5.2.4 Property: Protecting the Continuity of the Older Resident’s Self

One of the ways in which staff members accomplished respecting the older resident was by protecting the continuity of the older resident’s self. Staff considered this central in upholding the quality of life of the older resident and for facilitating meaningful
communication and interaction with others. In an attempt to facilitate the preservation of
the self, staff mentioned the importance of the life story of the older resident, including
earlier self-expressions, interactions, and relationships. Moreover, they thought that
listening to the older residents’ concerns about their present lives was more meaningful
than only having conversations about the past:

“Of course he likes to be able to do some work. But it is not possible now. I don’t
think one can imagine how he feels when he is unable to do anything. He was a
successful businessman before. He was active all his life. He liked to be outdoors.
But now he has been in this nursing home for several months and needs help with
everything. It’s very sad but we cannot do anything about it.”

(Interview: S1)

As theoretical sensitivity to the data increased, it became apparent that staff members used
previous knowledge about the older resident to protect the continuity of the older resident’s
self. Through shared experiences and narrated parts of the resident’s life story, the nurses
mostly succeeded in sustaining the older resident’s identity. Participants commented that
this approach helped to develop a common bond between themselves and the older
resident:

“You don’t see them any more as a patient, you see the person behind that. And, by
them telling you more about themselves it connects with things in your life as well.”

(Interview: S3)

Also, hearing about a resident’s life story helped staff to see the person in the context of
their whole life, rather than simply in terms of their medical condition and physical needs:

“You see them as people that have actually lived rather than looking at them in
terms of their medical needs. You get an insight into what they used to do years
ago.”

(Interview: S10)

Story telling and listening enabled staff nurses to gain a better understanding of the older
resident by providing knowledge which directly influenced decisions made about
appropriate care. This approach resulted in care that accorded with the residents’ personal
meanings and values and enhanced staff-resident relationship.
Staff members accomplished respecting the older person through the properties: showing concern; involvement in decision making; identifying their preferences; and protecting the continuity of the older person’s self, as illustrated in figure 8.

**Figure 8**

<table>
<thead>
<tr>
<th>Properties</th>
<th>Category</th>
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<tbody>
<tr>
<td>• Showing concern</td>
<td>Respecting the older person</td>
</tr>
<tr>
<td>• Involvement in decision making</td>
<td></td>
</tr>
<tr>
<td>• Identifying preferences</td>
<td></td>
</tr>
<tr>
<td>• Protecting the continuity of the older person’s self</td>
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5.2.5 *Theoretical Reflections*

After analysing the second series of interviews, the author returned to the data and started to read and re-read all the interview transcripts (Interviews S1-S11), beginning the time-consuming process of listening again to the audiotapes of each interview and consulting her theoretical memo fund. Frequent listening to the audiotapes, especially during transcription, helped to capture the powerful statements of the participants that led to the development of the codes. Whilst undertaking this exercise, the author concentrated her attention on a theoretical memo (entry dated 26.3.2010) which concerned the term ‘respecting’ as the potential name of a possible component of caring for the older person. The author attempted to assimilate data emerging from the study under this heading and the component was articulated most clearly during the seventh and the eleventh interviews in the study:

“I try to talk to every single older resident every day for 10 minutes at least. I sit down and listen to what they have to say. You know these residents suffer from loneliness; they feel that they don’t count, so when you give them your attention, they feel they are respected. Respecting them is the least we can do
to these residents. They are the people who made us reach what we are now. Imagine that they helped us start our lives and now we are helping them to finish theirs, see the difference, see what I mean.”  

(Interview: S7)

“I think from day one when they are admitted to the nursing home we have to give them a sense that they are respected, they are an individual, and that you just want to help them. We respect them for who they are, residents have their own values and beliefs which we respect, not hold against them, or try to impose our beliefs on the resident.”

(Interview: S11)

“I can tell you based on my experience, I am 100 percent sure that the services we are providing reflect a good quality of life because we are providing all what we can. I place myself in the shoes of these residents and I ask myself what could he possibly need; then I provide it for them. I read the newspaper to those who cannot see well, I let him watch his favorite show in the tv, I help him hear and see and perhaps participate even a little. I will ask him did you see what’s going on?”

(Interview: S7)

Accordingly, respecting the older person emerged as an essential determinant of quality of life for an older resident and as such became one of the supporting processes of the emerging model. Nurses stated that respecting the resident was ‘more of a way of doing everything else I have to do’. Respect for care staff is the basis of a trusting relationship between the older resident and the staff member.

5.3 Category 2: Creating a Home-like Environment

The next identified category that emerged from the data was ‘creating a home-like environment’ for the older person. During the interviews, staff touched on the importance of creating a home-like environment as an important determinant of residents’ quality of life. To them ‘home-like’ meant giving the residents control and choice over their day-to-day activities. It also involved enriching the environment with personal things like photographs, furniture, decorations that were familiar to the older resident. Care staff described how such personal things could contribute to supporting the identity and continuation of self for the older person and enhance feelings of ‘being at home’ in the
nursing home setting. Staff participants accomplished creating a home-like environment for the older person through ensuring an appropriate physical environment, interpersonal environment, and organisational flexibility. These are the three properties of creating a home-like environment for the older person and are presented in the next section.

5.3.1 Property: Physical Environment

The physical environment was regarded as important for both safety and security, as well as for life satisfaction. The nursing homes participating in this study had facilities such as a day room and a dining room which helped in creating a home-like environment for the older residents. Places with comfortable chairs and sofas outside the residents’ rooms fostered interaction between staff, residents, and family carers and thus supported creating and maintaining social relations in the environment. These facilities allowed the older residents to socialise with their fellows, and create the potential for activities to occur:

“We, as a working group, insist on concentrating all our efforts and attention on these older people in order to make them live their lives and help them not to consider themselves out of their homes, away from their families. Creating a home-like environment for these residents is very important. Ask any of them where they’d like to be, they all want to be at home, so I think it is very important to keep the environment homely.”

(Interview: S9)

“...and then comes the calendar in the room. It’s not part of the decoration; it’s for keeping the older person oriented. It’s very important that they know that today is Monday, tomorrow is Tuesday, the month, or when is Mother’s Day etc... We try to make the environment as natural as possible for them to feel that this is their home.”

(Interview: S7)

The staff participants also believed that it was important that residents ‘look their best’, and described how important it was that residents’ clothes are appropriate and matched:

“Some of them have nice clothes, and they look very clean and tidy in their clothes. But if they don’t have clothes, we (the institution) provide them with clothes so that they feel they are in a home-like environment. Being able to dress in private clothes, being able to read newspapers and watch television, and talking about topics apart from disease are examples of being in a home-like environment.”

(Interview: S2)
The needs for environmental cleanliness and space were clearly identified by the staff. They thought that cleanliness in the nursing home clearly affected the residents’ health and suggested that a clean, quiet, temperature controlled environment should be maintained to meet the needs of the older residents:

“The environment surrounding the older residents needs to be taken care of. The residents live in the nursing home for a long period of time, and some of them never leave after they move in. Fortunately the environment here is very clean as well as the toilet and it is good for the health of the residents.”

(Interview: S2)

In the two participating nursing homes, activity space was available for residents who were ambulatory as it allowed them to walk to improve their physical functions, while it gave them the feeling of freedom and the space for social interaction. Both facilities had a garden and they were multistorey buildings with rooms for the residents on upper floors. However, all units providing care on upper floors had lift facilities for residents. Some nurses pointed out that the space in the nursing home was enough:

“The environment is very good here. The space for activities is big enough for walking outside which is nice.”

(Interview: S9)

The facilities had wide corridors to accommodate residents who were wheelchairs users and those residents who walked persistently. The majority of rooms in each of these facilities were double rooms and also had some three-bedded areas. In all rooms residents had a call bell system to summon staff. Dining facilities were available with tables to seat four to six people.

5.3.2 Property: Interpersonal Environment

All participants suggested that a home-like environment was one where nursing staff are caring, friendly, and kind. The participants also indicated that caring includes things such as kindness, listening, thoughtfulness, and empathy:
“I don’t come here only to do my work, get paid and leave. I got used to this and I really feel that they mean a lot to me because I have a continuous relationship with them. It’s not a matter of a day or two and then they leave. It means you will see them every day for a long period.”

(Interview: S8)

“Our philosophy is about making these residents’ pattern of life as close to as what they would experience at home. I sit down and ask them, ‘what time did you wake up in the morning when you were at home?’ ‘what time did you go to bed?’ rather than getting them into the routine. It’s about patterns of life as close to what they were used to at home.”

(Interview: S7)

The interaction with residents was often seen by the staff as the most important prerequisite for their quality of life. Receptive, reliable, and continuous communication was considered a significant indicator of a well-functioning, caregiving interaction. This included conveying correct information, showing sensitivity to the older resident’s views and needs, and giving the resident kind treatment. For these reasons, nurses emphasised the importance of the general atmosphere and the development of an ethos of resident inclusion as part of creating a home-like environment for the older resident. The nursing staff gave examples of where this had failed. Usually the care system, not the nurses, was blamed for the lack of continuity. The nurse manager in nursing home B succinctly illustrates this point as follows:

“Yes, there is lack of continuity because nurses work in categories: there is a nurse responsible for administering medications, following the doses and the doctors’ order; she checks the date and the prescription etc. and there is a nurse who is assigned to help the first nurse. She is responsible for distributing the food trays, of course under the supervision of the first nurse who is the registered nurse.”

(Interview: S7)

The nursing staff often discussed reciprocity in terms of sharing invisible or past personal identities:

“The focus of our institution is to listen to the residents and incorporate that knowledge about them into the plan of care. Self-identity is at the core of our professional responsibility. It is necessary to understand the danger to one’s sense of identity that occurs when a person enters a nursing home.”

(Interview: S7)
“We encourage them to keep in touch with the outside world by reading the newspaper for example. Resident (name) gets the paper and then he passes it around to his friends so that everybody will have the chance to read the newspaper. Some of them have their own radio, so they keep connected with the outside world.”

(Interview: S8)

“It’s true that as a nurse, your job is to stand by the resident. But you can’t work with an older resident and just perform your duties or do your work. You have to share with him/her his/her life for example, his/her concerns, his/her complaints, to let him/her tell you about things that bother him/her, or if he/she is in pain or anything else that he/she wants to tell you, you have to sit and listen to what he/she has to say. At the same time you will feel closer to this person; so communication has a big impact on both the resident and the nurse. The older resident will care about small issues related to you the same way you care about even the tiny issues related to him/her.”

(Interview: S8)

A nurse would share with the resident previously unknown personal details related to her life outside of work; in turn, the resident could share personal identities from his or her past. Attending to these identities as they delivered care, affected the quality of life of the resident. By doing so, these nurses acknowledged the residents’ selves, other than those related to old age, illness, and disability.

Such attitudes become pivotal in creating a home-like environment for the older person. Care is respectfully and sympathetically delivered with the resident’s self-esteem being a priority. The author formed the general impression that the nurses effectively outlined the strategy to enhance the residents’ well-being. The components of this strategy included a vivid description of preserving their pride, their entitlement to respect, and giving the older person an opportunity to preserve their physical appearance by dressing according to their former style and keeping the same hairstyle.

5.3.3 Property: Organisational Flexibility

Creating a home-like environment for the older person was also accomplished by ensuring some organisational flexibility such as giving the residents control and choice over their
day-to-day activities. The staff members believed that the organisational structure of the facility significantly impacted on the residents’ quality of life. All nurses agreed that the goal of care should be making the residents’ life as similar as possible to the life they would choose to live at home. They made sure that residents were given choices about their day schedule, including the time they got up and went to bed and what they did during the day. In doing so staff members tried to create a home-like environment for the older residents. They argued that residents should not be expected to fit into the routine; rather, the routine should be sufficiently flexible to allow residents have choice. Care staff also believed that in a nursing home, the ethos of care should be based on resident involvement in decision making, maximising resident capacity, facilitating choice and keeping residents involved:

“When I first started working in this nursing home, I thought about the routine of care and I wished that it had been more person-centered and holistic.”

(Interview: S3)

Participants indicated that some staff members can be too immersed in the routine to see beyond it, and reported that making choices is not always possible because routine continues to dominate care organisation:

“Some of us are very task-oriented. People have to go back to bed at 8:00 pm because you’re going to have fewer people up in the evening time, so people don’t make a choice at all.”

(Interview: S1)

“It’s very hard to treat the residents as individuals because we have so many residents to take care of; we try to but it is very difficult.... We have a work schedule and we must get our round done.”

(Interview: S1)

While staffing constraints were an issue for the two facilities, care was organised to try and give residents maximum flexibility. Mealtimes were staggered and activities were at different times of the day to meet residents’ preferences. This meant that off-duty schedule for all staff had to be organised in a way which facilitated resident choice to enable
residents to go to bed at their desired time. This was recognised by the author in a theoretical memo made shortly after the above interview:

“It is becoming increasingly evident from the three nurses interviewed to date that organisational flexibility is core to quality of life if a more comprehensive and person-centred service is to be provided. Involving residents in drawing their own care plan, maximising resident’s choice about diet, clothes, mealtimes, daily routines are nursing interventions that help create a home-like environment for the older person.”

(Theoretical memo book entry: 07.01.2010)

Thus organisational flexibility led the nurses to relax the seemingly rigid rules and regulations of the nursing home and enter a new phase of care giving. Therefore, the author returned to her theoretical memo fund and interview transcripts to begin the task of discovering the next supporting process of the emerging model.

In summary, the main category of creating a home-like environment for the older person was accomplished by the properties of: ensuring an appropriate physical environment; interpersonal environment; and organisational flexibility as illustrated in figure 9.

**Figure 9**

<table>
<thead>
<tr>
<th>Properties</th>
<th>Category</th>
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<tbody>
<tr>
<td>Showing concern</td>
<td>Respecting the older person</td>
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<tr>
<td>Involvement in decision making</td>
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<tr>
<td>Identifying preferences</td>
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<td>Protecting the continuity of the older person’s self</td>
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<tr>
<td>Physical environment</td>
<td>Creating a home-like environment</td>
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<tr>
<td>Interpersonal environment</td>
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<td>Organisational flexibility</td>
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5.4 Category 3: Providing Quality Care

As theoretical sensitivity to the data increased, it became apparent that the category of providing quality care was characterised by the following properties: providing holistic care, individualising care, establishing empathic relationships with the older person, and fostering positive staff attitudes towards ageing and older people. Good or quality nursing care, or relationships involving some degree of reciprocity or empathy, were seen by staff members as the most significant for the older resident’s quality of life. When asked about what made care quality, care staff spoke about their relationships with the residents. They emphasised the degree of closeness they experienced in these relationships. Good care was described as care given by someone who ‘really likes their work...really cares about the people here’ (Interview: S7). Although the staff talked about the technical aspects of care, they also talked more about signs of individualised affection and friendship they find in the care they deliver.

5.4.1 Property: Holistic Care

According to care staff, holistic care was an important dimension of quality care and thereby quality of life. Holistic care included a focus on physical, psychological, social and spiritual needs of older residents. The nurses indicated that all these dimensions of care are important to ensuring that the older resident’s needs are identified and planned for. Staff members saw emotional care as a vital component of quality care for older residents. They perceived it as part of holistic care, but it was something that could be delivered if there was time to do so. They suggested that emotional care was crucial to older residents, as many experienced significant losses in their lives. Care staff also pointed out that it was the talking to older residents that helped make a difference:

“It's very important. Every morning we bathe the older residents. We care for them; we are like a family living in a house. If someone is unable to eat, we feed them, change their clothes, walk them to the toilet, bathe them, and change..."
their linen. But what we do is more than basic nursing care. We sit with the older residents, talk to them, try to support them psychologically and emotionally. During our free time we try to entertain them by playing chess or cards with them, for example.”

(Interview: S6)

After analysing the above interview, the author jotted down the following substantive area for subsequent comparative analysis in her theoretical memo book (entry dated: 23.01.2010):

Emerging sense of psychosocial needs of the older residents and the staff perception of that kind of nursing care.

Analysis of subsequent interviews revealed that additional nursing care, which went ‘over and beyond’ the usual expectations of care delivery and could include elements of both physical and psychosocial care was directed at meeting the resident’s extra care needs. An approach where ‘nothing was too much trouble’ was necessary in meeting these needs:

“If an older resident has special care needs, we go out of our way to meet those needs.”

(Interview: S9)

Interestingly, the psychosocial needs of the older resident were met only when there was enough time available for the nurse to deliver such care in amongst other duties and responsibilities.

5.4.2 Property: Individualising Care

Individualised care was perceived as an ideal, something that one should strive for. The staff members believed a resident should be treated as an individual and as a person, not as a patient. However, nurses suggested that individualised care does not necessarily mean there is no routine. They believed that some degree of routine was important and necessary, because it increased the predictability of events and helped older residents to
have more control over their lives. However, the primary goal in individualising care was to have as few rules as possible.

Many nurses identified the need to ‘know the person’ as an important prerequisite to individualised care. ‘Knowing the person’ reflected the process whereby nurses came to perceive a resident as someone more than an old person. Thus, knowing the older resident as a person enabled the staff to respond to their individual needs and to try and bring a personal dimension to care. Staff indicated that residents wanted to have their personal biographies recognised and valued as a basis for individualised care. They mentioned that the majority of older people in the nursing home enjoy talking about their lives, and that being listened to accords ‘personhood, identity and significance’ to the older resident.

Many staff participants described examples of care that involved ‘doing something’ for a resident that are important to them individually. An example illustrates the case of an older resident who enjoys listening to classical music and is given the opportunity and the means to listen to it:

“There is this older resident who loves listening to classical music. I have arranged for him to buy a tape recorder so he will be able to listen to classical music.”

(Interview: S2)

The staff who implemented the biographical approach in the nursing home said that collecting biographical material about people’s lives helped them to gain a more dynamic and complete picture of those they cared for, and that knowledge of the older residents’ life stories enabled them to find out more about their needs and behaviour. In addition, listening to a resident’s life story helped the staff to see the person in the context of their whole life, rather than simply in terms of their medical condition and physical needs. Staff thought that the implementation of the biographical approach maintained the older residents’ own identity. Indeed, the biographical approach required a great deal of time,
effort, ingenuity and, perhaps most important of all, an intimate knowledge of the person on the receiving end of care. Without this intimate knowledge and relationship, the attempts made by the nurses to find and attach meaning to their role would be very difficult. This was articulated most clearly during the fourth interview with a staff member:

“It helps you to understand how and why a resident behaves in a specific way... It helps you to understand why people are like they are in mood and behaviour when you do get to know them better.”

(Interview: S4)

“You don’t see them any more as patients. You see them as individuals. And, when they tell you more, it connects with things in your life as well.”

(Interview: S4)

Reflecting upon this interaction shortly after the interview, the author entered the following note in her theoretical memo book:

“In this interview the nurse is attempting to show the older residents that they are valued as individuals. He is focusing his efforts on the individual’s needs in a manner consistent with the resident’s life perspectives. This directly influences decisions made about appropriate care. This approach, which encourages story telling and listening, results in care that accords with the resident’s personal meanings and values and enhances staff-resident relationship. To motivate the resident to live positively through his/her experience of being in a nursing home the nurse is building upon the unique biographical knowledge in his possession to direct present caregiving efforts.”

(Theoretical memo book entry: 12.01.2010)

Hence by transcending the data, individualising care became the next supporting process of the emerging model.

**5.4.3 Property: Establishing Empathic Relationships**

The interaction between staff members and the older residents was frequently seen as the most important prerequisite for quality of life of the older residents. Empathy was considered to be the central component of a caring interaction. Receptive, reliable, and continuous communication, both with the older resident and with the family carer, was regarded as a significant indicator of a well-functioning caregiving interaction. This
included conveying correct information, showing sensitivity to the older resident’s views and needs, and giving them kind treatment. Staff members thought that empathy involving the understanding of the older residents’ situation, perspective, and feelings was a necessary basis for constructive helping relationships. They believed caregiving should occur in a relationship in which the older resident and the nurse establish good everyday knowledge about one another.

All staff members participating in this study used such knowledge. According to their descriptions, they strove for reciprocity and empathic understanding in their caregiving as these extracts convey:

“Nurses should love older people in order to work with them; they should spend time with them. They should not feel they are forced to come and take care of them. I wish schools of nursing would raise awareness in nursing students about this growing population in our country. Imagine that they give birth to us, help us to start our lives and now we are helping them to finish theirs. My mother and father helped me face the world and succeeded; they helped me build myself and start on my own, and now I am helping them to die in return. Do you see the difference?”

(Interview: S7)

“They are becoming very attached to us and we love them, just love them as our own grandfathers and grandmothers. For me, to have someone next to me, to have someone’s attention, that is the most important thing that I will make sure they have.”

(Interview: S10)

“Yes, we have so many residents who are so attached to us. For example, when we go on vacation or something they miss us and ask about us. If we didn’t talk to them then they wouldn’t be so attached to us. They feel as if we are their children; we are so important in their lives that they ask us about our families and kids. They care about us, and if one of us is transferred to another floor they ask about him/her because they miss that person.”

(Interview: S1)

Attempting to make a theoretical connection between these similar experiences led the author to place the following entry in her theoretical memo book:

“By drawing upon intimate knowledge of the older person, nurses appear to strive for reciprocity and empathic understanding in their caregiving. Such qualities appear to be important prerequisites for establishing a sense of security among the
older persons and for building trusting relationships between them and the staff members.”

(Theoretical memo book entry: 05.03.2010)

From the author’s theoretical sensitivity to the data, and as intimated in the above theoretical memo book entry, the author considered that establishing empathic relationships was a crucial property of providing quality care and therefore was considered as the third supporting process of the emerging model.

5.4.4 Property: Fostering Positive Staff Attitudes

Staff members also accomplished providing quality care by fostering positive attitudes towards ageing and older residents. They were concerned about the perception that working with older residents lacks value and status in the nursing profession and in society. Although many of the care staff indicated that they ‘love taking care of older residents and working with them’, they also suggested that others do not always view working with older residents to be very important. The lack of regard from the public for those nurses who choose to work with older residents was an issue for many participants. Participating care staff also underlined the need to promote the concept of working with older residents positively, which necessitated interviewing the nurse managers in order to find out their team views on and attitudes toward ageing and older residents. When asked about why she was working with older residents, a young nurse responded:

“Many people in our community think that working with older residents is not something important, but for me it’s the contrary. I don’t know why I love them, but I do. When I see someone old my heart starts beating. I like helping them. I am not perfect; sometimes I feel tired and weak, especially when I am sick but I try my best not to let the older resident feel anything. I make them feel that I am interested in what I am doing, otherwise they will feel so bad and think they are a burden on me, and they will start crying. When an older resident tells you “God bless you”, you feel as if you own the world and you forget all your efforts. You try to do anything that would make them happy and comfortable.”

(Interview: S3)
The nurse manager expressed the conviction that older residents are genuinely loved by her team members and that sensitivity to the feelings, needs, and rights of older residents is integral to effective caring:

“We love taking care of older residents. They (residents) also care about intimate relations with us, which means holding them, kissing them, making them feel that they are loved. They feel very happy when you kiss them after their bath; they feel that you are a family and that you love them.”

(Interview: S4)

In summary, the category of providing quality care was accomplished by the properties of providing holistic care; individualising care; establishing empathic relationships with the older person; fostering positive staff attitudes towards ageing and older residents as illustrated in figure 10.

**Figure 10**
5.5 Category 4: Fostering Well-being

Respecting the older person enabled the staff members to achieve specific interactions and actions whereby they accomplished fostering well-being. This category of fostering well-being involved important protective goals manifested in the protection of the older residents from the consequences of diseases, activity limitations, and dependence on help, all being perceived as threats to the older persons’ quality of life. However, staff members were well aware of the fact that fostering well-being was about much more than absence of illness and protection from harm. In their opinion, older residents who maintained positive well-being did so because they believed things would improve and they had goals to see that happen. Having goals enabled the older residents to have a focus and engage in behaviours that were desirable. Similarly, doing things, having an impact, and receiving feedback seemed to provide the keys to well-being and a good quality of life. Staff members encouraged the older residents to get involved in experiences that could increase their sense of purpose and personal satisfaction:

“I always encourage our residents to get involved in interesting activities, specially educational activities because they contribute to the resident’s well-being and life satisfaction in general. They also will have a more positive view about old age and the ageing process.”

(Interview: S5)

As the data were constantly compared it became evident that the way staff members accomplished the category of fostering well-being was by: encouraging the older person’s health and independence; protecting the older person from physical and emotional harm; and by advocating for the older person. Each of these properties represented the different actions nurses took when fostering well-being during the process of promoting a good quality of life for the older resident. The actions associated with fostering well-being were evident when the older residents were too disabled to be capable of accomplishing their
own needs of daily living without assistance. Each of the properties of fostering well-being is subsequently presented.

5.5.1 Property: Enhancing Health and Independence

One of the ways in which staff members accomplished fostering well-being was by encouraging the older resident’s health and independence. They tried to empower them to use their abilities to perform daily living activities by promoting their health and independence. This also involved encouraging their participation in activities and helping them experience success. Nurses focused on identifying and promoting the older residents’ strengths, as exemplified in the following testimony:

“You have to realise that you can’t change what the older person cares about. You don’t want them to go after something that they are likely to fail in. So if you can discover one strength and get them go at that, then they can successfully accomplish tasks.”

(Interview: S4)

Nurses also contributed to enhancing the older residents’ health and independence by combining their efforts with theirs, no matter how much support an older resident needed, such as great assistance in simply getting out of bed. By doing so, care staff helped the resident feel good about themselves, as the following statement illustrates:

“Any little effort the older person makes about caring for themselves, I try to praise them for that and encourage them to continue so that they maintain positive behaviour.”

(Interview: S4)

Staff members also enhanced the older residents’ health by closely following their health status, giving the appropriate treatment, and administering the ordered medications:

“In the first place there is a close and very important medical follow-up that they are in need of. Well, most of them take medications. In here, we follow up on their health status and give them the medications on time. And we watch for any side effects too.”

(Interview: S7)
The importance of independence was described as a matter of course and by referring to the older residents’ judgments. In addition, independence was sometimes associated with a sense of being an individual who takes responsibility in life:

“She wouldn’t like anyone to come and help her to get up in the mornings, because she doesn’t like to be dependent. It means a lot to her to be able to manage on her own, this makes her feel that she is an individual and that she has her own responsibility.”

(Interview: S11)

Participants talked about accessibility of multidisciplinary resources within their facilities:

“Multidisciplinary resources are readily available in our institution for our residents. There is physiotherapy, there is occupational therapist, we also have a speech therapist who comes in, so all these sources are available for them.”

(Interview: S1)

The above quotations represent supporting evidence of the property of enhancing the older person’s health and independence. Enhancing independence of the older resident ensured that the resident’s potential was realised giving dignity and purpose to his/her life. The availability of multidisciplinary resources in the two nursing homes impacted significantly on maintenance or recovery of independence. Multidisciplinary resources were perceived as an integral part of helping an older resident regain independence and to maintaining a worthwhile life. Staff suggested that these resources enabled residents to regain or maintain optimal functioning.

5.5.2 Property: Providing Protection

Staff members also accomplished fostering well-being by protecting the older person from physical and emotional harm. They believed that nursing care must be effective and safe, hence their commitment to the protection of the older residents from any harm. They saw themselves as primarily responsible for making sure that nursing care combines protective caregiving and technical expertise. Care staff did not appear to give the message that the older persons’ care was difficult for the staff, that they were a burden, or that their personal
preferences were ‘silly’ or ‘unimportant’. Staff members perceived their most important role to be protective caregiving, that is, any activity carried out for the purpose of protecting the older resident’s self-image. They constantly perceived this to be more important than instrumental care such as bathing, feeding, toileting, transporting, etc. Protecting the older resident in the nursing home was mainly for the purpose of maintaining dignity. This was expressed as protection of the older residents from the consequences of disease, activity limitations, and dependence on help which were perceived as threats to the older resident’s life satisfaction. The following testimonies illustrate the protective nature of nursing care:

“I offer the physically frail older residents maximum protection, because these residents are in a vulnerable position. Being old and frail, their level of responsibility for themselves might be dampened or might not be realised to the full extent.”

(Interview: S11)

“I think it is my duty to help them have a sense of control over their environment, and to let them believe that they are still the person in control and have responsibility.”

(Interview: S4)

Protecting the older resident was accomplished by providing adequate physical and psychosocial nursing care. Physical nursing care referred to ensuring that the residents’ daily living activities and grooming are completed daily, assisting the residents with toileting or other elimination measures, changing the immobile residents’ position every two hours, providing range of motion exercises, giving backrubs at bedtime and whenever residents are uncomfortable, altering the standard care regimens to meet individual residents’ care needs, and administering prescribed medications and treatments:

“Hygiene is important, so every morning we bathe the residents. If someone is unable to eat, we feed them. We change their clothes and walk them to the bathroom. In the evening, I usually walk them to the bathroom while I am getting them ready to go to bed. I get their teeth brushed, their face and hands washed, their back rubbed, and then I walk them back to bed.”

(Interview: S3)
“Safety and security come before anything else. Protecting them from falling either from bed or when they are walking. Our building is designed in such a way as to provide complete safety for the older person. The construction is very important.”

(Interview: S10)

The satisfaction of the older residents’ psychosocial needs involved nursing activities designed to address their psychological and social needs, such as incorporating their needs and wants into the daily nursing plan of care. This could range from spending time with residents, to visiting with residents, reading the newspaper to residents who have visual impairment, treating them as individuals, providing reassurance, and showing affection:

“There is this lady in particular. She has been here for almost five years now. When she first came here, she was very depressed and did not talk to anyone. She did not participate in any of the social activities we organised. But I just kept talking to her. I used to spend one hour talking to her every day, reading the newspaper for her, encouraging her to watch television. And finally she started getting involved with others.”

(Interview: S11)

Nurses believed that being available and responsive was important to building trust and establishing a relationship. By responding to the older resident’s needs, they were able to build some trust and a relationship. Nurses believed that they showed the older residents respect by really listening to the older resident and letting them know that they were being listened to and understood. Care staff also reported that showing a resident a respectful approach really made a difference in how the older resident responded to others. Moreover, care staff tried to help the older resident remember what they liked to do, when they were well and would say things like “if you just try to resume what you usually do, ... it may help you” (S11). This approach to exploring the older residents’ interests was seen to be effective in all interactive situations.

5.5.3 Property: Advocating Preferences and Concerns

Nurses also described accomplishing fostering well-being category by advocating for the
older resident to the team the older resident’s preferences and concerns. Even though nurses knew that keeping the older resident safe was important, especially with the most vulnerable in their care, they lobbied for opportunities that would allow older residents to make decisions in their lives. This meant voicing the older resident’s concerns when it seemed that the health care team objectives were not consistent with the older resident’s objectives, as the following statement illustrates:

“I believe that it is part of my role to try and convey the things that the older resident feels and to convey my perception of what the older resident is saying. It might be different from what other nurses believe, so we encourage the nurses to go back and ask the older resident if something is unclear.”

(Interview: S2)

Staff members in this study also believed that advocating for the older resident meant allowing the resident the right to choose whether they wanted to obtain a better quality of life, or whether they were satisfied with their current condition. Staff members reassured the older resident by identifying the nurse as someone who was available to help the resident. Moreover, staff members described providing the older resident with choices which, in reality, meant helping older residents take action and regain control over their own activities of daily living.

In summary, the category of fostering well-being was accomplished by the properties of: enhancing the older resident’s health and independence; providing protection; and advocating preferences and concerns as illustrated in figure 11.

5.6 Category 5: Encouraging Meaningful Activities

Staff members thought that individual, social and occupational activities, as well as integration in a group, contribute to reinforce family, social, and reminiscence identities. Individual activities also reinforce identity. Staff members indicated that activities that were meaningful to residents brought them most pleasure. The organisational routine of the
homes was seen to provide structure and meaning to activities. Some staff indicated that routine activities can both be beneficial and detrimental to residents. Routines could contribute to making residents feeling more secure, but at the same time, they could limit opportunities to engage in meaningful activities. What made the identified activities meaningful to residents also related to maintaining their skills and abilities as much as
This was often understood in terms of addressing motor and functional abilities, and trying to keep things ‘as normal as possible’. In the data from staff members, it was discovered that encouraging involvement in meaningful activities had the following properties: family and social activities, individual activities, and reminiscence activities.

5.6.1 Property: Family and Social Activities

Staff members expressed the view that having contact with their families and friends greatly mattered to the older residents, as did talking about them:

“They wait for their children and grandchildren to plant hope in their lives. When they see their family they change as if they come back to life. This is how they feel. At least once a week if they go out with their family and sit with them they will see life more beautiful. We let them go out and see their family and home, rather than just staying in the institution. This also makes the quality of their life better.”

(Interview: S8)

“Resident (name) is going to attend a wedding next week. Her grandson is getting married so she will be attending his wedding. She took special permission to go out of the nursing home. We encourage such activities as they feel that they are still part of their family.”

(Interview: S8)

“It is also very important that these residents maintain contact with their community. Being part of the community is important for quality of life. Nursing students come to our institution at times. They are somebody different, somebody residents could chat to and help to retain a link with the community.”

(Interview: S1)

Many participants felt that talking to and about family carers maintained links with important current and past relationships. They said that some older residents had their identity linked more with the past than the present and recalled family memories with great pleasure. However, social activities, particularly those specially organised by the nursing homes, were given more emphasis by staff. The majority of staff members expressed the view that specially arranged social events and outings were of value, as they were seen to be occasions when residents received more attention:
“We have the kitchen activity for example. We let them help in making jam. We get them apricots; they wash them and take the seeds off. They work with us and help us and they also help us in making pickles. Sometimes they prepare food with us.”

(Interview: S11)

Socialising with others was regarded as something that both facilitated activity and improved well-being. Many staff members described the older resident as being happier with people around. Isolation from others was considered as something negatively impacting the older resident’s quality of life.

5.6.2 Property: Individual Activities

Some staff members identified a range of activities that the older residents liked to do. These activities included reading, watching television, going for walks, listening to classical music, singing, looking after one’s appearance, knitting, and spending time alone. The factors that made them meaningful included the facts that these activities are interesting and enjoyable, in addition to helping them relax, learn new things, and be kept in touch. Most staff members admitted that it was important to identify each resident’s individual preferences, skills and abilities as this impacted on their level of engagement in activities, while some recognised the need to adapt activities to a resident’s capabilities, as a way of contributing to their well-being:

“If an older resident has the skill to knit we encourage her to do a sweater or a scarf. This will make her feel that she is still needed, that she is still capable of giving, and that she still has something to offer. They should always feel that they are needed and wanted people by the nurses.”

(Interview: S5)

“Some of our residents are very enthusiastic about playing cards. They even describe to you the satisfaction they get from such activities. They go into the main sitting area a couple of times a week and then they have the rosary another day. Some of the older ladies get their nails done, they get their hair done.”

(Interview: S6)

Activities were adapted to the individual resident’s ability so that their self-esteem could be enhanced by the successful completion of activities, rather than feeling defeated and
demoralised by being expected to undertake something that was beyond their capability.

The participants described how meaningful activities could provide the resident’s feelings of being able to participate in, and make a contribution towards, the life of oneself and others as the author noted at the time in her theoretical memo book:

“By encouraging the resident to get involved in meaningful activities the nurse is trying to provide a meaningful content to the day of the resident. What is important here is that he is providing a means in reaffirming the residents as individual persons who are able to do the things they enjoyed thus preserving the identity of the older resident.”

(Theoretical memo book entry: 12.01.2010)

Most staff members acknowledged that older residents could still engage in listening to music and enjoy it; therefore, they saw it as a way of stimulating the less able residents:

“It is good for conscious residents confined to bed in their rooms and who are able to talk and think, but their only problem is that they are disabled and can’t go out to see nature although they like to. They enjoy listening to music very much, and some of them become involved and start to clap.”

(Interview: S6)

Therefore, for frail older residents whose potential to engage in physically demanding social activities had been compromised, replacing such activities with others that make few physical demands, such as listening to music, could help the older resident retain their social engagement, and also maintain levels of well-being.

5.6.3 Property: Reminiscence Activities

Such activities included talking about past activities, experiences and interests related to each individual’s social and occupational roles, and at times the loss of aspects of them. Staff participants identified reminiscence as an activity the residents enjoyed doing. They considered that reminiscence can have a powerful influence on identity maintenance for older residents. According to staff, frail older residents can offer up a past, preferred identity that has significance and richness, in contrast perhaps to their current identity that accords little status. Through transmitting family narratives to children and grandchildren,
the older residents can again demonstrate the significance of events that they enacted in their past lives, and occupy a key family role. According to the staff members, reminiscence could be a focus of interaction that enhanced an older resident’s identity and sense of self:

“I do think they love it (reminiscence). They don’t get out that often, so they are cut off from the world, but the world they remember is the past, so that’s what they enjoy.”

(Interview: S4)

Staff in subsequent interviews gave similar descriptions of the impact of reminiscence activities on the quality of life of the older residents. However, staff members thought there was a risk that, through its concentration on the past, reminiscence locates older residents in the past, only.

In summary, the category of encouraging involvement in meaningful activities was accomplished by the properties of: family and social activities; individual activities; and reminiscence activities as illustrated in figure 12.

5.7 Maintaining Identity: Developing the Core Category:

As the author realised that each of the above categories, their supporting properties, and the supporting processes had the ‘fit and grab’ required for the formulation of substantive grounded theory, she sought to go beyond the data to devise a core category to link the data together. By going back and forth between the data, the author focused upon the idea that what the data was revealing was that staff members were primarily aiming to ‘maintain the identity’ of the older residents. Discussing this observation with her supervisors, the explanatory power of ‘maintaining identity’ to link the identified categories and their properties appeared to have the necessary ‘fit and grab’ of grounded
Figure 12

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theory (Glaser, 1978). By identifying the core category of ‘maintaining identity’, a relationship could be established between the staff efforts to ‘maintain identity’ of the older residents on the one hand, and their attempt to foster respect, well-being, create a home-like environment, deliver quality care, and encourage participation in meaningful activities on the other hand. From this realisation the core category of maintaining identity was applied to the data set and model at this moment in the study and prior to theoretical integration of the emergent models (Glaser, 1978). This core category stood for a conceptualisation of the relationships between the identified categories, their properties and the supporting processes. For the staff members, maintaining the older residents’ identity represented an essential determinant of life satisfaction. Figure 13 illustrates an heuristic outlining staff members’ meaning of ‘quality of life’ as expressed in the framework of maintaining identity, including the categories, their properties and the supporting processes.

5.8 Facilitating Conditions to the Process of ‘Maintaining Identity’

The staff members’ accounts revealed that their ability to preserve the identity of the older residents was subject to conditions that promoted the process of ‘maintaining identity’. The identified facilitating conditions were: non-task oriented care; staff continuity; reciprocity and empathy; open visiting policy; and a homely atmosphere. These facilitating conditions for staff were fundamental to the process of ‘maintaining identity’ for the older residents. They were regarded as determinants which helped staff members to consider each resident as a real person rather than as a diagnostic category, and they also predisposed staff to work with each older resident as an individual with a life history that is significant, remembered, and cherished. The facilitating conditions eased the movement of the five categories as they flowed into the core category. As shown in the figure 13, the quality of
Figure 13: Maintaining Identity: An Heuristic Outlining Staff Members’ Perceptions of Quality of Life

Properties
- Showing concern
  - Involvement in decision making
  - Identifying preferences
  - Protecting the continuity of the older person’s self
- Physical environment
  - Interpersonal environment
  - Organisational flexibility
- Holistic care
  - Individualising care
  - Establishing empathic relationships
  - Fostering positive staff attitudes
- Enhancing health & independence
  - Providing protection
  - Advocating preferences & concerns
- Family & social activities
  - Individual activities
  - Reminiscence activities

Categories
- Respecting the older person
- Creating a home-like environment
- Providing quality care
- Fostering well-being
- Encouraging meaningful activities

Supporting Processes
- Respecting
- Individualising
- Establishing empathic relationships

Core Category
- Non-task oriented care
  - Continuity of staff
  - Reciprocity & empathy
  - Open visiting policy
  - Homely atmosphere

Facilitating Conditions

Maintaining Identity

Fostering well-being
Encouraging meaningful activities

Providing quality care

Respecting the older person

Creating a home-like environment

Showing concern
Involvement in decision making
Identifying preferences
Protecting the continuity of the older person’s self

Physical environment
Interpersonal environment
Organisational flexibility

Holistic care
Individualising care
Establishing empathic relationships
Fostering positive staff attitudes

Enhancing health & independence
Providing protection
Advocating preferences & concerns

Family & social activities
Individual activities
Reminiscence activities

Respecting

Individualising

Establishing empathic relationships

Non-task oriented care
Continuity of staff
Reciprocity & empathy
Open visiting policy
Homely atmosphere

Facilitating Conditions
life of the older residents is constructed through the presence of all the facilitating conditions and supporting processes that contribute to the promotion and balance of maintaining identity. However, as the heuristic suggests, the absence of one of the facilitating conditions will expose the model to over-balance and will have a detrimental impact on quality of life.

5.9 Summary

This chapter has described the findings of the second series of interviews with the staff members that comprised the study, highlighting in particular the dynamic processes of conducting a grounded theory study. Working within a grounded theory approach, using constant comparison, the author constructed a model of quality of life for staff members with the supporting processes being named as: (a) Respecting; (b) Individualising care; and (c) Establishing empathic relationships. This model was generated through the author’s theoretical sensitivity to the data. A description of the concepts, categories and their properties that emerged from the data was offered from a theoretical perspective. Next the discovery of the core category of ‘maintaining identity’ was introduced and its relevance to the lives of the older residents was considered and finally the conditions facilitating the process of ‘maintaining identity’ were introduced.
CHAPTER 6

Results: Family Carers

_They are well aware of my desire to remain involved in the care of my brother and they make me feel welcome_  
(Interview: F5)

6.1 Introduction

This chapter will begin with a description of the emergence of the concepts, categories, their supporting properties on a model of quality of life that emerged from the experience of eight family carer before moving on to an overview of the emergent and generated theory. The four categories that emerged from the data are: (a) staff-relative relations; (b) staying in contact with the family; (c) personalised care that is responsive to residents’ individual needs; and (d) valuing a safe and homely environment, each being evidenced by its properties. The properties associated with each of the four categories will be explored when each category is introduced. Illustrative quotations from the participants are included throughout the chapter, as well as extracts from the author’s theoretical memo book.

6.2 Category 1: Staff-Relative Relationships

Upon constantly comparing and analysing data from family carers the category staff-relative relationships emerged and it had three properties: quality of relationship, frequency of contact, and level of trust. Most family members in this study were moderately involved in caregiving prior to admission of their relative to the nursing home and continued to be involved after their older family member moved to the nursing home. When the extent of caregiving in the community was high, participants were most likely to perform physical caregiver tasks in the nursing home.
6.2.1 Property: Quality of Relationship

Family caregivers sought a personalised relationship with the care providers in the nursing home; personalised in the sense that the care team both understood the needs specific to the caregiver’s situation and displayed empathy. In the absence of a personalised relationship, it was more difficult for family caregivers to have a sense that their experience was understood and considered important by the health care providers, and thus more difficult to promote their viewpoint regarding care of their loved one. For certain families, attention paid by the staff to their loved one’s tastes and habits could make a major difference in their perception of both personalised care and being listened to in order to assure a quality of life for their loved one:

“You know, my brother has some difficulty in swallowing and chewing solid food, and we used to give him soft diet at home. Sometimes I used to even give him mashed food. So when we brought him to this nursing home I told the nurses about his problem and now they always give him soft diet and whenever I am not here during lunchtime they supervise him very closely.”

(Interview: F5)

“She comes and checks on her every morning making sure that her hair is well combed and she looks presentable. She makes sure that she is wearing her earrings and her necklace, because she knows she loves wearing her jewelry, she asks her about her grandchildren cause she knows she likes to talk about them, so it’s really a matter of listening.”

(Interview: F 6)

Personal and responsive relationships were associated more often with small but important details in the care routines, which tended to result in more personalised care. Nurses working in this way concentrated on the older resident rather than the task itself, and they sought significant details about a resident’s preferences, such as the importance of having facial makeup, and about how they liked to dress. Such information was used to influence care delivery, which was further personalised by explicit involvement of the resident and their family members.
Personalised relationship was recognised by the author in a theoretical memo made shortly after interview F6:

“It is very important to note that a personalised relationship is built between the family and the health care providers upon entering of the older relative the nursing home. To be able to have a trusting and supportive relationship it is essential to construct this relationship over the months or years of the relative’s time in the nursing home. Health care providers need to understand the importance of working with family carers and to spend time with families to validate this partnership. Family and health care provider collaboration requires the building of good relationships. The purpose of this relationship for the family carer is to ensure the best quality of care and assuring that they would be part of the care team.”

(Theoretical memo book entry: 26.01.2010)

From this theoretical memo book entry, the author extrapolated the words ‘personalised relationship’ to describe the quality of relationship between the family carer and the health care provider.

An important characteristic of the empathic behaviour was staff valuing the relative’s knowledge of the older resident and discussing this with them so that it could be incorporated into the care plan. For example, staff asked relatives how they had performed care at home and whether the cared-for person had any special interests and/or certain likes or dislikes about food. Staff saw this as being particularly important if the cared-for person could not articulate their own needs. However, the extent to which relatives were encouraged to contribute to this process varied, with the majority being unaware of whether a detailed assessment of the older person’s needs had taken place, or whether a care plan existed. Nursing home staff occasionally failed to draw upon the knowledge and expertise of family caregivers in developing plans of care for residents.

Another important characteristic of empathic behaviour was staff being attuned to relatives’ wishes to remain involved (or not) in direct care. Examples of the type of care that relatives helped with was feeding and taking the cared-for person for walks:
“I visit him every day and I bring him food from home. I come to feed him during lunch time only. He eats breakfast and dinner with them and there are days that I can’t come so he eats lunch with them, there is no problem. Whatever food he asks for I cook and I bring for him.”

(Interview: F5)

To this older resident food brought from home symbolised maintaining family bonds and kept the older resident in touch with what was happening at home. It symbolised enjoyment, pleasure and contentment. It enabled the older resident to continue to experience and express his identity and to have desired continuity with the past.

It is important to note that a relationship of quality, for the family caregivers, is built from the first interaction upon entering the nursing home and it is essential to construct this relationship over months or years of the loved one’s time in the nursing home facility.

### 6.2.2 Property: Frequency of Contact

One of the greatest dissatisfaction expressed by family caregivers who participated in this study related to the limited contact between themselves and the professional staff working with their family member. Certain caregivers wished that regular meetings with the geriatrician in charge were planned in addition to an admission interview. In their view, such meetings would provide an opportunity to receive answers to their questions from knowledgeable professionals, an understanding of the condition of their relative, reassurance, with doubts dispelled:

“Every time I come to visit my father I ask the nurses and the staff about him and they tell me he is fine, but it is important for me to take the opinion of the physician about my father’s condition. Although they are very nice, I wish they could meet with us once in a while to answer our questions. When he asks for something they try their best to do it quickly.”

(Interview: F6)

For other family carers, a regular, but not necessarily frequent, contact (once every two months) would be sufficient especially if the condition of their relative was stable:
“It would be a good suggestion to have someone who really knew my relative meet with us once every two to three months.”

(Interview: F8)

Increased frequency of contact between family carers and health care providers seemed to enhance the quality of life of both the residents and their families. Almost all family members visited the resident more than once a week and the majority stayed for more than one hour. Family members who had a closer kinship, lived closer to the nursing home and/or were emotionally closer to the resident, visited the resident more frequently.

6.2.3 Property: Level of Trust

Trust between family caregiver and the care team existed when the family caregiver perceived that the care team intervened in the best interest of their relative. This trust was accorded on the basis of the professional status and medical knowledge of the care team. Thus, occasionally, caregivers had a high level of trust already established before their loved one entered the nursing home. However, for many other caregivers, trust was built through interactions with the care team in the nursing home setting. A number of elements facilitated establishing trust: regular contact with the family, advising families of changes in the loved older relative’s condition, establishing a personalised approach, and considering the family as a partner in the care of the older resident.

The relatives expressed that it was of utmost importance for them to feel that their opinions were taken seriously, and that their narratives about the residents’ earlier life-history were trusted and taken into account in the care of the resident. They wanted to be listened to and taken seriously when they talked to staff. It was obvious that the relatives wished to have an influence on how the care was carried out, but they did not know how to communicate this wish. Being asked about their opinions and being invited to participate in small tasks
made the relatives feel recognised, welcomed and appreciated. Not being taken into account made them feel neglected and not valuable:

“I think that trust is very important. It is really important for the family to trust the staff otherwise your conscience will not be clear because we are not with him every minute. I come and visit him every day but still they are the ones who actually are taking care of him. They usually consult me before a treatment for example or before taking a decision.”

(Interview: F2)

Family carers also placed a great deal of importance on how nurses demonstrated their interest in their relative. When they observed that staff members were on familiar terms with their relative or showed respect and human kindness in their contacts with residents, this bolstered their trust:

“From the start, I found that he was really surrounded…and the staff weren’t nice with just father either; they were with all the others as well… You listen in when they’re in the room talking, sometimes they don’t even know you’re there, they didn’t see you come in…they’re just not the type of people who are going to be rude with older people.”

(Interview: F3)

“Well they all love him, he tells me “sister they all love me, they get me things, they do things for me, they bathe me…” well to be fair they are all good hearted. They love all the older people. There are many employees that I love, they tell me come and see your brother, come and check on him every day.”

(Interview: F4)

As theoretical sensitivity to data increased, it became apparent that the family caregiver-health care provider relationship was built from the moment that the older person entered the nursing home, through regular contact over the entire course of institutionalisation up to the time of death of the loved one. A relationship of quality where the values and beliefs of each person were recognised and trust was established allowed the construction of a solid foundation for exchanges between the family and the health care providers.

The category of establishing staff-relative relationships was characterised by the properties of: quality of relationships; frequency of contact; and level of trust, as illustrated in figure 14.
6.2.4 Theoretical Reflections

After analysing the third series of interviews the author returned to the data and started to read and re-read all the interview transcripts (Interviews F1-F8). Frequent listening to the audiotapes, especially during transcription, helped to capture the powerful statements of the participants that led to the development of the codes, as further shared below:

“Our relationship with the staff members is almost familial. We often spend several hours at the nursing home on most days. I visit the nursing home in order to share pleasurable events such as coffee and dinner with my brother. We have a trusting relationship and our roles are well understood and negotiated openly. They are well aware of my desire to remain involved in the care of my brother and they make me feel welcome. However, I personally would like to meet with the geriatrician in charge of my brother more frequently.”

(Interview: F5)

Therefore, establishing ‘personalised relationship’ between family carers and staff members emerged as an antecedent condition of having a good quality of life. The most positive experiences described by family members were when they were able to work in partnership with staff, and the best relationships between family carers and staff featured open communication and involvement in care decisions that led to trusting relationships in which mutual roles were understood and negotiated openly. All the participants’ experiences with nursing home were therefore dependent upon good relationships with staff members. Accordingly establishing personalised relationship with staff became the first supporting process of the emerging model. Once the first supporting process was
identified from the data, the author returned to her theoretical memo fund and interview transcripts to begin the task of discovering the next supporting process(es) of the emerging model.

6.3 Category 2: Staying in Contact with the Family

The possibility of staying in contact with the family was reported as a category contributing to quality of life of the older resident. This category emerged mostly through data from family carers and has three properties: being a link to the community, providing personal comfort and emotional support, and acting as advocate of the older resident. The personal knowledge that the family carer had about the older person in combination with efforts aimed at the continuation of the relationship with the older person represented the relative’s unique contribution to enhancing the quality of life for the older person within their new home. However, this was not purely altruistic as most relatives continued to experience strong feelings of love and affection towards the older resident and perceived enormous benefit to themselves from their continued involvement. This was recognised by the author in a theoretical memo:

“Families maintained their emotional bond through visits with the resident and regular updates about family events and, sometimes through continuing pre-established care giving activities. In the family carers’ view, they were experts on the needs, values, and expectations of their relative. The most positive experiences described by family carers were when they were able to work in partnership with staff, confident that their views and opinions are taken into account and thus remaining involved in direct care of their older relative. They possessed a need to have their role and local knowledge afforded respect by the health care providers.”

(Theoretical memo book entry: 25.03.2010)

As the data intimates, a sense of worth was experienced in terms of family possessing special knowledge about the older resident which qualified family caregivers as experts in the care of their older relative. Such knowledge was described in terms of knowing the family context and history, and possessing a personal knowledge of the older resident
which was deemed important in providing an identity for the resident unknown to the nursing staff. Such information was critical in social approaches where continuity of life experience for the resident was emphasised. In the family carers’ view, they were not authorities on the provision of nursing care in general, but were experts on the needs, values and expectations of their older relative. They took and viewed their role very seriously and needed to have their expertise in providing personal care afforded respect by the nursing staff.

Family carers also described their continuing efforts to ensure that members of staff were aware of the older resident’s identity, likes and dislikes. Sometimes this involved facilitating communication between the older resident and staff within the nursing home. Often, maintaining continuity of life experience of the resident involved using their initiative and knowledge of the older person to make suggestions about ways in which their needs could be met.

6.3.1 Property: Being a Link with the Community

Being a link with the community refers to the family carer as being a ‘carrier’ between the nursing home and the community. Family carers considered that it was their responsibility to visit; to keep up contact; bring outside information to their relative; update the resident on other family members; check that everything is ‘okay’; remain involved and continue to share a fruitful relationship with their older relative. Residents in the nursing home were often vibrant members of their families and communities. To assume that they are no longer interested in the ‘outside world’ is to deny them the right of citizenship. Family members who continue to engage and inform the resident of current events contribute to fostering the residents’ identity and purpose:
“My daughter got married and she delivered a baby girl, so I brought them here so my aunt could see them and we all sat in the garden. My aunt was so happy to see them.”

(Interview: F1)

“My responsibility towards my brother is to come and visit him everyday, to see that everything is ok…to do whatever the nursing home doesn’t do. I take him to my house on special occasions and update him on other family members.”

(Interview: F8)

The sense of continuity was characterised by a fear of change, a loss of continuity, and a fear of ‘being forgotten’. The risk of having one’s role as carer downplayed, prompted all family carers to seek prospects that keep them involved in their relatives’ daily care and that allow updates on the latest community developments. Accordingly, maintaining family ties, rituals and routines assumed considerable significance. Thus, family carers ensured that their relative was aware of life outside the nursing home, and maintained cherished routines in their relationship. The family carers’ ability to cope with caring in an institutional context was powerfully affected by the possibilities of sharing with their relative the familiarity of happier past times and family traditions. Such sharing empowered family carers to continue to seek meaning in the future care of their older relative.

6.3.2 Property: Providing Comfort and Support

Family carers thought that providing ‘little extra things for the older person’ would enhance his/her quality of life. These included getting extras or treats, providing personal items and providing home-cooked meals. This component of responsibility demonstrated the personalised service that only family and friends were able to provide the resident:

“I get him everything he asks for. I cook everyday and I bring him food with me, and I feed him lunch in here. He loves pastrypastry with thyme so much, well whatever he asks for I bring him, if he asks for my soul I would give it to him.”

(Interview: F5)
Providing emotional support included visiting, looking for the resident’s personal well-being, and making sure that the resident was happy and comfortable. A sister whose brother was 66 years old at the time of the interview illustrated the meaning of this emotional support when she commented:

“I don’t feel I have any responsibilities in terms of the nursing home, but as his sister, I am still responsible for his psychological welfare.”

(Interview: F4)

According to the family carers interviewed, their main role was to visit older relatives, keep them company, read to them and take the resident out. Families saw themselves as a link with the outside world and a link with the resident’s past. Some family carers stated that they helped with their relative’s personal care and were happy to provide whatever care they could. This willingness to continue a caring role is demonstrated in the following quote:

“When I am here my role is, if she needs to go to the bathroom I’ll take her, if she needs to change her clothes I’ll help her do that, I help her while eating, or anything like that.”

(Interview: F2)

Part of the role of the family carer was to ‘keep an eye’ on the staff by observing the care their relative received and by trying to ensure that the staff members were providing the quality of care considered acceptable.

6.3.3 Property: Acting as an Advocate

Many family carers could be thought of as advocates when they stated that their responsibility to the older resident was ‘to be her/his voice,’ ‘to fight her/his battles for her/him,’ and to be a ‘mediator.’ The importance of advocacy was commonly expressed in terms of possessing ability, a degree of control, with which one is capable of negating the impact of the less than desirable aspects of nursing care which threatened quality of life.
Most family carers perceived their responsibility to be ensuring ‘proper care,’ ‘good care,’ and ‘that their needs were looked after.’ As the sister of an older male resident stated:

“My responsibility is to see that he is cared for. I come to visit him every day to let staff know that someone is watching. Although here they have good services to be honest and they watch for their residents.”

(Interview: F8)

This was recognised by the author in a theoretical memo made shortly after the interview:

“In the nursing home advocacy role of the family carer seemed to be characterised by serving as role model in the fulfillment of certain tasks, developing relationships with the staff to make a commitment with them to resolve problems, and providing surveillance of the care of their older relative.”

(Theoretical memo book entry: 25.03.2010)

Thus a sense of purpose and worth was experienced in actively contributing to the quality of life experienced by their relative, and actively working toward achievement and improvement in their relative’s condition.

In brief, the category of staying in contact with the family comprised the properties of: being a link with the community; providing personal comfort and emotional support; and acting as an advocate of the older resident, as illustrated in figure 15.

6.4 Category 3: Personalised Care

Personalised care was derived from the data and had three properties, namely requiring the staff members to assist the residents in maintaining identity and self-esteem, requiring the staff members to preserve the residents’ dignity, and requiring the staff members to create opportunities for autonomy and privacy to the residents. Family carers expressed a preference for personalised or individualised care that showed sensitivity to residents’ individual interests and needs. Moreover, family carers appreciated staff members who were kind and pleasant with their older relative. One family carer reported:
“The nurses, they come in and talk to them by name...They hug them. They also kind of tease my father. He always liked to tease and joke around, so they always do that. So they treat them real special and we appreciate that.”

(Interview: F7)

**Figure 15**

Thus, elements of a social approach, such as building meaningful connections between residents and staff, were a valued component of quality of life for family carers. In contrast, care that neglected the personal element upset the family respondents. They wanted staff to show interest in residents with personal, pleasant conversation, they also wished for special touches in care delivery. One daughter suggested that perhaps what was missing in her mother’s care was ‘not enough individual attention’. She added ‘combing the hair or may be doing her nails’ would be special for her mother.

Perceived lack of care and insensitivity to residents’ appearance and dignity was often attributed to staffing shortages, as noted by the following excerpts:

“I am concerned sometimes that they have enough staff and that they’re cued in to individuals.”

(Interview: F6)
“If possible, they should have more nurses on duty to take care of the residents. By increasing staff numbers, staff has the extra time needed to get to know residents and personalise care.”

(Interview: F7)

Family carers knew that adequate staffing was necessary for quality care and that low staffing levels prevented workers from getting to know residents well enough to meet their individual needs and preferences.

6.4.1 Property: Identity and Self-esteem

Maintaining the older resident’s dignity was a central and challenging goal for family members and required biographical expertise which was an intimate knowledge of the older relative and could only be gained from a long shared family history with the older resident. Specifically, biographical expertise gave the family caregiver privileged insight into the older resident’s likes, dislikes, idiosyncrasies, needs and vulnerabilities. This was based on respect for personal preferences, needs and vulnerabilities. They appreciated staff members who enabled residents to ‘be themselves’, as shown in the way they dress, the items they choose to bring to the nursing home, and the control they have over personal space. The aim was the maintenance of personality and identity and the prevention of rapid decline:

“Oh yeah, the hairdresser comes in. The hairdresser comes in whenever she wants you know. We get permission whenever she wants. She likes to have her hair in good shape. That’s the way she likes it.”

(Interview: F2)

Knowledge of the relatives’ family life, past, personal values, desires, and expectations enabled family carers to focus their caring role on the things that they knew their relative had liked in the past. Knowing that they were making a worthwhile contribution to their relatives’ quality of life provided a great source of pleasure and a positive reward. Preserving personal care to ensure a quality existence was important. Family carers very
much wanted to see the staff members treat their relative as a person and not as an object of care, something they viewed as a key indicator of high quality care. They very much appreciated when the staff regarded their older relatives as persons with rights, and assisted them sufficiently with activities essential to maintain their unique personality or identity:

“He has been an active and independent person. He has this talent... He can make speeches and whenever, on occasions, they need somebody to speak on behalf of the older residents, they send after him.”

(Interview: F7)

“He is very happy, like at home. He has his room with his roommate, and he has his own furniture; he also has his small table from home.”

(Interview: F7)

Anxiety was experienced when family carers perceived professionals to possess little capacity to appreciate the personal needs and wants of their relative:

“It happens that he (the father) has not been taken out of the bed when I come, but some days they are just too busy to manage that.”

(Interview: F3)

When family carers gave negative examples of care, they usually tried to find explanations for this insufficiency, for example that the ward was short of staff, or that the things complained about happened only occasionally.

6.4.2 Property: Dignity

Family carers appreciated staff members taking a person-centred approach to the care of their relative; treating them with respect, knocking on their doors, listening to their preferences and whenever possible offering them choice. They saw one of their roles as being to monitor the quality of care that their relative receives. This required achieving a balance between the technical aspects of care, largely seen as the province of staff, and the personal, biographical knowledge of the family carer. Carers expected nurses actively to seek such knowledge, for example, regarding the older resident’s likes and dislikes, hopes and aspirations, and to incorporate this into their care planning. This blending of technical
and biographical knowledge was intended to maintain the dignity and self-esteem of the older resident:

“Well my brother doesn’t like to wake up early in the morning and since he is confined to the wheelchair he needs their help in his morning care. We tell them finish all your work and then come to him because he knows that if they are going to start with him they will be in a hurry, that’s why he likes to stay till the end in order to have his bath and this way he can sleep more too especially that he stays up late at night.”

(Interview: F8)

The biographical approach was not just about staff gathering information on the resident, but it also involved the resident and the family in the process of gathering and reviewing the information, and in negotiating how care was to be delivered to ensure it was helpful and appropriate:

“I think the staff attitude has changed a lot. Before, they just used to deliver physical care to my father, but now they are talking to him more. I think their relationship is better, and regarding communication, there has been a big progress. Now there is respect; they encourage the verbalisation of feelings; they prioritise nursing care activities in response to the residents’ care needs, they also attend to their psychosocial needs.”

(Interview: F7)

Taking a biographical approach aims to understand ‘what matters’ to the individual, including their values and wishes. The value of such approaches may be two-fold. Firstly, the review of one’s life story to date and its integration into the present and the potential future may be therapeutic for the older resident. Secondly, the process and outcomes of such work can enable the staff to get to know individual residents well and to work with them on tailoring care accordingly. Taking a biographical approach required that family carers work in partnership with staff to enhance the quality of life of the older resident. It follows that, by transcending the data, working in partnership with staff in order to remain involved in direct care of the older resident became the next supporting process of the emerging model.
6.4.3 Property: Opportunities for Autonomy

This category was explored by focusing on two key aspects of autonomy: involvement in decision-making and exercising choice. Family carers identified the inclusion of the older residents in decision-making as an important aspect of quality of life. Most family members were not sure if their relative was consulted about their care or not. Some suggested that the illness of their relative made consultation difficult:

“Since my aunt is here every day and it has been almost a year now and the nurses are here every day, so by now they know what my aunt wants and what she doesn’t like.”

(Interview: F1)

Family carers emphasised the importance of having choice during the day. Choices about the time residents were woken, had breakfast, went back to bed, had meals and what they did during the day were identified by the respondents as important. It was also evident from the respondents’ accounts that choice could only be facilitated when there was flexibility in care giving routines. Care was demonstrably more routine based, which had an important effect on the residents’ ability to make choices. Rigid policies and inflexible rules are likely to have repercussions for partnership working and shared decision-making.

Family carers were divided regarding the extent to which they perceived that the residents had choice. The majority suggested that the residents did, whereas two stated that they did not. However, these respondents attributed the lack of choice to the resident’s disability rather than to practices in the care environment. Mealtimes were set at fixed times for the majority of residents and most days were scheduled accordingly. Only one of the family carers stated that his relative could choose his mealtime because he had a small refrigerator in his room. This was greatly appreciated by the older resident and positively contributed to his quality of life:

“Dinner is served at 5:30pm and everybody has to eat at this time. My father is not used to sleeping early and he likes to eat at a later time. So we got him a small
The degree to which relatives were able to participate in shared decision-making depended to a large extent on the relationships they were able to develop with the staff. The most positive experiences were described when family members were able to work in partnership with the staff and when their opinions were taken into consideration.

To sum up, personalised care that meets the older residents’ individual needs rests on: requiring the staff members to assist the residents in preserving their identity and self-esteem; maintaining their dignity; and creating opportunities for autonomy, as illustrated in figure 16.

6.5 Category 4: Valuing a Safe and Homely Environment

Valuing a safe and homely environment was reported as a category contributing to quality of life of the older resident. This category emerged through data from family carers and has two properties: safety and security, and physical environment. Family carers made it clear that they favoured features and care routines that created a more home-like environment and experience for their older relative. Their preferences were consistent with the social approach whose main goal was the creation of residential settings that resembled the natural aspects of home and community life, in terms of physical features of the housing, the mealtime experience, daily routines, safety, and personal choice issues.

6.5.1 Property: Safety and Security

Certain family members developed tremendous confidence in the residential centre. They were aware that things were not perfect, but they felt that existing problems were minor and did not undermine their trust in the nursing home’s staff. Often, they compared their relatives’ current situation, especially as regards safety and security, with what they had
Figure 16

- Quality of relationship
- Frequency of contact
- Level of trust

- Being a link with the community
- Providing comfort and support
- Acting as advocate

- Identity and self-esteem
- Dignity
- Opportunities for autonomy

Staff-relative relations

Staying in contact with the family

Personalised care

gone through prior to the placement, concluding that their relative was safer in the nursing home under the supervision of the staff and that they did not have to worry about him/her any more:

“He is safe here and it’s better for him and for us. Although he loves to go out, but we are comfortable that he is not on the streets, for example, not hit by a car, well psychologically we are relieved, it’s best for us and for him too.”

(Interview: F4)

“Being here is much better for her than anywhere else. In here they have a better care, special food, at home we used to make food that she wasn’t supposed to eat because of her disease, and here she is provided with everything. She feels she is at the best place and she always talks about how much the nurses care for her. She loves them very much.”

(Interview: F1)
Attempting to make a theoretical connection between these similar experiences led the author to place the following entry in her theoretical memo book:

“Although family carers were aware that things were not perfect, it seemed that trust allowed them to leave their older relative in the care of nursing staff without worrying. What they had observed since their relative’s admission to the nursing home had allowed them to develop a good level of confidence in the facility and its staff and that living in the nursing home facility was much safer for their older relative.”

(Theoretical memo book entry: 26.01.2010)

After completing the series of interviews and constantly comparing experiences, it was noted that valuing a safe environment by the family carers could represent the third supporting process of the emerging model.

6.5.2 Property: Physical Environment

Family members when asked what they particularly like or dislike about the physical environment of the facility, their responses highlighted positive features of the environment, such as cleanliness, lack of odor, lack of noise, home-like atmosphere, safety, private space, comfort, and outdoor space. Some openly admitted that the physical environment was not more important than care delivery. Quality care and security issues were of greater concern to family carers. They favoured care routines that created a more home-like environment and experience for their resident family members. These families centred their criticism on aspects of care that violated the goals of more social, person-centred approaches. Lack of social engagement and participation by residents, for example, upset family members, though such features as centralised living rooms and enhanced outdoor space were to promote community and social involvement:

“When I come to visit him and see him sitting all alone I tell him go to the living room and watch television, do something, don’t just sit there or lie down, no, do something, walk, watch a movie. I feel so happy when I see him do these things.”

(Interview: F3)
To conclude, valuing a safe and homely environment is ensured by the properties of safety and security, and physical environment, as illustrated in figure 17.

**Figure 17**

<table>
<thead>
<tr>
<th>Properties</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>• Quality of relationship</td>
<td>Staff-relative relations</td>
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<tr>
<td>• Frequency of contact</td>
<td></td>
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<tr>
<td>• Level of trust</td>
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<tr>
<td>• Being a link with the community</td>
<td>Staying in contact with the family</td>
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<td>• Providing comfort and support</td>
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<td>• Acting as advocate</td>
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<td>• Identity and self-esteem</td>
<td>Personalised care</td>
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<td>• Dignity</td>
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<td>• Opportunities for autonomy</td>
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<tr>
<td>• Safety and security</td>
<td>Valuing a safe and homely environment</td>
</tr>
<tr>
<td>• Physical environment</td>
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</tr>
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</table>
6.6 Maintaining Continuity: Developing the Core Category

In her attempt to transcend the data in order to find the core category, the author was struck by family members striving to ensure the continuity of the life experience as lived by their loved one:

(1) Family carers demonstrated eagerness to carry additional responsibility, especially in areas of personal care and activities; they also showed the same positive attitude regarding the delivery of all sorts of care.

(2) Family carers were aware of the importance of establishing partnerships with staff members resting on effective communication, and on the realisation by the staff of both the aim of family carers to maintain their involvement in care delivery, and to acknowledge their unique familiarity with the older residents.

(3) Family perceptions of good quality care were conditioned by shared care and education between the family carers and staff members.

(4) Family carers regarded themselves as a connection with the outside world and with the older residents’ past.

(5) Family carers defined the major components of their role as consisting of paying visits to their older relatives, keeping them company, reading for them, and taking them out.

By going back and forth between data, the author focused upon the idea that what the data was revealing was that family carers were primarily aiming to ‘maintain continuity’ of the older residents. Discussing this observation with her supervisors, the explanatory power of ‘maintaining continuity’ to link the identified categories and their properties appeared to have the necessary ‘fit and grab’ of grounded theory (Glaser, 1978). By identifying the core category of ‘maintaining continuity’, a relationship could be built directly between the
family carers making efforts to ‘maintain continuity’ for the older residents on the one hand, and their attempt to create personalised relationships with the staff members, keeping the older relative in contact with the family, assuring personalised care for the older relative, and valuing a safe and homely environment for the older relative on the other hand. Therefore ‘maintaining continuity’ was considered the core category and principal psycho-social process at this moment in the study and prior to theoretical integration of the emergent models (Glaser, 1978). This core category stood for a conceptualisation of the relationships between the identified categories, their properties and the supporting processes. Thus, ‘maintaining continuity’ helped residents to remain ‘in contact’ with the family, ensuring personalised care for the older relatives, and valuing a safe environment.

For the family carers, maintaining the older residents’ continuity of life experiences represented an essential determinant of life satisfaction. In addition, the author depended on her theoretical sensitivity to the data in the interpretation of the family members’ perception of quality of life relating to the older residents.

Figure 18 illustrates an heuristic outlining the family carers’ meaning of ‘quality of life’ as expressed in the framework of maintaining continuity, including the categories, their properties and the supporting processes.

6.7 Facilitating Conditions to the Process of ‘Maintaining Continuity’

It emerged from the interviews conducted with the family carers that their ability to maintain continuity for the older residents depended upon conditions that facilitated the process of ‘maintaining continuity’. As figure 18 reveals, the identified facilitating conditions were: staff supporting and facilitating family visits; staff-relative partnership; staff responsiveness to family carer’s knowledge; and empathic awareness. Such conditions were considered pivotal in ‘maintaining continuity’ of the older residents. Their
Figure 18: Maintaining Continuity: An Heuristic Outlining Family Carers’ Perceptions of Quality of Life

Properties
- Quality of relationship
- Frequency of contact
- Level of trust
- Being a link with the community
- Providing comfort and support
- Acting as advocate
- Identity & self-esteem
- Dignity
- Opportunities for autonomy
- Safety and security
- Physical environment

Categories
- Staff-relative relations
- Staying in contact with the family
- Personalised care
- Valuing a safe and homely environment

Supporting Processes
- Personalised relationship
- Partnership with staff
- Safe environment

Core Category
- Maintaining continuity
  - Staff
  - Supporting family visiting
  - Staff-relative partnership
  - Staff being responsive to carer’s knowledge
  - Empathic awareness

Facilitating Conditions
function was to improve communication and collaboration between staff members and family carers and create a harmonious working environment, which in turn influenced the meaning of quality care. In the opinion of family carers, these facilitating conditions assisted them in striving to maintain a sense of self in the residents, encouraging them to have a sense of belonging, and promoting a sense of autonomy. They also eased the movement of the four categories as they flowed into the core category. As illustrated in the model (figure 18), ensuring the older residents’ quality of life rests on the presence of all the facilitating conditions and supporting processes which serve to enhance and balance maintaining continuity. In the event that one of the facilitating conditions is compromised, the model would over-balance and be at risk of collapse.

6.8 Summary

This chapter has described the findings of the third series of interviews conducted with the family carers, and it particularly has underlined the dynamic processes of conducting a grounded theory study. Working within the framework of a grounded theory approach and using constant comparison, the author constructed a model of quality of life for family carers with the supporting processes being named as: (a) personalised relationship; (b) partnership with staff; and (c) valuing a safe environment. This model was generated by the author’s theoretical sensitivity to the data. A description of the concepts, categories and their properties that emerged upon data analysis was offered from a theoretical perspective. Subsequently, the discovery of the core category of ‘maintaining continuity’ for family carers was introduced, its relevance to the lives of the older residents was considered and finally the conditions facilitating the process of ‘maintaining continuity’ were introduced.
A Theoretical Integration of the Developed Models

The credibility of the theory should be won by its integration, relevance and workability
(Glaser, 1978 p. 134)

7.1 Introduction

As discussed in Chapter 3, grounded theory aims to produce theories of ‘fit and grab’ driven by properties of process, which makes sense to the lay person. So far, the author has outlined the properties of process attached to the models of quality of life generated separately from the perspectives of the older residents, staff members, and family carers. This chapter aims to add a further conceptual layer to this process by theoretically integrating the models at different phases in their trajectory by adopting the dimensions and strategies already outlined. This process resulted in the identification of four basic social processes involved in achieving an optimal quality of life, namely: (a) having a sense of comfort and security; (b) engaging in worthwhile activities; (c) having significant relations; and (d) holding spiritual beliefs. More importantly, by improving the understanding of shared experience in nursing home life, the integration of the models resulted in the identification of the linking scheme ‘maintaining interrelationships’ and the core category ‘relating’ that subsumed and assumed the previous three core categories outlined in the preceding chapters. In this reconceptualisation, ‘maintaining self’, ‘maintaining identity’, and ‘maintaining continuity’ now functioned as sub-core categories (Glaser, 1978) in the integrated model. As the core category for the integrated model, ‘relating’ was discovered to have temporal dimensions that work on maintaining, sustaining, restoring and creating interrelationships.
7.2 Integrating the Models

As seen in chapters 4, 5, and 6 respectively, by implementing a grounded theory approach following the work of Glaser (1978) this study has, so far, outlined the properties of three core categories: ‘maintaining self,’ ‘maintaining identity,’ and ‘maintaining continuity’. At present, however, these models remain separate entities which, while offering a ‘best fit’ conceptual description of the phenomenon under study, do not fully capture the complex dynamics surrounding quality of life as a collective experience, i.e. that seen, lived, and negotiated between older residents, staff members, and family carers. That said, the author has attempted to make some tentative conceptual links towards a more integrated model when outlining the categories and properties ascribed to the emergent quality of life models. Thus, in order to continue the building of theory as a process, the author will now theoretically integrate the three generated models to produce a more complete explanatory framework of quality of life.

7.3 Integrating the Perspectives of Older Residents, Staff Members and Family Carers

To best understand the multidimensional concept of nursing home quality of life, a comparative analysis was undertaken to theoretically and conceptually integrate the models and perspectives of the older residents, the staff members, and the family carers. This analysis resulted in a new, integrated multidimensional model of nursing home quality of life which was underpinned by four interrelated basic social processes:

1. Having a sense of comfort and security
2. Engaging in worthwhile activities
3. Having significant and friendly relationships
4. Holding spiritual beliefs
These basic social processes are interrelated and illustrate the essence and complexity of the participants’ perspectives of quality of life. The sequential relationship is important. Older residents, who experience a reasonable degree of comfort and security, are more likely to be involved in meaningful activities organised by the nursing home. They can also see some meaning in life, build friendly and significant relationships, and maintain existing relationships. Older residents, who consider themselves as persons of value, have friendly relationships, and hold spiritual beliefs, can be said to have a reasonably good quality of life. These four basic social processes are now described in more detail.

7.3.1 Having a Sense of Comfort and Security

Adaptation to life in the nursing home starts a process which the author has named ‘having a sense of comfort and security’. Within the scope of the presented grounded theory, having a sense of comfort and security, engaging in worthwhile activities, having significant relations, and holding spiritual beliefs are all considered basic social processes as they have temporal dimensions with a discernible breaking point that allows them to be perceived as a theoretical whole (Glaser, 1978). The basic social process of having a sense of comfort and security emerged upon the integration of the categories identified previously and upon analysing the data. It captures the dynamic that exists in managing the early processes of adjustment as attempts are made by all stakeholders to help the older residents adapt to nursing home life.

Both the family carers and the staff members had an important role in helping the older residents adapt to nursing home life. Instead of providing 24-hour care, the family carer assumed the role of assuring quality of care within the nursing home setting. As discussed in the properties associated with ‘maintaining continuity’, family carers wanted to participate in delivering quality nursing care to their loved ones within this new
environment. They shifted from their role of care provider to the one of care ‘advocate’, assuring their loved one’s well-being and trying to find new ways of caring for their older relative. Through their engagement in providing care, family carers tried to actively seek meaning in terms of experiencing a personal sense of feeling useful, worthwhile, and satisfied with the quality of care experienced by their relative. Family involvement and advocacy were linked to positive outcomes for both the residents and the family carers. Family carers experienced a sense of worth in terms of possessing special knowledge about their older relative and whilst they did not consider themselves authorities in the provision of nursing care in general, they did see themselves as experts in the needs, values and expectations of their relative. A sense of purpose and worth was experienced in actively contributing to the quality of life of their older relative.

Staff members valued the family carers’ knowledge of the older residents and frequently discussed it with them so that this biographical knowledge could be incorporated into the care plan. As discussed in the supporting processes of ‘respecting’ and ‘individualising’ of the [previous] core category ‘maintaining identity’, staff members asked family carers how they had performed care at home and whether the cared-for person had any special interests and/or certain likes or dislikes about food or any other aspect of care. Whilst the partnership with care staff was first identified in the family carers’ model, its theoretical application to the staff members’ actions is equally relevant. Just as family carers sought to create partnerships with staff members, staff members also grasped the importance of creating partnerships with family carers through the basis of good and effective communication. For care staff, this partnership led to an awareness of both the desire of family carers to remain involved in the care of their relative and also the recognition and validation of their unique knowledge of their older relative.
Older residents experienced safety in the nursing home, which emanated from being in an environment that could meet needs of treatments, diagnosis, support, and in which the participants knew what was going on. Older residents and family carers expressed the need to have confidence that residents would be cared for 24-hours a day, that staff would assume responsibility for helping each resident, and that staff would consistently meet residents’ needs. They expressed the need to feel that they can talk with staff about any concerns they have about the care or environment. Older residents and family carers also felt the need to be free from fear of harm from staff or other residents. Safety also represented experiencing honesty in answers and actions, not receiving conflicting messages or experiencing contradictory actions, as well as feeling confident that needs and requests would be responded to quickly. Experiencing safety also involved the cleanliness and appearance of the physical environment for family carers especially; these indicators were a reflection on how their older relative would be cared for in the nursing home.

It should be noted that the feeling of security experienced by older residents has also been seen as leading to feelings of well-being. This was explained in the data through the older residents having gained wisdom in later years and being more able to adapt to their new surroundings. By making the nursing home comfortable and providing a safe environment that takes account older residents’ individual circumstances, quality of life can be enhanced. Health can be promoted through spending time in personally meaningful and enjoyable ways, such as by socialising, sharing, physical activity and exercise, as explored further in the next basic social process.

7.3.2 Engaging in Worthwhile Activities

Analysis of the data revealed that the three groups of participants expressed the need to have worthwhile activities in life. They all believed that such purpose and meaning could
stem from an obligation, responsibility, or from an enjoyable task or activity. Moreover, the data suggests that providing worthwhile and stimulating activities for nursing home residents plays an important part in the physical, emotional, and mental health of the older residents. Accordingly, the basic social process of ‘engaging in worthwhile activities’ emerged upon the integration of the categories identified previously upon analysing the interviews and reported models. By engaging in activities the older residents considered to be worthwhile, they were able to maintain a sense of self, their personal dignity and continuity with the past. When they took part in activities, the benefits of participation far outweighed the benefits of any one activity in and of itself.

Whilst meaningful and worthwhile activities were first identified in the older residents’ and staff members’ model, its theoretical application and transferability to the family carers’ actions is equally relevant. Just as older residents and staff members valued the importance of meaningful activities to the quality of life of older residents, family carers believed that activities fostered feelings of belonging to the nursing home community. Friendships developed and older residents gained a sense of accomplishment and feelings of self-worth that may have been overshadowed by feelings of loneliness and depression. Regardless of their personal health or circumstances, older residents repeatedly expressed the need to ‘have something to do’. As discussed in the previously identified core categories of ‘maintaining self’, ‘maintaining identity’ and ‘maintaining continuity’, the three groups of participants all mentioned the importance of ‘keeping busy’ in relation to well-being. This process occurred when most of the participants underlined the centrality of stimulating activities to their quality of life, including reciprocal activities such as helping other residents, which also made them feel valued. Thus, the pursuit of meaningful
and worthwhile activities was important to older residents for retaining their interest in life and in keeping themselves busy and active.

The types of activities that the nursing homes provided depended partially on the residents’ health and interests. It was essential that all residents had the opportunity to participate in activities even if their performance of the activity, or their participation, was somewhat modified. For instance, a resident living with Alzheimer’s disease enjoyed sitting in a wheelchair quietly moving back and forth as other residents took part in a sing along, whilst another bedridden older resident enjoyed listening to the music and felt satisfied by just clapping.

There were also similarities between the groups regarding their views on what made activities worthwhile and meaningful. Most participants appeared to use the concept of ‘enjoyment’ as a measure of the meaningfulness of activities. Conversation with family and friends and singing were some of the most common activities during which this state was experienced. Activities were also seen to be meaningful when they addressed the residents’ psychological needs. Older residents spoke about the feeling of being useful, concern for others and their identities, autonomy, and belonging as indicated in comments such as “anything that’s needed...as long as there wasn’t a big job, I wouldn’t mind doing it”, and “just to learn that they know you’re there, and they are there if you want anything”, highlighting the importance of social inclusion. Participants expressed their personal identity through a variety of means, the most visual being the personalisation of their private space. Older residents who had a room of their own had the best opportunity to create a personal space.
The older residents’ sense of identity was strongest when they perceived harmony between their sense of their own value and uniqueness and other people’s actions conveying their worth. Staff members and family carers also touched upon some of these needs that are met primarily through quality interactions, which residents reported they valued. Older residents reflected some ambivalence about engaging in activities they used to do in the past, which may relate to a fear of seeing oneself fail in a previously skilled task. Staff and family carers, however, valued activities which were seen to be therapeutic and produced a positive response, such as organised trips and sessions facilitated by the activity organisers. This related to their perceptions that physical exercise and preservation of skills and abilities was important. By contrast, older residents with disabilities experienced restricted participation and social isolation, and consequently engaged in more passive activities than their non-disabled counterparts.

Receiving visitors served the purpose of enabling residents to feel connected to the outside world. An older resident described visitors as bringing news from outside and helping her to keep up to date on social events occurring within the family. Residents reported that the open visiting policy, especially in the absence of set times for visiting hours in the facilities, helped their families maintain contact because many carers worked and would have found it difficult to visit if visiting hours were restricted.

Involvement in worthwhile and meaningful activities in the nursing home could provide feelings of being able to participate in and make a contribution to one’s life and other people’s life, foster self-esteem, experience a sense of group belonging, prove usefulness to others, maintain unity with the past, and anticipate the future, with the result that older residents are enabled to maintain a sense of self-worth, a sense of human dignity, and a sense of continuity. Preserving self was a key task for the older residents and revolved
around the three elements of maintaining one’s own identity and continuity through the past, present and future. Involvement in regular and well-planned activities lightened any personal feelings of burden and improved social interaction with peers in the nursing home.

7.3.3 Having Significant Relationships

Older residents who had a sense of comfort and security and engaged in worthwhile activities seemed more able to maintain significant relationships and develop new ones. It appears from the data that relationships with staff members, family carers, and fellow residents were a principal concern for all the participants in this study, with significant and friendly relationships denoting a good quality of life. The basic social process of maintaining interpersonal and friendly relationships was identified in the three models of the older residents, staff members and family carers and as such it represented a concern for the three groups of participants. The three groups valued the major role played by interpersonal and friendly relationships in enhancing the older residents’ quality of life. Close bonds with others created a feeling of a maintained self, identity and continuity.

Older residents defined friendly relationships with staff members on the basis of the latter’s caring attitude and behavior, whereas the staff members perceived the significance of relationships on the basis of the degree of reciprocity they experienced with their residents and on the basis of the emotional connection they established with them. Family carers determined the significance of relationships between their older relatives and the staff members according to the positive effects of the staff members’ behaviour on their relatives’ well-being. All groups spoke about the need for points of connection, but they mentioned inadequate staffing and workload as barriers to the staff members’ devotion of time to meaningful one-to-one relationships.
Older residents and family carers explained that it is essential that staff be attentive and caring with residents and truly listen to what residents say, that staff really talk with older residents and take time with them. It is important that residents, even those who were cognitively impaired, are engaged in conversations with staff. Ignoring or dismissing cognitively impaired residents on the basis of their diagnosis, or treating them in a less than humane and respectful way is perceived as poor quality care.

Older residents considered that developing a close relationship with the staff members rested mainly on having a confidant whom they see as sharing their concerns, having their best interest at heart, acting on their own initiative, and being reliable. They believe the staff members want the best for them or they see them as their own children. Working on one’s own initiative is a manifestation of a friendly relationship as seen in the little unsolicited gestures made toward older residents. The familiarity of staff members with the older residents, their preferences, and routines is a prerequisite for such an initiative to take place. From the perspective of the staff members, feeling connected formed the pivot of a close relationship with residents. The development of this bond is consolidated by possessing knowledge about the older residents and reciprocity in exchanging life stories and personal information. It is this life knowledge that enabled staff members to understand the residents’ needs and emotions and to deliver care that satisfied their needs. Staff also understood reciprocity as a mutual togetherness, a commitment, and a partnership created between older residents and themselves.

Family carers employed different strategies to foster the integration of their older relatives in their living environment. The aim of these strategies was to adjust their actions/interactions to the new conditions under which their advocacy role was to be exercised. Family carers described a close relationship between staff members and older residents in terms of
a caring attitude displayed by staff members, including a genuine sense of concern and a focus of attention. These attributes were interpreted as wanting the best for their older relatives and fostered a collaborative exchange and relationship.

The ways in which older residents, staff members and family carers interact in connection with care routines greatly influenced interpersonal relationships in the nursing home. This suggests that understanding and valuing everyday ‘routines’ is a useful starting point in supporting the development of positive relationships between residents, staff members and family carers. Nursing care provider socialisation with residents and their families could be incorporated into the residents’ overall plan of care and re-evaluated when the care plan is reviewed or when the residents’ health status changes.

7.3.4 Holding Spiritual Beliefs

Spirituality referred to the affirmation of life in a relationship with God, self, and environment. It was depicted as the drive for meaning and a sense of purpose in life. It provided older residents with a sense of connectedness and was characterised by certain identifiable values with regards to self, others and life. Spirituality also involved the act of being connected with a divine being through the act of prayer and worship. Holding spiritual beliefs provided a sense of purpose, meaning, spiritual nourishment and renewal which generated quality of life.

The basic social process of holding spiritual beliefs created a positive outlook for older residents. Here, residents could exercise their choice to actively participate in maintaining their relationships and look to establish new ones. Having long-term relationships provided a sense of history and emphasised continuity of relationships that, in turn, contributed to self-identity and self-worth. The construction of social networks offered various degrees of
assistance such as emotional support. Maintaining a sense of continuity, whether by preserving self-identity or through the preservation of familiar surroundings, remained important while older residents underwent life transitions. All of the participants described praying and religious activities as a major focus in the older residents’ lives. Praying provided a sense of purpose, responsibility, or simply a source of fellowship. Older residents reported that God played a central role in providing the strength enabling them to deal with daily challenges. Their spirituality was seen as a source of emotional support, a positive influence on health, and contributing to life satisfaction and quality of life. They discussed how it alleviated their worry which is known to cause adverse effects on a person’s health. Most of the older residents explained that they were spiritual all day and prayed for their families and communities throughout the day. Spirituality was also directly connected to the older residents’ emotional well-being and positive attitude toward life.

Participants spoke of their spirituality as preserving continuity with the past, shaping reflections on life, guiding present thoughts and actions, and providing an active strategy to face difficult times. Religious beliefs acted to buffer feelings of helplessness engendered by perceptions of the uncontrollability of their illnesses. The respondents characterised their beliefs as giving them a sense of hope, purpose, and control, with prayer providing a vehicle for emotional expression. Older residents emphasised continuous religious beliefs as the main factor ensuring continuity between their past, present and future. Consequently, spirituality was seen to play an important part in the residents’ ability to cope with illness and stress, and maintain well-being. For older residents, spirituality played an increasingly important role in determining quality of life, especially toward the end of life.
7.4 Relating and Maintaining Interrelationships: Developing the Core Category and the Linking Scheme

As the author realised that each of these four basic social processes emerging from a re-analysis of the data and developed models had the ‘fit and grab’ necessary for the generation of substantive grounded theory, she attempted to transcend the data to conceptualise a linking scheme that embodied the three core categories identified by the three groups of participants. This theoretical exercise was undertaken much along the lines of Glaser and Strauss (1965) and their generation of an ‘awareness context’ to conceptually link the experience of dying in hospital. In her use of theoretical sensitivity to the data to explore the subjective experience of nursing home life, the author hit upon the idea that those in the study, older residents, staff members and family carers, strove to experience relatedness by preserving and maintaining interpersonal relationships in their lives.

Discussion between the supervisors and the author during planned supervision sessions shared these ideas and the concept of ‘relating’ and ‘maintaining interrelationships’ supported by the four identified basic social processes and their properties. A connection could instantly be made and examples included older residents wanting to build trusting relationships with staff members, staff members trying to establish empathic relationships with older residents and family carers, and valuing personalised care that is responsive to the residents’ individual needs. From this theoretical insight, the core category of ‘relating’ and the linking scheme of ‘maintaining interrelationships’ emerged. This linking scheme integrated all aspects of care provided in the nursing home by the three groups of participants, which would maintain an optimal quality of life for the older resident, consisting of ‘maintaining self’, ‘maintaining identity’, and ‘maintaining continuity’, now
re-named as sub-core categories as suggested by Glaser (1978). In the integrated model, these interrelated sub-core categories were conceptually connected through the linking scheme of ‘maintaining interrelationships’. These sub-core categories and the linking scheme of maintaining interrelationships became subsumed under the core category of ‘relating’. The integrated model as expressed through the processes of ‘relating’ and ‘maintaining interrelationships’ is illustrated in figure 19.

### 7.5 An Integrative Model of Quality of Life

Quality of life is multidimensional and as figure 19 suggests, can be explained in a conceptual model that integrates the views of the older residents, staff members, and family carers. This theoretical integration of the three models generated in chapters 4, 5, and 6 added a further conceptual layer to the process of outlining the processes and the properties attached to the models of quality of life. The theory emerged as the relationships between the core category, the linking scheme, the basic social processes, the sub-core categories and the social actions combined into an integrated framework that helped explain the phenomenon of quality of life in the substantive area of nursing home life for older residents in the Lebanon. Here, staff members are providing an important service by addressing the needs of family carers who have members in need of nursing home service. The importance of staff members and how staff is essential to meet each resident’s individual needs and promote quality of life are recognised in the integrated model (figure 19).

Older residents, staff and family carers are acknowledged as vital to the mission of the nursing home. Quality of life is central to the model and therefore on figure 19 it is placed
Figure 19: Relating: An Integrative Model of Quality of Life
at the centre of the set of circles and linked into the sub core-categories and the social actions necessary to keep the model revolving and balanced. The three interacting and overlapping sub-core categories ‘maintaining self’, ‘maintaining identity’, and ‘maintaining continuity’ therefore form a contextual and dynamic background for the core category of ‘relating’. When taken together, this contextual background formed the basis for the older residents to experience the centrality of ‘relating’ through ‘maintaining interrelationships’. ‘Relating’ and ‘maintaining interrelationships’ promote a good quality of life for older residents through a unification of ‘maintaining self’, ‘maintaining identity’, and ‘maintaining continuity.’ If any of the identified social actions are missing or fail to be realised, then, in this heuristic, quality of life will be compromised.

As will be more fully addressed shortly, ‘relating’ is the core category in the integrated model. Optimal quality of life is sustained, restored and created by being related to the forces and processes that constitute the elements in figure 19; in other words, the best life can be in any given situation. For example, the need to sustain ‘relating’ in everyday life was seen in the data through the need for interaction of the older residents with others, their environment and the community. This interaction was related to resident well-being and offered reassurance and contentment. An inability to sustain ‘relating’ resulted in the older residents feeling isolated and experiencing relationship dissatisfaction, which in turn could lead to psychological distress and a diminished quality of life.

Beginning to describe the properties of the core category ‘relating’ and the linking scheme of ‘maintaining interrelationships’ validated Glaser’s (1978) assertion of the notion of trust in the analyst. The author’s theoretical sensitivity to the data and immersion in the field were the crucial factors in generating a substantive grounded theory. It also helped to explain why the formulation of classic grounded theory is such a time-consuming task,
although the author enjoyed its fulfillment. The relevance of ‘relating’ and ‘maintaining interrelationships’ to the older residents, staff members, and family carers suggests that a theoretical integration of the three models yielded yet further insights. Older residents enjoyed a good quality of life as they experienced ‘relating’ through ‘maintaining interrelationships’ with the four interrelated basic social processes. If one of the basic social processes is taken away, then the model will start to lose its shape and foundations and be at risk of collapse. What is needed for quality of life is for all the basic social processes to be present so that ‘relating’ is in place and balanced as reflected in figure 19.

The emergent theory embraces a global multidimensional, holistic approach to viewing quality of life which includes all aspects of the older residents’ life and focuses on the comprehensive nature of quality of life. The integrative model also suggests that quality of life is a dynamic personal construction that is enhanced by sustaining, restoring, and creating ‘relating’. In this model, ‘relating’ sustains an assenting existence because older residents are social beings that thrive on interactions. Personal interactions and connections generate a positive feedback loop. Older residents who sustain, restore, and create relationships receive fulfillment and validation, which allows them to perpetuate an interactive and communicative cycle. When older residents are unable to sustain these social actions, the feedback loop does not occur and quality of life is diminished. For example, according to the data, older residents sustain ‘relating’ and generate quality of life when they watch their favorite movie, sing Christmas carols and so on. These seemingly minor everyday events are powerful affirmations of self that become an opportunity to nurture and generate quality of life. As mentioned earlier, these social actions were seen as a hinge on which the constructions of quality of life are supported.
7.6 ‘Relating’: the Core Construct of the Theory

The explanation of the core category of ‘relating’ in this study includes an individual’s degree of involvement with self, others, objects, environment, and society, and the concomitant rate of satisfaction or dissatisfaction connected with that involvement. Thus, the term ‘relating’ in this study refers to a state of interactive presence and interpersonal attachment. Support for this position is found in the suggestion made by Hagerty et al. (1993) who viewed relatedness as a functional and behavioural system rooted in early attachment behaviours and patterns. Preserving interrelationships with the self implies acting in accordance with one’s feelings and values; preserving interrelationships with others is also defined as creating opportunities and a predisposition to communicate with others, including family, fellow residents and staff members. These links maintain a positive outlook on life since humans are social creatures that thrive on communication.

Maintaining interrelationships with the environment denotes making conscious steps to relate oneself to the personal living environment by spatial orientation, contentment with daily routines and personal safety measures. Older residents sustained interrelationships with society by being updated on their children’s and grandchildren’s activities, birthdays, and accomplishments, and by being updated on the daily news cycle. Those who preserve interrelationships with their personal and global society and reject being marginalised, created a sense of ownership, stewardship, and continuity that paved the way for an assenting existence producing quality of life.

The bond to the family, community, nature, the Creator, land, environment, ancestors, and traditional lifestyle carries a deep spiritual dimension. In fact, the literature underscores the role of interrelationships in the nursing home residents’ comfort and that of community dwelling older people. The preservation of interrelationships connotes a socially
constructed meaning and gives a sense of security. The experience of ‘relating’ within specific relationships is a function of higher levels of interrelationships. Interrelationships characterised with a high conflict are accompanied by a low sense of relatedness that may bring about feelings of hopelessness, with a possible negative cycle into depression. This is a multifaceted phenomenon that can be observed from the different perspectives of psychological, sociological, physical, and spiritual dimensions of the individual. The preservation of interrelationships creates a shared sense of socially constructed meaning, thus giving individuals a sense of security and satisfying their relatedness needs. The core category of ‘relating’ acts as a means through which older residents sustained, restored, and created the most useful and meaningful relationship with staff members and family carers.

‘Relating’ and involvement with others was integral for nursing home life and quality of life. These interrelationships represented social ties that reinforced acceptance and contributed to friendships, belonging and reassurance. Close relationships between residents contributed greatly to ‘relating’ within the nursing home. A reciprocal relationship with staff also contributed to quality of life in the nursing home. Where staff provided emotional and/or psychosocial care, e.g. by sharing their own life experiences, residents reported this affirmed respect and feelings of worth. Therefore, quality of life was sustained and restored by the types of relationships older residents held with fellow residents, staff, their families, and the community, and was related to residents achieving each of the four basic social processes displayed in figure 19. The heuristic in figure 19 therefore has an explanatory power that is necessary for a grounded theory model (Glaser, 1978) and provides a mechanism for theorizing quality of life that is available for further empirical testing and refinement.
7.7 Summary

This chapter commenced with the identification of four basic social processes that emerged from the interaction of the categories and the sub-core categories identified from the data earlier in the study. The four basic social processes were: (a) having a sense of comfort and security; (b) engaging in worthwhile activities; (c) having significant relations; and (d) holding spiritual beliefs. Thus quality of life can be said to be about living in a home that gives pleasure and feels safe, engaging in stimulating activities, having significant relationships, having the needs of the spirit recognised and met, thus experiencing a sense of normality in the nursing home. Working within the framework of a grounded theory approach and the integration of the generated models to produce a more complete trajectory of quality of life paved the way for the discovery of the core category of this grounded theory, ‘relating’, and for the introduction of the linking scheme ‘maintaining interrelationships’. The core category and the linking scheme were seen to be meaningful and have the ‘fit and grab’ necessary to fulfill the criteria for a substantive grounded theory. The generation of this model was made possible by the author’s theoretical sensitivity to the data.
CHAPTER 8

Discussion and Conclusion

*Long-stay care settings are not places to die: they are places to live and live well*

(Murphy et al., 2006 p. 229)

8.1 Introduction

It is the purpose of this final chapter to begin to pull together some of the threads that have informed this thesis, and to reflect upon theoretical, methodological and policy/practice issues that it raises. In this chapter, comparison between the presented theory with the existing and recent literature relevant to the research will be presented so that it is possible to assess the enhancement to knowledge made by this work. On the basis of the findings, recommendations for changing the perception of ageing in Lebanon, educating healthcare professionals, and improving the nursing homes are presented. Finally, the chapter will highlight the main study limitations before providing a brief personal conclusion.

8.2 Restating the Study Findings

The data generated in this study consolidates the major themes highlighted in the literature in that the results are comparable to those achieved in Western studies (Bradshaw et al., 2012; Crespo et al., 2012; Register and Scharer, 2010; Cooney et al., 2009; Murphy et al., 2007; Hjaltadottir and Gustafsdottir, 2007; Kane et al., 2005; Tester et al., 2004b), although they present more sophisticated indicators for quality of life relative to nursing home care in Lebanon. The findings of this study support previous research findings that regard quality of life as a complex phenomenon related to all aspects of human life and closely associated with a person’s living conditions (Murphy et al., 2007; Register and Herman, 2006; Robichaud et al., 2006; Bowling and Gabriel, 2004; Leung et al., 2004;
Bowling et al., 2003; Shannon, 2002; Anderson et al., 2000; Hagerty et al., 1993; Hagerty et al., 1992).

In addition to providing a description of quality of life from a Lebanese perspective, this study represents a theoretical construction of the categories and processes conducive to maintaining quality of life for nursing home residents. The theory presented in this thesis maintains that experiencing a sense of comfort and safety, participating in worthwhile activities, building friendly and strong relationships, as well as holding spiritual beliefs were found to be central to experiencing ‘maintaining self’, ‘maintaining identity’, and ‘maintaining continuity’ through ‘relating’ that is recognised as the core category in this classic grounded theory study. Another development was made to the effect that the linking scheme ‘maintaining interrelationships’ creates positive expectations and gives meaning to the life of the older residents, staff members, and family carers. As Keady and Williams (2007) have previously contended, what is important is that the presented theory makes sense to those it purports to represent and has the ‘fit and grab’ necessary to communicate its central ideas to the lay person.

The importance of feeling safe and secure within the older residents’ environment is a recurring theme in this study. Developing an increased sense of security and personal safety since moving into the nursing home is underlined by the residents and their family carers. The findings of Tester et al. (2004a) and Edwards et al. (2003) show a relationship between experiencing a sense of comfort and safety on the one hand and quality of life on the other hand. Having this sense is also linked to a sense of belonging, security, independence, and purposefulness (Cooney, 2011; Murphy et al., 2009; Bowers et al., 2009; Hauge and Heggen, 2008; Low et al., 2007). Comfort and security promoted peace of mind in the resident, thus allowing space to personalise their own living area which also
enhanced their well-being. As seen in the integrative model in this study, comfort and security impacted significantly on the quality of life of the older resident. The exploration of quality of life in older residents in a nursing home milieu by other researchers (Bowers et al., 2009; Nolan et al., 2004; Edwards et al., 2003) has identified factors similar to the ones shared in the present study.

Family carers suggested that the nursing home should be homelike and that the nursing home must move from the present institutional focus. They also stressed that residents should be involved in decision making and should have choice and control. The need for nursing home environments to be more homelike was also identified by Murphy (2007) who suggested that such environments were more likely to be friendly, interpersonally safe and relaxed.

The two nursing home facilities who took part in this study provided activities for the older residents. The significance of participating in activities comes from the belief that they allow the older residents to spend time enjoying a pleasant experience, rather than develop or maintain their skills which some may say is a more worthwhile activity (Timonen and O'Dwyer, 2009; Kalis et al., 2005; Ice, 2002; Mckee et al., 1999). As seen in this study, activities also create an opportunity for the establishment of relationships and the maintenance of identity. It is also believed that small group activities are better suited for the older residents (Cooney, 2011; Kane, 2003).

The identification of each resident’s priorities necessitated transcending the instrumental notion of individualised care to grasping the effects of care on that resident. In a comparable framework, Bowers et al (2001) depicted ‘care as relating’ whereby the staff members relied on personal relationships built in the care routines to meet the little needs that mattered to the older residents. It appeared that the prospect for the promotion of
relationships, as far as the older residents and their family carers were concerned, depended on the staff members’ empathy, trustworthiness, and adoption of a steady behavioral pattern (McGilton et al., 2003; Sandberg et al., 2002). Placing trust in the staff members relied on their past experience and facilitated the establishment of confidence-based relationships. McGilton and Boscat (2007) referred to the establishment of such relationships in the frame of close and personal ties between the staff members and residents in nursing homes. According to Ronch (2004), shifting the focus from task-based care to the relationships developed between the older residents and staff members is likely to be advantageous to both parties. In the context of this study, this scenario became evident when the older residents and the staff members described their relationships from the perspective of the care delivered and of each person’s contribution to the relationship. Reciprocal relationships resulted from the staff members’ negotiations of options with their colleagues, older residents, and family members, with each seeing value in their input. Indeed, as previous studies have reported, a fundamental aspect of quality of life in residential care is being able to develop new relationships and maintain existing ones (Bradshaw et al., 2012; Murphy et al., 2006).

In the research conducted by the author to report this study, two of the older residents were cautious in dealing with other residents and staff. They were guarded in establishing relations with other residents, especially those whose behaviours and actions provoked concern and upset. Interestingly, neither of these participants informed the staff of these events as they did not know what the staff-resident relationship should look like. This highlights the need for better quality information and a more egalitarian model of support. Here, staff members should be taking the lead to create such social actions and conditions necessary for the resident to feel confident in themselves and their sense of agency. Put
simply, staff need to ascertain what is preventing such residents from engaging and, more importantly, feeling empowered to engage.

Findings from this study also corroborated previous research and literature about spirituality. The American Occupational Therapy Association (2002) suggests that spirituality is “the fundamental orientation of a person’s life; that which inspires and motivates that individual” (p. 623), whereas Baptiste (2003) suggests that spirituality may be viewed as “one’s inner culture” (p. 83). That is, culture is said to evolve from shared values and beliefs of individuals. The significant contribution of spirituality to quality of life found in the present study suggests there is a need for nursing homes to create opportunities to support and enhance spiritual practices. Interpersonal connectedness and relatedness with a higher being or some purpose greater than oneself may be especially important in the lives of older residents. Participants in the study spoke openly of the meaning and importance of spirituality in their lives, with many stating that without it ‘you have nothing’. Spirituality, though complex and often ambiguous, has a definite impact on who we are, what we become, and how this is accomplished (Williams, 2008). Moreover, previous research findings suggest that spirituality has been linked with positive states of well-being, a reduction in depression and morbidity, and an increase in the lifespan of older adults. (Burack et al., 2012; MacKinlay and Trevitt, 2010; Wallace and O’Shea, 2007; Crowther et al., 2002).

Participants in this study regarded self, identity, and continuity as major factors influencing the older residents’ quality of life. Maintenance of self, identity, and continuity for the older residents can be ensured by reinforcing self-care routines that are similar to their past habitual activities (Register and Scharer, 2010; Jensen and Cohen-Mansfield, 2006; Cohen-Mansfield and Jensen, 2005; Tester et al., 2004a). The findings of this study
suggest that the routine imposed on the nursing home older residents hindered the preservation of their routines and habits, a conclusion also reached by the international literature (Cooney, 2011; Jensen and Cohen-Mansfield, 2006; Tester et al., 2004a; Lee et al., 2002). In fact, self-care activities, such as getting up in the morning or going to bed, were not preserved upon admission to the nursing home, as Jensen and Cohen-Mansfield observed (2006). For Aberg et al. (2004), continuity represents a major part of the cherished routine activities. The majority of participants often emphasised the aspects of resident-centred care that helped them maintain the person they were, and carry on with their previous way of life. Edvardsson et al. (2010) reached similar conclusions and suggests that staff members plan care in accordance with the older residents’ needs, and not with their own. They also suggest that the fulfillment of tasks should not compromise the time spent with the older residents and their family members. This process of ‘relating’ could therefore be considered a bridge to help further understanding and shape practice development.

8.3 Contribution to Knowledge

The author began the present study motivated by a desire for a better understanding of the experience and meaning of quality of life for nursing home residents in order that clinical practice in the Lebanon might improve. Consistent with a grounded theory approach (Glaser and Strauss, 1967; Glaser, 1978), the aims of this study evolved having been driven by the notion of theoretical sampling and the constant comparative method. Data collection initially resulted in the development of three distinct and separate models of the experience of quality of life reported from the perspective of older residents, staff and family carers. The theoretical integration of these models into one, with the emergence of the linking scheme of ‘maintaining interrelationships’, and the core category of ‘relating’, resulted in driving forward understanding of quality of life. Although still in need of
further empirical testing, the substantive grounded theory is considered to have utility at a number of levels adding to knowledge and understanding of quality of life, whilst also having the potential to inform policy and practice in nursing and care home practice.

The underlying principle justifying the application of a Glaserian approach to grounded theory was explained in Chapter 3. In light of this approach, the two fold objectives consist of producing and testing theory with a view to interpreting and predicting human behaviour in the framework of a distinct area of study (Glaser, 1978). However, the assessment of the validity and soundness of the interpretations offered by grounded theory is ensured by its own criteria. In this regard, theory as process is a major foundation of a Glaserian approach to grounded theory with the result that theory interprets and predicts human behaviour and enhances knowledge. The theory described in this thesis has the ‘fit and grab’ (Glaser, 1978) necessary to highlight the temporal characteristics of the phenomena under study.

The results of the reported study underscore a need for greater humanisation in Lebanese nursing homes and triangulation of viewpoints with each care partner ‘relating’ to one another. Managers, nurses, and doctors need to accord respect to the residents’ views during service delivery as these residents spend part of the most important stage of their life in the nursing home. An appropriate sense of community should be created in the alternative living milieu in such a way that it involves the staff members and family carers and respects each individual’s life engagement (Crist, 2000). By offering a clearer picture about the residents’ needs, the results raise the nurses’ awareness about what matters to residents. In addition, further empirical research can build on the findings and extend the applicability of quality of life indicators (Low and Molzahn, 2007; Robichaud et al., 2006).
The findings also contribute to the existing literature by allowing a deeper understanding of the way the older residents experience good quality of life in Lebanon and the way it can be facilitated by care staff. Up until the reporting of this study, contemporary research literature has lacked a Middle-Eastern perspective on the meaning and construction of quality of life in nursing homes and the findings of this study therefore bring new insights, particularly to the substantive contribution of ‘relating’ and ‘maintaining inter-relationships’. Arguably, the findings can also be applied in clinical practice when nursing staff take into account the views and meanings provided by residents and family carers. It is important that future research studies build upon the foundation presented in this thesis.

8.4 Contribution of the Synthesised Model to the Field

Understanding the dimensions of quality of life from the perspectives of the residents, staff members and family carers is an important step toward achieving a good quality of life. Much of what was learned from this research would seem to be achievable. Quality of life in nursing homes in the Lebanon is multidimensional and can be explained in a conceptual model that integrates the views of older residents, staff members and family carers. This model encompasses broad categories, three sub-core categories, a linking scheme, and a core category with its supporting processes and social actions which can assist in interpreting the multidimensional concept of nursing home quality of life and the variety of approaches to measuring it. The conceptual model displayed in figure 19 will help guide quality improvement efforts. The integrated model contributes to the literature by providing a conceptual basis for reflecting upon and evaluating nursing home quality of life. It provides broad principles rather than rules of thumb to be used in practice. This means that nurses and other healthcare professionals can apply findings by integrating them with their own professional practice and reflecting upon what these understandings mean in nursing home settings. As an understanding of quality/quality of life advances,
new or additional features of the model may emerge. If this happens, it will be necessary to refine the model to ensure it reflects accurately the complex, multidimensional nature of nursing home quality of life. A well-developed conceptual model can guide research and instrument development. Moreover, the integrative model in this thesis highlights the features of quality of life and orients older residents, staff members, family carers and policy makers to features that, in the spirit of quality improvement, should be operationalised, maintained, and/or improved.

8.5 Attributes of a Good Quality of Life in Nursing Homes in Lebanon

This study demonstrates that older residents highly value identity and maintaining a sense of self in nursing home life. The importance of personal identity is supported by other researchers in the field (Cooney et al., 2009; Winter and Artinian, 2009; Age and Opportunity, 2003). The feeling of being ‘at home’ is experienced by the residents whose identity finds expression in their physical appearance, personal belongings, spirituality, and the use of personal space. The preservation of identity and encouraging self-expression depend to a large extent on the personalisation of the residents’ life in nursing homes (Cooney et al., 2009).

This study indicates that social support family members lend to the older residents is a basic determinant of a good quality of life. However, it disagrees with one conducted by Patterson (1995) in a United States nursing home study that suggested that social support came mostly from the nursing staff, not from family members. A potential explanation for this dichotomy could be that children in the United States experience greater autonomy in their relationship with their parents, in contrast to Lebanon where traditional family values still occupy a prominent position whereby older people positively receive support from
their family carers. However, this observation is in need of greater research and empirical testing.

Most of the residents interviewed in this study asked for additional relatedness with the outside world. The visits paid by family carers and friends play a major role in maintaining the residents’ contact with their home and community. The works of Cooney et al. (2009), Tester et al. (2004b), Age and Opportunity (2003) also underlined the importance of social relationships as basic features of care home practice, and indicated that social relationships established with fellow residents, caregivers, and family members are seen by the older residents as fundamental to quality of life. From the findings of this study, it would appear that ‘relating’ [to the care home environment] could be improved by adopting more flexible and personal values, such as by adopting an open visiting policy, a welcoming and homely atmosphere, and close ties with the local community.

The findings of this study suggest that it is necessary that gerontological nursing specialists ‘get to know’ the older residents individually, using personal, comprehensive knowledge of their personal and family biography to better interact with them and their families. The biographical approach is important in creating a ‘caring community’ (Heliker, 1999), which is an important factor for both the older residents and their family carers (Davies and Nolan, 2002). These findings are consistent with the results of Clarke et al. (2003) who showed that the biographical approach strengthens the individuality of the older resident, consequently promoting person-centred care. Furthermore, the approach strengthens relationships across the board, between the older resident, staff member and family carers.

In this study it was found that there was not always enough staff to allow for the building of personalised relationships to promote individualised services, supporting values and preferences to create more of a community. The provision of additional staff in each of the
participating nursing homes may have enabled more individualised relationships to grow and flourish, as individual staff members would have more time to learn residents’ preferences (Doumit and Nasser, 2010). Educational resources could also be employed so that staff members develop the necessary communication and interactive skills.

Good quality care is an important factor in quality of life (Holtkamp et al., 2000). Older residents need to be cared for by knowledgeable staff members who treat them with respect and kindness, and are able to professionally address personal characteristics (Ford and McCormack, 1999). This study reinforced the values underpinning relationship-centred care (Wilson et al., 2009; Ryan et al., 2008; Nolan et al., 2004; Nolan et al., 2002) and it has also shown that staff support positively impacts upon the residents’ quality of life (Jacelon, 2002; Bowers et al., 2000). Participants in the current study emphasised that their quality of life was closely ‘related’ to their relationships with other residents, staff members, and family carers supporting other qualitative research. Indeed, Williams et al. (2009, p. 45) argued that “relational practice lies at the heart of high quality care for older people”. In previous studies, for example Jacelon (2002), it was found that when the staff did not have time to interact with residents, the residents were not able to sense a rapport with staff and, as a result, felt a loss of dignity. The older residents also considered relationships with ‘outsiders’ important and often enjoyed seeing new faces in the nursing homes. These ‘outsiders’, who include volunteers, researchers, research assistants, and transitional students, encouraged older residents to maintain links and sustain relationships with significant people outside the nursing home, improving life quality.

As mentioned earlier, socialising with others generated a great deal of pleasure for the older residents. For many residents, relating through maintaining interrelationships stems from relationships with family members that also represented a continuity of their previous
lives outside of the nursing home. To those without family or friends, relationships with staff and peers were even more important, a phenomenon also seen in other studies (Jacelon, 2002).

Participants in this study needed to feel at home while in care in order to comfortably express their individuality, which they made manifest through appearance, memory, possessions, spirituality, and personal space. Many residents greatly treasured photographs and enjoyed speaking at length about the people or events depicted. Photographs provided relatedness to residents’ past lives, prompted memories and seemed to help maintain their sense of identity. Moreover, conflicting with the conclusion of Molzahn (2007), spirituality was also found to be a significant component of quality of life of older residents in this study. However, some older residents found that living with residents who were cognitively impaired was both difficult and distressing, a finding which is in need for further investigation and research (Buckley and McCarthy, 2009; Chao and Roth, 2005; Ragneskog et al., 2001).

Continuity theory (Atchley, 1999, 1989) argues that as people grow older they strive to preserve continuity in their activities, behavior, habits, thinking, relationships, values, and attitudes. Central to the continuity theory is the assumption that older people continue to use the adaptive strategies they developed in earlier life to interpret what is happening and adapt to change (Atchley, 1999). The older residents’ social life does not have to come to an abrupt end when they are admitted to the nursing home. Adams (1987) and Matthews (1986) found out that older adults maintain the motivation and ability to initiate friendships, while social networks have proven to be pivotal in the lives of the majority of older adults. Maintaining a sense of continuity, both in self-identity and in familiar surroundings, remains essential as the older residents experience life transitions. Typically
the older residents were attempting to maintain continuity by dealing with the new environment in familiar ways, by searching for linkages and familiarity; they were trying to maintain continuity with their ‘old’ life through the continuation of their usual personal routines, for instance by dressing the way they used to, or by having a bath when they usually would.

8.6 Promoting Resident-Centred Care in Nursing Homes

Considerable efforts are required to reframe existing programs or create new ones that carry out resident-centred practices. Recent evaluations point to challenges in implementing resident-centred philosophies (Edvardson et al., 2010; Edvardson et al., 2008; Eales et al., 2001). Researchers have found fundamental difficulties in actualising the new philosophy of person-centred residential care (Whitler, 1996; Clemens et al., 1994). A failure of staff members to involve residents in realising their choices, in addition to conflicts between what the residents want and what the case managers believe they need, are amongst such challenges (Whitler, 1996). According to Hofland (1994), much work needs to be done to put this resident-centred approach with its personalised care plans into everyday action. In this study, the participants’ narrations suggested that the core of quality of life was experienced as ‘relating’. All participants repeatedly described how ‘relating’ included aspects that supported the older resident in being the person they were and supported them to continue with a life as normal as possible. Examples of such aspects of ‘normal life’ included being addressed and acknowledged as a valuable person who people know and respect and being provided with opportunities to do enjoyable things and make decisions about everyday life.

A key element of resident-centred care is control over decision-making. Some professionals believe that residents have the right to be actively involved in the planning of
their care (Clemens et al., 1994), to make informed decisions and exercise choice and control over the services they receive. Others, like Brown et al. (1997), argue that residents should have control over basic daily decisions, choose the people who provide the most basic and intimate support, and to determine the quality of services. Kane (2001) refers to the ‘unshakable routines of the organisation’, as working against personal autonomy. It is important that those caring for older residents in nursing homes focus on ways to maximise the independence of residents. Existing evidence is consistent in showing that resident-centred programmes require the formation of strong relationships between residents, staff members and family carers, and that these relationships are built on mutual trust, understanding and the sharing of collective knowledge (Dewing, 2004; Nolan et al., 2004; McCormack, 2004, 2001).

The findings of this study acknowledge this contribution and add to the current literature by providing new insights into how residents experience quality of life and how staff can provide or facilitate it through their actions. Previously, these perspectives have largely been missing in the contemporary research literature and specifically in Lebanon. These findings add an existential dimension to the understanding of the meaning of quality of life, ‘relating’. As briefly mentioned earlier, care provision should be guided by a respect for the individuality of the patient, taking into consideration their preferences, reality, and past (Hofland, 1994). Knowledge of what is important to individual residents can help care providers be faithful to their wants and beliefs, while coincidentally preserving the resident’s personal integrity. As Kane and Degenholtz (1997, p.20) state:

“As we learn what clients’ values are, what they perceive as important and desirable in their lives, we also learn about how they perceive themselves and what is important to their maintaining a sense of who they are.”

According to Kitson (1991), the nurse manager’s notion of quality care was the most determinant and influential factor regarding the quality of life and attention given to older
residents. Wright and McCormack (2001) were able to help develop the role of the nurse manager as a facilitator of practice development and, as a result, care moved from a focus on physical needs to a more individualised approach. As moving into and living in a nursing home can significantly threaten personal identity, for both the older resident and their family, the findings of this study are clinically applicable by suggesting ways that gerontological nurses can apply more personalised care. This approach can help to support both the life previously experienced outside the care facility by the older resident and their family, and their experiences of being a whole person rather than being seen as a ‘patient’ or a ‘task’.

8.7 Family Carers’ Participation in Nursing Home Care

Though the data analysed in this study came from a relatively small group of family members, it provides corroboration for previously published findings (Abrahamson et al., 2009; Chen et al., 2007; Castle, 2004; Davies and Nolan, 2003; Nolan et al., 2001a; Nolan and Dellasega 1999). More importantly, the data provides meaningful and in-depth insight into what it is about the nursing home and aspects of care delivery that matter to family members and why. Maintaining good relations with family was very important to the residents. The relationship between the older residents and their respective families confirmed the residents’ personhood since they still had a place in the family. McGarry (2010) also reinforces this notion, stating that spending time with the family is an important aspect of quality of life.

Family members made it clear that they favoured care routines that created a more home-like environment for their older relatives, consistent with the social approach or model. Quality of life issues prominently figured in their responses, with most concerns revolving around care routines that violated privacy, limited social interaction and participation, and
compromised integrity and dignity (Kane et al., 1998), the latter of which is central to social models of care (Bond et al., 1996). Physical amenities and features mattered more to families of higher functioning residents, whereas quality care and security issues were likely to be of greater concern to families of lower physical-functioning residents. Family members appreciated staff that provided personal care that was sensitive to the resident’s individualised needs and preferences.

A major challenge in the paradigm shift to social care is training the staff how to respond to residents’ preferences. Some aspects of care delivery may be beyond the authority of lower-level staff. Though the staff may understand and appreciate providing greater autonomy and control to residents, they may have limited choice and opportunity to individualise care when actualising defined care plans and keeping residents secure (Kane et al., 1990).

It is also important that long-term care leaders recognise that the physical environment is important to family members but only in concert with process-oriented features of care delivery. As Chou and colleagues (2002, p. 196) contend:

“If the physical environment is less than satisfying, perhaps staff care could compensate in some way…. If staff care is insufficient, then no matter how well designed and equipped a facility is, residents are likely to live under the staff’s shadow.”

As this study demonstrated, family carers mostly wanted more individual care and more activities for the residents. The importance of family and staff members working together to meet the personal needs of the older resident was also seen in this study. When staff and carers had trusting relationships, and strong interpersonal communication, they were better at meeting the resident’s individualised care needs. The findings of this study suggest that staff within nursing homes should consider family carers as fellow experts and partners in care, unless contrary to the wishes of the resident or the family carer. It was important that
staff members appreciated the many challenges that family carers experienced by supporting the older resident in a new environment; and they should be encouraged to perceive a role in supporting and facilitating family visiting. It is essential that training for staff members should incorporate a consideration of the roles that family carers might wish to perform, and ways of developing relationships that enable them to achieve this.

Participants expressed that quality of life was intimately connected to relationships, and that by maintaining these relationships they were able to experience ‘relating’. ‘Relating’ allowed older residents to be and maintain themselves, and consequently, the continuity of their lives. These findings are supported by prior research (Cooney et al., 2009; Wilson et al., 2009; Wilson and Davies, 2009; Murphy et al., 2007; Aberg et al., 2004) and enhance our understanding of the role of relationships in nursing home settings and of the factors that condition them. These findings have implications for developing practice in nursing homes to improve the experience of older residents and their families by encouraging staff to develop a relationship based approach to care routines.

The factors identified as enhancing the residents’ quality of life in this study are supported by previous work and they include: finding out what the residents like and dislike; granting more choice and autonomy; facilitating more relationships to the outside world; establishing trusting relationships with residents and their family carers so to maintain self, identity, and continuity of life experience (Winter and Artinian, 2009; Cooney et al., 2009; Aberg et al., 2004; Tester et al., 2004b). What differs in this study is the construction of a model of determinants of quality of life that incorporate core themes at both a personal and an institutional level and placing these within a Middle-Eastern cultural context. This model expands and develops an understanding of quality of life by identifying factors that facilitate the residents’ standard of living, and helps to explain why residents may
experience this quality of life differently within the same nursing home. The research clearly indicates that, in order to create a more home-like environment and reduce the institutional feel of the nursing homes, staff require encouragement and positive affirmation of their role.

8.8 Implications for Nursing Practice

On the basis of the findings presented in this study, a number of strategies can be implemented in practice to satisfy the needs of the nursing home older residents. Staff members’ flexibility with respect to timetables and options allows the older residents to enjoy a higher measure of autonomy. The reduction of the number of persons per room may also ensure better privacy and mitigate the problems of noise, light, and disagreements (Cooney and McClintock, 2006).

These findings about quality of life and the residents’ priorities have implications for the staff members and for optimal practice. In the first place, the findings about the importance of family members’ visits indicates that it is desirable to promote open-door visiting policies, with the allocation of proper visiting spaces that respect privacy in nursing homes to encourage the visitors to see their older relatives. Consequently, nursing homes are expected to make an effort to engage family members in the life and culture of the nursing home (Haggstrom and Kihlgren 2007; Davies, 2003; Nolan et al., 2003).

The author also suggests, on the basis of the findings reached in this study, that nurses providing long term care reassess their perception of the role of family carers and establish ties with them on new foundations. Indeed, in light of the family carers’ desire to play an active and involved role in the life of their older relatives, nurses are urged to regard family members as care partners (Davies, 2003; Lundh et al., 2003; Nolan et al., 2003). The cooperative efforts are likely to be reinforced when the nursing staff facilitates the
contribution of family carers to the comfort of their older relatives, while their potential and limits are taken into consideration.

A more fundamental issue has to do with the kind of relationships that should develop between family carers and the nurses in order to ensure the hoped for partnership (Lundh et al., 2003). Very clear statements were made in this study by family members with whom the interviews were conducted. They asked for relationships of reciprocity whereby they wanted to express their ideas freely and were willing to listen to the staff members in return. In the same vein, they expected the nurses to lend them a listening ear and take into account their comments, objections, and suggestions. In summary, the collaborative efforts made by the nursing staff and family carers should be channeled into building and cementing a relationship of confidence between both parties (Davies and Nolan, 2004). The development of the relationship between the older residents, the nursing staff, and their family carers revolves around the pivot of relatedness. Being a dynamic and explanatory process, ‘relating’ provides a discourse and value-laden foundation for nursing staff and family carers that could be used to build and sustain working relationships with residents. There is certainly evidence, both from the present study and within the literature (Keady and Williams, 2007), that older residents and their family carers should be considered as partners not only in their care, but also as partners in conducting any future research endeavour.

Equally important are the relationships with ‘outsiders’ that some older residents consider as opportunities to see new faces visit the nursing home. Visits made by volunteers, researchers, interns, nursing students, and research assistants to the nursing home, and the approaches promoting the older residents’ establishment and preservation of ties with prominent outsiders, can also contribute to enhancing their quality of life (Murphy et al.,
In addition, the innovations in health care technology and delivery in nursing homes require creative practice approaches capable of handling complicated resident problems. Nurses are in the process of reconsidering the fundamentals and assessing their approach to practice. The long held assumptions, frameworks, interventions, and outcomes are now subject to appraisal by the nursing profession. The old paradigms that underscored the time spent with older residents and control of their conditions need updating to make nursing practice respond to the current needs of the clients (Hagerty et al., 1993).

8.9 Recommendations and Study Implications

8.9.1 Recommendations for Nursing Education

(1) The findings of this study, and specifically the importance of ‘relating’, should be incorporated within the nursing curricula and the continuing education programmes to help develop better familiarity with the older residents’ needs in a nursing home milieu. Information from this study could also inform the content of continuing education programmes for staff.

(2) For nursing staff to adopt caring strategies that demonstrate respectful attitudes towards older people. Such values should be incorporated into nursing curricula and continuing education programmes. These programmes should focus on developing an understanding of quality of life issues and putting in place person-centred models of care within nursing homes.

(3) ‘Geriatrics’ represents a new academic subject for the graduates of medical and nursing schools in the Lebanon, although it is still to be a popular choice of specialism like is the situation in the Western countries. To help combat this, and based on the quality of life opportunities presented in this thesis, ‘geriatrics’ and ‘gerontology’ should be integrated in the nursing curricula, whilst graduate training...
and continuing education programs should be developed and made available to staff.

(4) Nursing homes should be acknowledged as learning environments for nursing staff and students; however, their teaching role needs to be enhanced with increased financial investment.

8.9.2 Recommendations for Policy and Practice

(1) Biographical assessment of all nursing home residents should be carried out, with a written account of the residents’ retained abilities such as daily activities and hobbies and psychological well-being.

(2) The scope of nursing home activities should be broadened and customised to personal interests, needs, and life history ‘relating’ to each older resident. The activities can be of the domestic or curative type and they can be performed either on an individualised basis or in groups. This approach will help to develop and promote a person-centred approach to care and help to challenge a culture that, at times, is too driven by routine and fixed time schedules.

(3) Increase the number of professional nurses working in the care home setting and their preparation for practice, including access to supervision. Recruitment and training of geriatric experts such as physicians, nurses, psychologists, dietitians, occupational therapists, physical and speech therapists.

(4) The Lebanese national standards and regulations applicable to nursing home residents should be improved to allow for the fulfillment of resident’s care needs, such as the creation of a home-like design.

(5) The involvement of family carers in nursing homes should be encouraged and seen as a measure of good practice.
8.9.3 Changing the Perception of Ageing in Lebanon

(1) Drawing on the data, provide opportunities for examples of good practice to be shared in order to promote the contribution of nursing and other disciplines to the care of older people.

(2) Develop awareness campaigns that challenge and overcome the current stigma that is associated with a loved one’s admission into a nursing home.

(3) Promote the value of the family and place a focus on intergenerational care and what can still be achieved in old age.

(4) Develop a strategy to tackle ageism and see the value in courses and specialty disciplines for older people. This can be expressed through the American University of Beirut University for Seniors which is meant to help a rising number of older people to fulfill their needs and ambitions by presenting educational and cultural opportunities in a companionable setting. The findings of the present study will be made available for attendees at this University.

8.9.4 Educating Healthcare Professionals and Fostering Research

(1) There is an increased demand for a practical initiative involving changing the Lebanese system by enacting and enforcing new laws on the integration of geriatrics and gerontology in the curricula of health education such as nursing, medicine and health sciences, as well as in the social sciences, in addition to providing post graduate training and continuing education in these fields. Such steps will promote health education on older people, which in turn improves the quality of health care offered to the ageing population.

(2) There is a need for bringing the academic community together with policy makers, practitioners and service users to facilitate discussion about research and developments within the nursing home industry to shape the future in this area of
health and social care provision. This relationship needs to be strengthened and developed in mutual collaboration in order to enhance the quality of life of older residents living in nursing homes, as well as other stakeholders.

(3) University academics can make an important contribution by encouraging more students to carry out research in ageing and by urging these students and junior faculty members to pursue careers in the field, thus introducing variety to the health care personnel. The creation of multidisciplinary networks at the national, regional, and international levels further enhances the quality of research and care related to the ageing population.

(4) Undertaking further focused qualitative studies on frail nursing home residents is likely to offer a better perception of the path and causes leading to their well-being. These studies can be used as a means for the assessment of the policies and practices followed by the stakeholders.

(5) Developing a Lebanese quality of life assessment tool for the older residents of nursing homes based on the findings of this study. The assessment scale could be culturally relevant, feasible and measurable. The findings of this study provide a sound basis to develop the instrument, which will help researchers or clinical professionals to assess and detect the care needs of the older residents in nursing homes in Lebanon.

(6) As researchers, it is imperative that we consult the group being researched and consider them a part of the process, rather than making assumptions about what is relevant for them, thus enabling research to truly benefit those on whom it focuses.

8.9.5 Improving Nursing Homes in Lebanon

(1) Increase the strength and influence of all residents’ voices in their day-to-day care and to increase their choice and control over support. As an initial step, encourage
the setting up a resident advisory committee in each nursing home to give older people a voice in their care and the care system.

(2) Involve residents and family carers in the initial assessment of the older resident’s needs and the proposed care plan to be negotiated and agreed between all parties.

(3) Encourage the departure from traditional routine care patterns towards person-centred care patterns by continuing education, supervision of staff, and up-to-date training programmes centred on building awareness of quality of life issues.

(4) All care staff should prioritise quality of life objectives in everyday situations if they are to provide good quality of care for older residents and visiting family members.

(5) The findings reached in this study indicate that there needs to be a recognition that families may continue to carry a large caregiving load after their older relative has moved to residential care. Nurses need to recognise and validate this relationship in order to provide family carers with a sense of belonging and attachment to the nursing home community.

(6) Disseminate information in creative ways to all members of the nursing home community to ensure that everyone feels involved and is aware of decisions and developments.

(7) Multidisciplinary teams to work with staff members and residents within nursing homes in order to support staff to develop their skills and knowledge.

(8) Work to develop uniform national care standards for all nursing homes in Lebanon.

8.10 Grounded Theory: Methodological Reflections

The author expects that the work she has done in this thesis will underline the significance and influence of grounded theory both in the formulation of substantive theory and in the
incorporation of the necessary ‘fit and grab’ in the theory with a view to benefiting policy makers and practitioners. This would seem to commend grounded theory to other researchers in the health and social care field. When Glaser and Strauss (1967) used the term ‘fit’ they referred to the importance of conceptual categories that can be easily applied to the examined data and that emanate from the same data. For these authors theory ‘worked’ when it had meaning, pertinence, and the ability to interpret the examined behaviour. In this study, the author’s development of a ‘working knowledge’ of Glaser’s ideas on the formulation of grounded theory was best realised by employing theoretical memos to elucidate conceptual thoughts. Driven by the desire to enhance her understanding of the grounded theory language, the author sought to explore meanings and relationships in the data, which paved the way for creativity in data analysis that Glaser (1978) expects students of grounded theory methodology to demonstrate. She also acknowledges the importance of his contribution to the methodology and admits that it facilitated her formulation of the theory presented in this thesis due to the fact that it was Glaser (1978) who promoted the advancement of theory as process, trusted the analyst’s sensitivity and skills, and described the temporal processes in terms like stages, phases, basic social processes. It is because of Glaser’s contribution and his belief in the relative value of reflecting on the data that the author recognised the significance of quality of life of nursing home residents that facilitated the discovery of ‘Relating’ and its applicability in the care home setting for residents, staff members and family carers.

8.11 Limitations of the Study

Glaser (1978) acknowledged that ‘theory will always contain gaps’ (p. 10), and that it is the existence of gaps in knowledge that leads to further empirical study and a more critical appraisal of presented theory. While the author considers that the theory as presented is robust, it has raised numerous areas for further research and these have been alluded to
throughout this final chapter. Two specific limitations of the study however deserve specific attention, these are:

8.11.1 Sample Size and Setting
The findings of this study may be limited by sample size and setting (two nursing homes). The resident sample is comprised of the more able subpopulation of residents and is not representative of all individuals in the nursing home. Therefore, it is not known whether the theory of ‘relating’ applies in the same way to those who are less able. The author can only speculate about the residents who did not consent to participate. This should be explored further in future research. A greater focus on cognitively impaired residents should also be considered a priority given that they number such a significant proportion of residents in nursing homes in Lebanon (Chahine et al., 2007). Moreover, the two nursing homes participating in this study were sampled based on their geographical accessibility and the willingness of their administrations to take part in the research so they may not represent the typical nursing home in Lebanon. These nursing homes are among the few nursing homes in Lebanon where comprehensive services are provided for the older residents including rehabilitative, preventive, and curative services which is not the situation in other nursing homes in Lebanon. Both nursing homes are assumed to provide good care to their residents and have pleasant accommodation. However, despite these limitations and in the author’s opinion, the findings provide important and invaluable information about older residents’ needs for a good quality of life in nursing home settings.

8.11.2 Methodological Weakness of Relying on Cross-Sectional Interview
Interviews in the present study were ‘one-off’ events and this affected the opportunity to ‘check-out’ participants’ interpretations of the data collected. Whilst the constant comparative method and theoretical sampling in grounded theory compensate for this to a
degree, the limitations of a ‘one-off’ interview have to be acknowledged. There is a need for a longitudinal work which represents the ideal. However, the challenges, both financial and operational, of repeated interviewing over a period of several years, are quite apparent. One way forward in testing the presented theory might be to try and collect data over a longer period to try and capture some of the key transition points and relevant dynamics.

8.12 Conflicts between the Residents’ and Staff’s Ideas of Care in the Home and that of the Family Members

Residents frequently described their quality of life in terms of how successfully they as individuals were able to create meaning in their lives through effectively coping with the age-related changes of increased dependence and living in a nursing home. Nurses described quality of life more in terms of their professional responsibility of providing for private space, personal possessions, choices, control, involvement in decision making. This may be due to nurses focusing more on what nurses can provide for the residents, rather than building on the personal strengths and assets that residents already possess. Family carers indicated that the provision of information was most significant. Residents also suggested that communication was a significant aspect, but in their case communication for skilled emotional support was more important than communication to provide information. Residents were interested in speaking to someone who would listen, understand and support them emotionally. For the older residents an important aspect was the staff’s openness towards them and the possibility of supporting all their emotional needs.

The finding that family carers were least satisfied with resources available for the care of their older relatives may reflect the low level of funding and shortage of professional nurses. Nurses who believe that they have a limited amount of time to provide care tend to
be more preoccupied with getting the necessary custodial tasks completed and are less apt to invest time in considering additional interventions. Furthermore, limited resources may make staff more inclined to keep family members in the role of outsiders with little control over care. It is possible that the family carers’ more frequent contacts with nurses may have also resulted in more role conflict, ambiguity, and incongruity in interactions with staff as they transferred the care-giving role. Nurses in the nursing homes should realise the significance of their interactions with family carers and strive to provide role clarity, facilitate role transition, reduce role conflict, and reduce institutional barriers that may interfere with family carer satisfaction with care. The results of this study indicate that family carers are dissatisfied when their assistance is not solicited by staff and that they are concerned that adequate resources and activities are not provided for their older relatives.

The finding that residents, staff members and family carers placed different emphasis on quality of life variables is consistent with previous research indicating that items such as need for assistance with bathing and loss of usefulness were considered more of a problem by residents than by nurses and family carers (Kelley-Gillespie, 2009; Murphy et al., 2006; Oleson et al., 1994). In general, perspectives of staff and family were closely aligned with each other than the perspective of residents. Deciding which point of view is most valid is particularly challenging because quality of life assessment from different sources seems to be poorly correlated. Nevertheless, the data suggest that the resident’s quality of life assessment should include their own view whenever possible because it provides a unique and different perspective from that of the proxies.

8.13 Concluding Remarks

Quality of life in nursing homes is gaining prominence in Lebanon due to heightened awareness of the issue. The Centre for Studies on Ageing in Lebanon has set the prime
objectives of shedding more light on older adult issues at the domestic and regional levels and making policy makers and funders prioritise ageing. Lebanese nursing homes place greater emphasis on tasks rather than on the residents as persons. It is hoped that the findings in this thesis will draw the attention of administrators, nursing staff, and policy-makers and will bring about cultural transformations leading to the perception of older residents as individuals and to improve flexibility in care delivery. Service needs to be increasingly centred on the residents based on consultation, independence, making selections, personal care, and resident participation in decision-making (Clarke et al., 2003; McCormack, 2003; Davies et al., 1999). The shift in nursing home culture toward the resident-centred approach to care could establish a future trend. This implies that questions of inadequate staffing, nursing home design, care protocols, insurance and social welfare need reconsidering from the policy and legal standpoint. Consequently, it is imperative to expend sustained efforts to guarantee a good quality of life for older residents in Lebanese nursing homes, which, the author suggests, should be based on the notion of ‘relating’.

The advancement of the theory presented in this study, as well as the policy and implications on practice, reflect the efforts made by the author to highlight the transformation of values. She is fully aware of the challenges facing the operationalisation of some concepts presented in the theory presented in this study. As the Lebanon is a country in transition with limited resources, introducing change as part of reform should utilise the least resources. However, the success of reforms depends on a thorough analysis of the present conditions, effective teamwork, the provision of research grants, and the upgrading of the current facilities and the creation of new ones. Education in all areas of older adult care should be provided to healthcare professionals and society at large. There is also a need to increase the number of geriatric specialists in various fields in proportion to the growth of the ageing population.
Another important consideration is the perception of nursing home residents as not only patients, but also as persons who deserve to live the last stage of their life in dignity and to be treated with respect in an empowering and enabling milieu, away from undermining conduct. It is incumbent on policy makers, nursing management, and staff members to embrace change and define their roles in the context of advancing the quality of life of the older residents. Long-stay institutions should not be seen as places where older individuals die, but as places where they live and lead a decent life (Murphy et al., 2006). Ensuring a respectful and independent life to the older residents brings about good quality of life in nursing homes and we, as nursing professionals, must undertake the task of caring for and protecting these older individuals. For the older residents their time in the nursing home becomes a rite of passage to a new role in life, where it matters to all who they are and how they can best live their final days.

8.14 Summary

This chapter began by reviewing the findings of the present study, including how the study findings contribute to the understanding of quality of life experience of nursing home residents in the Lebanon. The results of the study were considered within the broader context of current literature, thereby outlining the implications of this study for future education, practice, policy and research in quality of life. Recommendations for further research were also described and the chapter then gave a resume of methodological reflections. Finally, the chapter highlighted the main study limitations before providing a brief personal conclusion.
REFERENCES


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APPENDIX 1: Consent Forms (English)

1. Older Person – Nursing Home Resident
2. Staff Member
3. Family Carer
Consent to participate in a research study

Generating a model of quality of life for older nursing home residents in the Lebanon: A grounded theory study

Older Person

Investigator: Marina Adra

Address: School of Nursing, Faculty of Medicine
American University of Beirut
Riad El Solh 1107 2020
PO Box: 11-0236
Beirut, Lebanon

Phone: (01) 350 000 ext: 5961/5950

Site where the study will be conducted:

- Dar Al Ajaza Al-Islamiya Hospital
- Foyer Saint George

You are being asked to participate in a clinical research study conducted by a researcher at the American University of Beirut who is undertaking the study as part of a PhD programme supervised by a Professor of Mental Health Nursing and Older People and a Senior Lecturer in Social Work from the School of Nursing, Midwifery and Social Work, University of Manchester (England, UK). Please take time to read the following information carefully before you decide whether you want to take part in this study or not. Feel free to ask the researcher if you need more information or clarification about what is stated in this form and the study as a whole.

The purpose of the study is to explore the perceptions and perspectives of a sample of older people living in two nursing homes in Lebanon, their family carers, and care staff about the meaning and constituents of quality of life, and to better understand what is it like for older people living in nursing homes and to suggest improvements.

I intend to explore this by interviewing a theoretical sample of older people who live at Dar Al Ajaza Al-Islamiya Hospital & Foyer Saint George, their family carers and staff members employed in these nursing homes. I am interested in all that they have to say about the term "Quality of Life" and what kind of things does the term quality of life make them think of? I am interested in their ideas about anything that could make the life of the older person living in a nursing home better.
• Taking part in the study is entirely voluntary.
• You may choose not to participate in this study. Even if you choose to participate, you are free to withdraw at any time. In either case, this will not affect the quality of care you will receive and there will be no penalty or loss of any benefits to which you are otherwise entitled. The nature of the study, the risks, inconveniences, benefits and other pertinent information about the study are discussed below.
• Your participation may be ended by the investigator at any time she finds there is a need to do so.
• Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

The research will consist of a series of interviews which will be audio recorded. It is anticipated that each interview will last between 30 - 60 minutes. Each participant will be interviewed twice by the researcher within a period of four months. At the end of the first interview you will be asked to fill in a structured quality of life questionnaire (Quality of Life Index nursing home version).

All interviews will be conducted in the Arabic language.
If you agree to take part in the research, the researcher will arrange a mutually convenient time and place with you.

Interviews are commonly used in research and do not have any specific risks. The interview questions are non-threatening, so minimal discomfort, if any is expected. However, sometimes people may disclose personal information in an interview and then later regret doing so. If this should happen, you can ask the researcher to destroy all or part of the recording of your interview.

The interviews will be transcribed verbatim (i.e. the content of each interview will be written out word for word using a computer word-processing programme). Then each interview will be translated to English and back translated to Arabic to check for accuracy of translation. The researcher will then analyze all the interviews to identify themes which recur in different interviews. This information will be used in a research report and may also be used in journal articles and conference papers.

Electronic copies of audio-recordings and transcripts will be stored on secure servers and protected with appropriate IT security measures (e.g. password protection) in accordance with American University of Beirut, School of Nursing policy.

Recordings and transcripts will be anonymised and given a code number. Any documentation which identifies which participants provided which interviews will be stored separately from the interview material itself.

Any interview material that is quoted in conference papers, journal articles etc will be referenced by a code number.
It is hoped that new information about the perceptions of older people about quality of life will be discovered which can then be passed on to those responsible for the management of nursing homes. By participating in this study you will be contributing to science and the well being of the older population residing in nursing homes in Lebanon.

No payments will be made for your time and for the information you give, however significant findings will be conveyed to you by the end of the study.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
Investigator's Statement:

I have reviewed, in detail, the informed consent document for this research study with _________________ (name of older person) the purpose of the study and its risks and benefits. I have answered to all his/her questions clearly. I will inform the participant in case of any changes to the research study.

___________________________
Name of Investigator or designee

___________________________
Signature

___________________________
Date

Older person's participation:

I have read and understood all aspects of the research study and all my questions have been answered. I voluntarily agree to be a part of this research study and I know that I can contact Mrs. Marina Adra at 01/350000 ext. 5961 or any of her designee involved in the study in case of any questions. If I feel that my questions have not been answered, I can contact the Institutional Review Board for human rights at 01/350000 ext. 4914. I understand that I am free to withdraw this consent and discontinue participation in this project at any time, even after signing this form, and it will not affect my care or benefits. I know that I will receive a copy of this signed informed consent.

___________________________
Name of older person

___________________________
Signature

___________________________
Date

___________________________
Witness's Name

___________________________
Witness's Signature

___________________________
Date

Protocol No. NUR.MA.02
Version Date: June 4, 2009
Consent to participate in a research study

Generating a model of quality of life for older nursing home residents in the Lebanon: A grounded theory study

Staff Member

Investigator: Marina Adra

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Phone: (01) 350 000 ext: 5961/5950

Site where the study will be conducted:
- Dar Al Ajaza Al-Islamiya Hospital
- Foyer Saint George

You are being asked to participate in a clinical research study conducted by a researcher at the American University of Beirut who is undertaking the study as part of a PhD programme supervised by a Professor of Mental Health Nursing and Older People and a Senior Lecturer in Social Work from the School of Nursing, Midwifery and Social Work, University of Manchester (England, UK). Please take time to read the following information carefully before you decide whether you want to take part in this study or not. Feel free to ask the researcher if you need more information or clarification about what is stated in this form and the study as a whole.

The purpose of the study is to explore the perceptions and perspectives of a sample of older people living in two nursing homes in Lebanon, their family carers, and care staff about the meaning and constituents of quality of life, and to better understand what is it like for older people living in nursing homes and to suggest improvements.

I intend to explore this by interviewing a theoretical sample of older people who live at Dar Al Ajaza Al-Islamiya Hospital & Foyer Saint George, their family carers and staff members employed in these nursing homes. I am interested in all that they have to say about the term "Quality of Life" and what kind of things does the term quality of life make them think of? I am interested in their ideas about anything that could make the life of the older person living in a nursing home better.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
• Taking part in the study is entirely voluntary.
• You may choose not to participate in this study. Even if you choose to participate, you are free to withdraw at any time. The nature of the study, the risks, inconveniences, benefits and other pertinent information about the study are discussed below.
• Your participation may be ended by the investigator at any time she finds there is a need to do so.
• Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

The research will consist of a series of interviews which will be audio recorded. It is anticipated that each interview will last between 30-60 minutes. Each participant will be interviewed twice by the researcher within a period of four months.

All interviews will be conducted in the Arabic language.
If you agree to take part in the research, the researcher will arrange a mutually convenient time and place with you.

Interviews are commonly used in research and do not have any specific risks. The interview questions are non-threatening, so minimal discomfort, if any is expected. However, sometimes people may disclose personal information in an interview and then later regret doing so. If this should happen, you can ask the researcher to destroy all or part of the recording of your interview.

The interviews will be transcribed verbatim (i.e. the content of each interview will be written out word for word using a computer word-processing programme). Then each interview will be translated to English and back translated to Arabic to check for accuracy of translation. The researcher will then analyze all the interviews to identify themes which recur in different interviews. This information will be used in a research report and may also be used in journal articles and conference papers.

Electronic copies of audio-recordings and transcripts will be stored on secure servers and protected with appropriate IT security measures (e.g. password protection) in accordance with American University of Beirut, School of Nursing policy.

Recordings and transcripts will be anonymised and given a code number. Any documentation which identifies which participants provided which interviews will be stored separately from the interview material itself.

Any interview material that is quoted in conference papers, journal articles etc will be referenced by a code number.
It is hoped that new information about the perceptions of older people about quality of life will be discovered which can then be passed on to those responsible for the management of nursing homes. By participating in this study you will be contributing to science and the well being of the older population residing in nursing homes in Lebanon.

No payments will be made for your time and for the information you give, however significant findings will be conveyed to you by the end of the study.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
Investigator’s Statement:

I have reviewed, in detail, the informed consent document for this research study with __________________________ (name of staff member) the purpose of the study and its risks and benefits. I have answered to all his/her questions clearly. I will inform the participant in case of any changes to the research study.

__________________________________________
Name of Investigator or designee Signature

__________________________________________
Date

Staff member's participation:

I have read and understood all aspects of the research study and all my questions have been answered. I voluntarily agree to be a part of this research study and I know that I can contact Mrs. Marina Adra at 01/350000 ext. 5961 or any of her designee involved in the study in case of any questions. If I feel that my questions have not been answered, I can contact the Institutional Review Board for human rights at 01/350000 ext. 4914. I understand that I am free to withdraw this consent and discontinue participation in this project at any time, even after signing this form. I know that I will receive a copy of this signed informed consent.

__________________________________________
Name of staff member Signature

__________________________________________
Date

Protocol No. NUR.MA.02
Version Date: June 4, 2009
AMERICAN UNIVERSITY OF BEIRUT

Consent to participate in a research study

Generating a model of quality of life for older nursing home residents in the Lebanon: A grounded theory study

Family Carer

Investigator: Marina Adra
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Site where the study will be conducted:
- Dar Al Ajaza Al-Islamiya Hospital
- Foyer Saint George

You are being asked to participate in a clinical research study conducted by a researcher at the American University of Beirut who is undertaking the study as part of a PhD programme supervised by a Professor of Mental Health Nursing and Older People and a Senior Lecturer in Social Work from the School of Nursing, Midwifery and Social Work, University of Manchester (England, UK). Please take time to read the following information carefully before you decide whether you want to take part in this study or not. Feel free to ask the researcher if you need more information or clarification about what is stated in this form and the study as a whole.

The purpose of the study is to explore the perceptions and perspectives of a sample of older people living in two nursing homes in Lebanon, their family carers, and care staff about the meaning and constituents of quality of life, and to better understand what is it like for older people living in nursing homes and to suggest improvements.

I intend to explore this by interviewing a theoretical sample of older people who live at Dar Al Ajaza Al-Islamiya Hospital & Foyer Saint George, their family carers and staff members employed in these nursing homes. I am interested in all that they have to say about the term "Quality of Life" and what kind of things does the term quality of life make them think of? I am interested in their ideas about anything that could make the life of the older person living in a nursing home better.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
• Taking part in the study is entirely voluntary.
• You may choose not to participate in this study. Even if you choose to participate, you are free to withdraw at any time. In either case, this will not affect the quality of care your relative receives and there will be no penalty or loss of any benefits to which he/she is otherwise entitled. The nature of the study, the risks, inconveniences, benefits and other pertinent information about the study are discussed below.
• Your participation may be ended by the investigator at any time she finds there is a need to do so.
• Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

The research will consist of a series of interviews which will be audio recorded. It is anticipated that each interview will last between 30 - 60 minutes. Each participant will be interviewed twice by the researcher within a period of four months.

All interviews will be conducted in the Arabic language. If you agree to take part in the research, the researcher will arrange a mutually convenient time and place with you.

Interviews are commonly used in research and do not have any specific risks. The interview questions are non threatening, so minimal discomfort, if any is expected. However, sometimes people may disclose personal information in an interview and then later regret doing so. If this should happen, you can ask the researcher to destroy all or part of the recording of your interview.

The interviews will be transcribed verbatim (i.e. the content of each interview will be written out word for word using a computer word-processing programme). Then each interview will be translated to English and back translated to Arabic to check for accuracy of translation. The researcher will then analyze all the interviews to identify themes which recur in different interviews. This information will be used in a research report and may also be used in journal articles and conference papers.

Electronic copies of audio-recordings and transcripts will be stored on secure servers and protected with appropriate IT security measures (e.g. password protection) in accordance with American University of Beirut, School of Nursing policy.

Recordings and transcripts will be anonymised and given a code number. Any documentation which identifies which participants provided which interviews will be stored separately from the interview material itself.

Any interview material that is quoted in conference papers, journal articles etc will be referenced by a code number. It is hoped that new information about the perceptions of older people about quality of life will be discovered which can then be passed on to those responsible for the management of nursing homes. By participating in this study you will be contributing to science and the well being of the older population residing in nursing homes in Lebanon.

No payments will be made for your time and for the information you give, however significant findings will be conveyed to you by the end of the study.

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Version Date: June 4, 2009
Investigator’s Statement:

I have reviewed, in detail, the informed consent document for this research study with ____________________________ (name of family carer) the purpose of the study and its risks and benefits. I have answered to all his/her questions clearly. I will inform the participant in case of any changes to the research study.

______________________________
Name of Investigator or designee

______________________________
Signature

______________________________
Date

Family carer’s participation:

I have read and understood all aspects of the research study and all my questions have been answered. I voluntarily agree to be a part of this research study and I know that I can contact Mrs. Marina Adra at 01/350000 ext. 5961 or any of her designee involved in the study in case of any questions. If I feel that my questions have not been answered, I can contact the Institutional Review Board for human rights at 01/350000 ext. 4914. I understand that I am free to withdraw this consent and discontinue participation in this project at any time, even after signing this form, and it will not affect my relative's care or benefits. I know that I will receive a copy of this signed informed consent.

______________________________
Name of family carer

______________________________
Signature

______________________________
Date

Witness's Name
(if family carer does not read) Date

______________________________
Witness's Signature

______________________________
Date
Consent Forms (Arabic)

1. Older Person – Nursing Home Resident
2. Staff Member
3. Family Carer
الجامعة الأمريكية في بيروت

موافقة للإشتراك في البحث العلمي

تكوين نموذج لنوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية متعززة

للمسنين

اسم الباحث: مارينا عدره - استاذة مساعدة

عنوان البحث: الجامعة الأمريكية في بيروت - شارع القاهرة - الحمرا - بيروت

تلفون: 01/3500000 المقسم 15961

عنوان البحث: تكوين نموذج لنوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية متعززة

مكان إجراء البحث: مستشفى دار العجزة الإسلامية.

بيت القديس جاورجيوس.

يطلب البك هذه المشاركة في دراسة كلينيكية يقيمها باحث في الجامعة الأمريكية في بيروت كجزء
من رسالة الدكتوراه التي يتابع دراستها في جامعة مانشستر في إنكلترة وذلك تحت إشراف أستاذ
في التمريض المختص بالصحة العقلية ومحاضر في مجال العمل الاجتماعي في كلية التمريض
والقبول والعمل الاجتماعي في جامعة مانشستر في إنكلترة.

الرجاء أن تأخذي الوقت الكافي لقراءة المعلومات التالية بنظر أن تقرر (ن) إذا كنت تريد (ن)
المشاركة أم لا. وبإمكانك طلب إيضاحات أو معلومات إضافية من الباحث عن أي شيء مذكور في
هذه الإستمارة أو عن هذه الدراسة ككل.

تهدف الدراسة عموما إلى إستطلاع مدى إدراك وجهات نظر حول مفهوم ومفاهيم نوعية الحياة
كما تهدف إلى فهم أفضل لوضع إقامة المسنين المقيمين في دور العناية في لبنان وبالتالي وضع
مقترحات لتحسين الوضع. ستقوم الدراسة عينة نموذجية من المسنين القاطنين وأقاربهم الذين
يقومون برعايتهم وفريق العمل المشرف على رعايتهم في دار المسنين وذلك في إثنين من دور
العناية بالمسنين في لبنان.

بهدف هذه الدراسة ساقوم ب استطلاع عين نموذجية من المسنين القاطنين في مستشفى دار العجزة
الإسلامية وأمان جورج، وأقاربهم الذين يقومون برعايتهم وفريق العمل المشرف على رعايتهم
في دار المسنين. يركز إهتمامي على كل ما سبق، لتفهيم "نوعية الحياة" بما تويح به
إليهم. كما يركز إهتمامي على أفكارهم حول تحسين حياة المسنين في دور الرعاية.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
إن المشاركة في الدراسة اختيارية.

- إن المشاركة في الدراسة اختيارية، وفي حال قررت المشاركة ب自愿ية الانسحاب مني شنته، في جميع الأحوال لن يترتب عليك أي عقوبات أو إيقاف من المناصفة التي خصصت لك ولن تتأثر نوعية العبارة التي تحظى بها. فيما يلي شرح عن طبيعة الدراسة والمخاطر والصعوبات المراهقة لها والظروف غير الملاءمة.

- إن مشاركتك في هذا البحث قد تنتهي من قبل الباحث في أي وقت بحاجة وجد ضرورة لذلك.

- لا توقع هذا المستند إلا بعد أن تسمح لك ألفرصة لطرح الأسئلة والحصول على إيجابية كافية.

يقوم البحث على إجراء مقابلات صوتية مسجلة. الوقت المتوقع لكل مقابلة هو 30-60 دقيقة كما سيتم إجراء المقابلة مرتين مع كل مشترك خلال فترة أربع أشهر. عند الأنتهاء من المقابلة الأولى سيطلب منك أن تتم استمارة تفصيلية حول نوعية الحياة.

سيتم إجراء كل المقابلات باللغة العربية في حال وافقت على المشاركة في الدراسة سيقوم الباحث على تحديد موعد ومكان مناسب للطرفين لإجراء المقابلة.

عادة ما تستخدم المقابلات كوسيلة لجمع المعلومات وهي لا تحمل أي مخاطر محددة وإن الأسئلة غير مضرة وغير مهينة. لذا سوف تنتسب إلى إزعاج ممكن. إذا أن البعض قد يذكر بعض المعلومات في مقابلة ما ومن ثم يندم. في هذه الحالة يمكنك أن تطلب من الباحث إتألف جزء من المقابلة المسجلة أو المقابلة كلها.

سيتم نسخ المقابلة حرفيًا (أي سيتم كتابة المقابلة كلمة بكلمة) باستخدام برنامج طباعة على الكمبيوتر وترجمتها إلى الإنجليزية ومن ثم إعادة ترجمتها إلى العربية للتأكد من صحة الترجمة. سيتم البحث فيما بعد على تحليل المقابلات لتحديد الفكرة الرئيسية المتكررة في جميع المسالطات. سيتم استخدام هذه المعلومات في تقارير علمية كما سيتم استخدامها في مقابلات ومؤتمرات علمية.

سيتم حفظ النسخ والنسخ المنقولة في شبكة الإلكترونية محصنة بواسطة نظام أمان الإلكتروني متزاسب (مثل شفرة للدخول على بنك المعلومات) مع قوانين كلية التمريض في الجامعة الأميركية في بيروت.

سيتم تسهيل المقابلات بحيث لا يبقى لأحد التعرف على المشاركين إلا الباحث. كما سيتم حفظ الوثائق التي تدلى على شخص المشترك في مكان منفصل عن مادة المقابلات نفسها.

في حالة نشر أي مادة مأخوذة من المقابلات في مجالات علمية أو عرضها تعرض في مؤتمرات علمية ستتم الإشارة إليها بواسطة رقم مرجع رمزي.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
نأمل أن المعلومات التي ستقضي بها إلينا ستقدمنا بها هذه الدراسة حول مفاهيم ووجهات نظر المسنين عن نوعية الحياة وبالتالي سيتم إعلام المسؤولين عن إدارة دور الرعاية إن المشاركة في هذا البحث هو مساهمة علمية لخير ورفاهية طبقة العجزة والمسنين.ليس هناك بدل مادي مقابل المشاركة في هذا البحث. سوف نعلن لك نتائج البحث عند انتهاء الدراسة.

موافقة الباحث:

لقد شريحت بالتفصيل للمشترك في البحث الغيبي ل (اسم المشترك أو ممثله القانوني أو وليه الحري أو وصيه إذا كان المشترك قاصرًا أو غير قادر على التوقيع) طبيعته ومجريات وتأثيراته السلبية. وقد أبلغت على كل أسئلته بوضوح على أفضل ما أستطيع. وسوف أعلم المشترك بأي تغييرات في مجريات هذا البحث أو تأثيراته السلبية أو فوائده.

توقيع الباحث أو الشخص المولي على موافقة المشترك

الحصول على موافقة المشترك

التاريخ

موافقة المشترك:

لقد قراءت استمارة القبول هذه وفهمت مضمونها. تمت الإجابة على أسئلتي جميعها. وبناء عليه فاني، حا مختاراً أجزاء إجراء هذا البحث ووافق على الإشراف في، وأني أعلم أن البحث السيدة مارينا عدور وزملائها وتعليمني أو مساعدتي سيكونون مستعدين للإجابة على أسئلتي، وأنه باستطاعتي الإتصال بهم على الهاتف 01/3500000 المقسم 5961. وإذا شعرت لاحقا أن الأجهزة تحتاج إلى مزيد من الإيضاح سوف تصل بأحد أعضاء لجنة الأخلاقيات (01-3500000 المقسم 4914). كما أعرف تمام المعروفة باني حر في الإسحاب من هذا البحث متي شئت حتى بعد التوقيع على الموافقة دون أن يؤثر ذلك على العناية الطبية المقدمة لي. أعلم أنني سوف أحصل على نسخة طبق الأصل عن هذه الموافقة.

Protocol No. NUR.MA.02
Version Date: June 4, 2009
إسم المشترك
توقيع المشترك أو ممثله القانوني أو وليه الجبرى أو وصيه

إسم الممثل القانوني أو الولي الجبرى أو الوصي

التاريخ (ببید المشترك أو ممثله القانوني أو وليه الجبرى أو وصيه)

توقيع الشاهد

إسم الشاهد

التاريخ

Protocol No. NUR.MA.02
Version Date: June 4, 2009
الجامعة الأميركية في بيروت

موافقة للإشتراك في البحث العلمي

تكوين نموذج نوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية معززة

المشرفون على رعاية المسنين

اسم الباحث: مارينا عدره - استاذة مساعدة

عنوان الباحث: الجامعة الأميركية في بيروت - شارع القاهرة - الحمرا - بيروت

تلفون: 01/3500000 المقسم 961

عنوان البحث: تكوين نموذج نوعية الحياة في دور العناية في المسنين في لبنان: دراسة نظرية معززة

مكان إجراء البحث: - مستشفى دار العجزة الإسلامية.

- بيت القديس جاورجيوس.

يرجى أن تأخذ (ي) الوقت الكافي لقراءة المعلومات التالية قبل أن تقرر (ي) إذا كنت تريد (ين) المشاركة أم لا. إنها تطلب إيضاحات أو معلومات إضافية عن البحث عن أي شيء مذكور في هذه الاستمارة أو عن هذه الدراسة ككل.

تدفع الدراسة عموما إلى استطلاع مدى إدراك وجهات نظر حول مفهوم ومقومات نوعية الحياة كما تهدف إلى فهم أفضل لوضع إقامة المسنين المقيمين في دور العناية في لبنان وبالتالي وضع مقترحات لتحسين الوضع. ستضمن الدراسة عينة نموذجية من المسنين القادرين وأقرانهم الذين يقومون برعايتهم وفريق العمل المشرف على رعايتهم في دار المسنين وذلك في إذن من دور العناية بالمسنين في لبنان.

بهدف هذه الدراسة ساقوم باستطلاع عين نموذجية من المسنين القادرين في مستشفى دار العجزة الإسلامية والرسان جورج، واقرينهم الذين يقومون برعايتهم وفريق العمل المشرف على رعايتهم في دار المسنين. يركز إهتمامي على كل ما سيقوله عن عبارة "نوعية الحياة" بما توجيه به إليهم. كما يركز إهتمامي على أفكارهم حول تحسن حياة المسنين في دور الرعاية.

Protocol No. NUR.MA.02
Version Date: May 13, 2009
- إن المشاركة في الدراسة اختيارية.
- في إمكانك عدم المشاركة في الدراسة، وفي حال قررت المشاركة بإمكانك الانسحاب متى شئت. فيما يلي شرح عن طبيعة الدراسة والمخاطر والصعوبات المراقبة لها والظروف المطلوبة.
- لا تكون هناك فرضية ولا يوجد وقت محدد لطرح الأسئلة.

يقوم البحث على إجراء مقابلات صوتية مسجلة. الوقت المتوقع لكل مقابلة هو 30-60 دقيقة. سيتطلب ذلك منك أن تشمل تفصيلية حول نوعية الحياة. سيتطلب ذلك منك أن تشمل تفصيلية حول نوعية الحياة.

سياستنا في إجراء مقابلات باللغة العربية.

في حال وافقنا على المشاركة في الدراسة، فإننا سنقوم في نهاية مسجدها على تحديد موعد ومكان مناسب للطرفين.

عادة ما نستخدم المقابلات كوسيلة لجمع المعلومات وهي لا تحمل أي مخاطر محددة وإن الأسئلة غير مضررة وغير مهينة. لذا سوف نتطلب منك إجابة ممكن. إن البعض قد يذكر بعض المعلومات في مقابلة ما ومن ثم ينتمي. في هذه الحالة يمكننا أن نطلب من الطرفين إجابة جزء من المقابلة السارية أو المقابلة كلها.

سيتم نسخ المقابلة حرفيًا (أي ستتم كتابة المقابلة كلمة بكلمة باستخدام برنامج كتابة على الكمبيوتر) وترجمتها إلى الإنجليزية ومن ثم إعادة ترجمتها إلى العربية للتأكد من صحة الترجمة. سيقوم الباحث فيما بعد على تحليل المقابلات لتحديد الفكرة الرئيسية المتكررة في جميع المسائلات.

سيتم استخدام هذه المعلومات في تقارير علمية كما سيتم استخدامها في مقابلات ومؤتمرات علمية.

 سيتم حفظ التسجيلات والنسخة المنقولة في شبكة الكترونية محصنة بواسطة نظام أمان إلكتروني متناسب (مثل شفرة للدخول على بنك المعلومات) مع قوائم كلية للمستخدم في الجامعة الأميركية في بيروت.

سيتم تسهيل المقابلات بحيث لا يتبين لدى أحد النتائج على المشاركون إلا الباحث. كما سيتم حفظ الوثائق التي تدل على شخص المشترك في مكان منفصل عن مادة المقابلات نفسها.

في حال نشر أي مادة مأخوذة من المقابلات في مجالات علمية أو عرضها تعرض في مؤتمرات علمية ستتم الإشارة إليها بواسطة رقم مرجع مزم.
نأمل أن المعلومات التي ستقضي بها إلينا ستفيدنا بها هذه الدراسة حول مفاهيم وجهات نظر المسنين عن نوعية الحياة وبالتالي سيتم إعلام المسؤولين عن إدارة دوري الرعاية إن المشاركة في هذا البحث هو مساهمة علمية لخير ورفاهية طبقاً العجزة والمسنين.
ليس هناك دلائل مادياً معيار المشاركة في هذا البحث. سوف نعلن لك نتائج البحث عند انتهاء الدراسة.

موافقة الباحث:

لقد شرحت بالتفصيل للمشارك في البحث الطبي ل . (اسم المشارك) طبيعته ومجرياته وتأثيراته السلبية. ولقد أجبت على كل أسئلته بوضوح على أفضل ما أستطيع. وسوف أعلم المشارك بأي تغييرات في مجريات هذا البحث أو تأثيراته السلبية أو فوائده في حال حصولها أثناء البحث.

التوقيع: __________________________

الاسم الباحث أو الشخص المولى للحصول أو الشخص المولى على موافقة المشارك.

الموافق على موافقة المشارك:

التاريخ: __________________________

موافقة المشارك:

لقد قرأت استمارة القبول هذه وفهمت مضمونها. تمت الإجابة على أسئلتي جميعها. وبناء عليه فاتني، حراً مختاراً، أجريت إجراء هذا البحث ووافق على الإشراك فيه، وإن أعلم أن المشاركة السيئة مارينا عرده وزمانها ومعاونيتها أو مساعدتها سيكونون مستعدين للإجابة على أسئلتي، وأنه باستخضاعي الإتصال بكم على الهاتف 0135000000 المقسم 5961. وإذا شعرت لاحقاً أن الأجواء تحتاج إلى مزيد من الإيضاح فسوف أتصل بأحد أعضاء لجنة الأخلاق (01-0350000000 المقسم 4914). كما أعرف شمل المعرفة باني حر في الإحسان من هذا البحث مثلما شنت حتى بعد التوقيع على الموافقة. أعلم أنني سوف أحصل على نسخة طبق الأصل عن هذه الموافقة.

Protocol No. NUR.MA.02
Version Date: May 13, 2009
الجامعة الأميركية في بيروت

موافقة للإشتراع في البحث العلمي

تكوين نموذج لنوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية معززة

الأقراء المشرفون على العناية بالمسن

اسم الباحث: مارينا عبرة - استاذة مساعدة

عنوان الباحث: الجامعة الأميركية في بيروت - شارع القاهرة - الجمار - بيروت

 الهاتف: 3500000 المقسم 5961

عنوان البحث: تكوين نموذج لنوعية الحياة في دور العناية في المسنين في لبنان: دراسة نظرية معززة

مكان إجراء البحث: - مستشفى دار العجزة الإسلامية.

- بيت القديس جاورجيوس.

يطلب الابتكار هذه المشاركة في دراسة كلينية تقييمها باحث في الجامعة الأميركية في بيروت كجزء من رسالة الدكتوراة التي يتابع دراستها في جامعة مانشستر في إنكلترا وذلك تحت إشراف أستاذ في التمريض المختص بالصحة العقلية ومحاضر في مجال العمل الاجتماعي في كلية التمريض والقبالة والعمل الاجتماعي في جامعة مانشستر في إنكلترا.

الرجاء أن تأخذ(ي) الوقت الكافي لقراءة المعلومات التالية بتأني أن تقرر(ي) إذا كنت تريد(ين) المشاركة أم لا. بإمكانك طلب إيضاحات أو معلومات إضافية من الباحث عن أي شيء مذكور في هذه الاستمارة أو عن هذه الدراسة ككل.

تهدف الدراسة عموما إلى استطلاع مدى إدراك وجهات نظر حول مفهوم ومصطلحات نوعية الحياة كما تهدف إلى فهم أفضل لوضع إقامة المسنين المقيمين في دور العناية في لبنان وبالتالي وضع مقتراحات لتحسين الوضع. ستضمن الدراسة عينة نموذجية من المسنين القاطنين واقرابهم الذين يقومون برعايتهم وفريق العمل المشرف على رعايتهم في دار المسنون وذلك في إثني من دور العناية بالمسنون في لبنان.

هناك هذه الدراسة ساقوم بإستطلاع عين نموذجية من المسنين القاطنين في مستشفى دار العجزة الإسلامية والسند جورج، وأقرابهم الذين يقومون برعايتهم وفريق العمل المشرف على رعايتهم في دار المسنون. يركز إهتمامي على كل ما سيقدوه عن عبارة "نوعية الحياة" وما توفي به إليهم. كما يركز إهتمامي على أفكارهم حول تحسين حياة المسنين في دور الرعاية.

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- إن المشاركة في الدراسة اختيارية.
- في إمكانك عدم المشاركة في الدراسة، وفي حال قررت المشاركة بإمكانك الانسحاب متي شئت. في جميع الأحوال لن تترتب على قبريك أي عقبات أو إفاقس من المنافع التي خصصت له وإن تتأثر نوعية الدراسة التي يتم بها. فيما يلي شرح عن طبيعة الدراسة والمخاطر والصعوبات المراهقة لها والظروف غير الملائمة.

إن مشاركتك في هذا البحث قد تنتهي من قبل الباحث في أي وقت بحال وجد ضرورة لذلك.

لا توقع هذا المستند إلا بعد أن تسمح لك ألفرصة لطرح الأسئلة والحصول على إجابة كافية.

يقوم البحث على إجراء مقابلات صوتية مسجلة. الوقت المتوقع لكل مقابلة هو 30-60 دقيقة كما سيتم إجراء المقابلة مرتين مع كل مشترκ خلال فترة أربع أشهر. عند الانتهاء من المقابلة الأولى سيطلب منك أن تتم استمارة تفصيلية حول نوعية الحياة.

سيتم إجراء كل المقابلات باللغة العربية في حال وافقتك على المشاركة في الدراسة سيقوم الباحث على تحديد موعد ومكان مناسب للطرفين لإجراء المقابلة.

عادة ما ستستخدم المقابلات كوسيلة لجمع المعلومات وهي لا تحمل أي مخاطر محددة وإن الأسئلة غير مضرة وغير مهدمة. لذا سوف نناسب بأقل إزعاج ممكن. إلا أن البعض قد يذكر بعض المعلومات في مقابلة ما ومن ثم يندم. في هذه الحالة يمكنك أن تطلب من الباحث إتلاف جزء من المقابلة المسجلة أو المقابلة كلها.

سيتم نسخ المقابلة حرفيًا (أي ستتم كتابة المقابلة كلمة بكلمة باستخدام برنامج طباعة على الكمبيوتر)، وترجمتها إلى الإنجليزية وإن ثم إعادة ترجمتها إلى العربية للتأكد من صحة الترجمة.

سيقوم الباحث فيما بعد على تحليل المقابلات لتحديد الفكرة الرئيسية المتكررة في جميع المسالطات، وسيتم استخدام هذه المعلومات في تقارير علمية كما سيتم استخدامها في مقالات ومؤتمرات علمية.

سيتم حفظ التسجيلات والنسخ الملموسة في شبكة كترونية محصنة بواسطة نظام أمان كتروني متخصص (مثل شفرة للدخول على بنك المعلومات) مع قوانين كليّة التمريض في الجامعة الأميركية في بيروت.

سيتم تشفير المقابلات بحيث لا يتسنى لأحد التعرف على المشاركيين إلا الباحث، كما سيتم حفظ الوثائق التي تدل على شخص المشترك في مكان منفصل عن مادة المقابلات نفسها.

في حال نشر أي مادة مأخوذة من المقابلات في مجلات علمية أو عرضها تعرض في مؤتمرات علمية ستتم الإشارة إليها بواسطة رقم مرجعي رمزي.

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نأمل أن المعلومات التي ستفضليها إليها ستقيدنا بها هذه الدراسة حول مفاهيم وجهات نظر المسنين عن نوعية الحياة وبالتالي سيتم إعلام المسؤولين عن إدارة دور الرعاية إن المشاركة في هذا البحث هو مساهمة علمية لخير ورفاهية طبقة العجزة والمسنين.
ليس هناك بدال مادي مقابل المشاركة في هذا البحث. سوف نعلن لك نتائج البحث عند انتهاء الدراسة.

موافقة الباحث:

لقد شرحت بالتفصيل للمشارك في البحث الطبي ل (اسم المشارك) طبيعته ومجربته وتأثيراته السلبية. ولقد أجبت على كل أسئلته بوضوح وأفضل ما أستطيع. وسوف أعلم المشارك بأي تغييرات في مجريات هذا البحث أو تأثيراته السلبية أو فوائده في حال حصولها أثناء البحث.

<table>
<thead>
<tr>
<th>اسم الباحث أو الشخص المولى الحصول</th>
<th>توقيع الباحث أو الشخص المولى على موافقة المشارك</th>
</tr>
</thead>
<tbody>
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</table>

التاريخ

موافقة المشارك:

لقد قرأت استمارة القبول هذه وفهمت مضمونها. تمت الأجبة على أسئلتي جميعها. وبناء عليه فإني، حرا مختارة، أؤيد إجراء هذا البحث وأوافق على الإشراك فيه، واني أعلم ان الباحث السيدة مارينا عدرة وزملائها ومعاونيها أو مساعديها سيكونون مستعينين بالإجابة على أسئلتي، وأنه باستطاعتي الإتصال بهم على الهاتف 0135000000 المقصد 961. إذا شعرت لاحقا ان الأجوبة تحتاج إلى مزيد من الإيضاح فسوف أتصل بهم بأحد أعضاء لجنة الأخلاق (01-35000000 المقسم 4914). كما أعرف تمام المعرفة بانني حر في الإنسحاب من هذا البحث متي شئت حتى بعد التوقيع على الموافقة دون أن يؤثر ذلك على العناية الطبية المقدمة لفريبي. أعلم إنني سوف أحصل على نسخة طبق الأصل عن هذه الموافقة.

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Version Date: May 13, 2009
توقيع المشترك أو ممثله القانوني أو وليه الجبري أو وصيه

الناظر (بيد المشترك أو ممثله القانوني أو وليه الجبري أو وصيه)

توقيع الشاهد (إذا كان المشترك أميا)

التاريخ
APPENDIX 2: Example of Coding a Transcript
<table>
<thead>
<tr>
<th>Interview</th>
<th>Initial Coding</th>
<th>Focused Coding</th>
<th>Theoretical Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Q: How would you describe quality of life?</td>
<td>Having had a full and rich life before coming to this nursing home.</td>
<td>Grieving the loss of personhood.</td>
<td>Social relationships and networks</td>
</tr>
<tr>
<td>2. A: I used to live by my own in the village, i received stuff from my neighbours and relatives and i was alive. My sisters’ children live in Beirut and they care a lot about me, they always check on me, care about me and see what i need. My neighbours are very good with me too, i was at their house when their maid noticed the mass in my breast and she told me to check what it was. At first i didn’t believe her, i kept thinking where would i get this mass from? it must be untrue, but when i went home i did some self assessment and yes there was something weird, and i used to listen to Mariam Nour (a tv personality) on the television, she said “those of you who feel something strange like a mass or something in their bodies must never neglect it and should check with their doctors”</td>
<td>Having strong family ties. Has help from family social relationships and networks.</td>
<td>Relationships with family and friends. Social relationships</td>
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<td>Interview</td>
<td>Initial Coding</td>
<td>Focused Coding</td>
<td>Theoretical Coding</td>
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<tr>
<td>1. Q: what does it mean to you when i tell you “quality of life”?</td>
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<td>3. A: what do i know about life!! What shouldi understand and not understand!!</td>
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<td>5. i called my nephew who took me to the doctor, after assessment i was diagnosed with theUN-NAMED “that is cancer “,</td>
<td>Having positive attitude to life and self contemplation.</td>
<td>Coping</td>
<td>Ensuring physical safety</td>
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<tr>
<td>6. we did all the paper work, tests and then a surgery, I had a radical mastectomy for this side, and thank GOD we started the therapy, i used to lie down for seven hours in bed with aninavenous line in my hand and receive alot of medications. Later i started radiation for two months, then the doctor told me that the disease is gone thank GOD but i have to be maintained on pomedications for the rest of my life , i thankGod the lord of all worlds . A long, longtime ago i had a pimple at my urinaryorifice sometimes it’s painful, sometimes I have dysuria, so i get a kind of herb named “Khebayzi” i boil it and wash the area with it to feel better, but during the last three days i have been in pain; i guess it’s infected because i have pain upon urination too, moreover and excuse me forthat but i have difficulty in defecation, and it doesn’t resolve until i take laxatives for help. And now they brought me here, and here i stay thank GOD.</td>
<td>Ability to cope with bad things</td>
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</table>

Having constipation.Meeting basic need for survival. | Physical comfort | Being healthy | |

Looking for method to protect self. | | | |

Experiencing pain/discomfort. | | | |

Maintaining the body | | | |

Being concerned about pain | | | |

Ensuring physical safety | | | |

Coping | | | |
1. Q: Tell me about your life in her?
2. A: Everybody is good in here thank GOD, and the doctor with all my respect to you
3. is a very nice person, even the director
4. here is very good with me, the girls (older
5. women), everyone is good, but there is
6. that women whom i had a conflict with ,
7. she is sick when she first came she
8. started to put her hands on my bed and
9. scream then started to pull her hair and
10. hit herself shouting and crying, i asked
11. her what’s wrong, why is she screaming ,
12. did anyone
13. die or something, there is no need to
14. shout, so we had a conflict. Her bed is
15. near the window, i asked her the other
16. day to open the window for some fresh
17. air, you know it’s a closed room and we
18. are seven inside and they change the
19. diapers and the smell, it’s just not right!!
20. She refused to open, she said i am going
21. to tease you because you want me to
22. open it, i am not going to. She was
23. challenging me, so i decided to tell the
24. doctor who told the manager and they
25. both came to hear my side of the story,
26. they told her to open the window but
27. once they left she closed it again, and she
28. started yelling and shouting and she
29. keeps gossiping about me. I told the
30. doctor that i came here for therapy
31. Having good relationships with staff
32. Being irritated, being bothered
33. Feeling belittled and humiliated by
34. the demented resident.
35. Expressing concern about the
36. environment.
37. Building strong bonds with
38. staff
39. Having human dignity
40. respect
41. Living environment
42. Social relationships and networks
43. Self-esteem
44. The human environment
1. and not to suffer, he told me that i have
2. to be patient with this kind of people, i
3. told him may GOD relieve us from this
4. kind of people and we started laughing,
5. now the doctor opened the window but
6. you can’t imagine how much that woman
7. hates me, she can’t stand me. Well, they
8. should either transfer her or me, i can’t
9. take it anymore, we don’t speak to each
10. other, and this is the story, this is life,
11. what else you want??

<table>
<thead>
<tr>
<th>Interview</th>
<th>Initial Coding</th>
<th>Focused Coding</th>
<th>Theoretical Coding</th>
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<tbody>
<tr>
<td>1. and not to suffer, he told me that i have to be patient with this kind of people, i told him may GOD relieve us from this kind of people and we started laughing, now the doctor opened the window but you can’t imagine how much that woman hates me, she can’t stand me. Well, they should either transfer her or me, i can’t take it anymore, we don’t speak to each other, and this is the story, this is life, what else you want??</td>
<td>Stressing need to be separated from this woman who displayed disruptive behavior.</td>
<td>Living environment</td>
<td>The human environment</td>
</tr>
<tr>
<td>Interview</td>
<td>Initial Coding</td>
<td>Focused Coding</td>
<td>Theoretical Coding</td>
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<tr>
<td>1. Q: Tell me what is important to you living in this nursing home?</td>
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<td>2. I have been here for more than nine months, it’s Gods’ will what can</td>
<td>Concern for feeling safe</td>
<td>Being safe, being cared for</td>
<td>Ensuring physical safety</td>
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<tr>
<td>3. A: I have been here for more than nine months, it’s Gods’ will what</td>
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<td>4. can’t live alone because my legs hurt me a lot.</td>
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<tr>
<td>Interview</td>
<td>Initial Coding</td>
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<tr>
<td>1. Q: what do you like most about being in this nursing home?</td>
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<td>2. A: I like the people in here, they are good people, the girls are all</td>
<td>Enjoying the company of the people who are friendly and tolerant of one another.</td>
<td>Strong sense of collegiality</td>
<td>Social relationships and</td>
</tr>
<tr>
<td>nice except for that one I told you about, soon they will transfer me</td>
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<td></td>
<td>networks</td>
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<td>to another room once they finish the renovations.</td>
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<tr>
<td>Interview</td>
<td>Initial Coding</td>
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<tr>
<td>1. Q: what kind of activities do you enjoy most here?</td>
<td>Enjoying day trips, sharing good times with relatives, feeling like part of a group.</td>
<td>Interpersonal characteristics</td>
<td>Activities</td>
</tr>
<tr>
<td>3. A: I like when we go to picnics, my nephews are the bus drivers, they ask me if i am happy, and i answer by saying i am happy because i am with you. Tomorrow we are going to a picnic i guess but i don’t know where exactly, we went three times before to a place named ‘multaka el nahrain’. I sit with the girls and we watch TV, we enjoy our time, what else can we do. I pray, i use my rosary, i thank God and this is what i do. We talk, me and the girls but i don’t ask them to do anything for me, i walk myself to the bathroom slowly and i manage myself in any possible way. Four days ago, i told the manager to do some tests for me so i can know the origin of this pain, heaviness and burning i told you about before.</td>
<td>Purposeful activity.</td>
<td>Meaningful activities</td>
<td>Activities</td>
</tr>
<tr>
<td>4.</td>
<td>Opportunities within the residential setting to pursue meaningful activities.</td>
<td>Praying</td>
<td>Spiritual well-being</td>
</tr>
<tr>
<td>5.</td>
<td>Needs and concerns for religion and prayer are met.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Thankful for the health she enjoys.</td>
<td>Performance ability</td>
<td>Ensuring physical safety</td>
</tr>
<tr>
<td>7.</td>
<td>Being independent, managing physically on her own.</td>
<td>Functional competence</td>
<td></td>
</tr>
<tr>
<td>Interview</td>
<td>Initial Coding</td>
<td>Focused Coding</td>
<td>Theoretical Coding</td>
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<tr>
<td>1. Q: Didn’t you tell the doctor about that?</td>
<td>Wishing that her pain and discomfort will be noticed and addressed by staff.</td>
<td>Physical comfort</td>
<td>Ensuring physical safety</td>
</tr>
<tr>
<td>2. A: No, i haven’t seen him yet, he didn’t come today and yesterday i missed him.</td>
<td>Rapid worsening of pain upon ambulation</td>
<td>Physical comfort</td>
<td>Ensuring physical safety</td>
</tr>
<tr>
<td>3. If i feel more energetic tomorrow, i will go to the picnic, but if i don’t then i won’t go, this pain!! It’s severe, bilateral, goes down to my lower extremities, when i am sitting i am fine but when i try to walk it hurts so badly.</td>
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<tr>
<th>Interview</th>
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<th>Focused Coding</th>
<th>Theoretical Coding</th>
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<tbody>
<tr>
<td>Q: Do you walk frequently, do you go downstairs to the garden?</td>
<td>Confined to upstairs except when visited</td>
<td>Going beyond the constraint</td>
<td>In search of comfort</td>
</tr>
<tr>
<td>Interview</td>
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<td>Theoretical Coding</td>
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</tr>
<tr>
<td>1. Q: Do you like it when you go downstairs?</td>
<td>Visits from family and friends are highly valued. These visits help maintain family bonds and keep her in touch with what is happening at home.</td>
<td>Relationships with family and friends.</td>
<td>Social relationships and networks</td>
</tr>
<tr>
<td>2. A: Yes, i like when someone comes to visit me, may GOD bless you, i like my visitors, my niece and nephews come to visit, sometimes some relatives visit me from the village, i enjoy my time with them. I wish they allow me to go out on pass just for one week but they don’t, and you know winter is on doors and i can’t live by my own in the village. My nephew lives in Beirut, but he has a small house and already his mom is staying with him, and she has poor eyesight. My niece works here but now she is sick and she supports her school aged daughters, at first i used to be stronger and i used to help her, but now i can’t and this is the story of my life, thank GOD.</td>
<td>Expressing desire to make choices for her life.</td>
<td>Care environment</td>
<td>Autonomy/choice</td>
</tr>
<tr>
<td>3.</td>
<td>Used to be stronger, getting weaker.</td>
<td>The lived past</td>
<td>Self assertion</td>
</tr>
<tr>
<td>4.</td>
<td>Needing someone and being needed.</td>
<td>Interpersonal relationships</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Grief over lost abilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview</td>
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<tr>
<td>1. Q: What are the 3 or 4 things you feel essential for having a good quality of life living in this nursing home?</td>
<td>Struggling to remove pain</td>
<td>Physical and functional well-being</td>
<td>Performance ability</td>
</tr>
<tr>
<td>2. A: I just want the pain to go away, just that, so i can keep on walking to the bathroom by myself and this is it.</td>
<td>Wishing to remain independent within the limits of her physical abilities</td>
<td></td>
<td></td>
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<td>Interview</td>
<td>Initial Coding</td>
<td>Focused Coding</td>
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<tr>
<td>1. Q: When you talk to the girls in here, do you feel happy?</td>
<td>People are friendly, tolerant of one another. Feeling that she is treated with respect</td>
<td>Relationship with staff dignity</td>
<td>Social relationships and networks</td>
</tr>
<tr>
<td>2. A: yes, the manager here GOD bless her is very very nice with me, they all are nice.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Interview</td>
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<td>Focused Coding</td>
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<tr>
<td>1. Q: What other things are of big importance to you?</td>
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<td></td>
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<tr>
<td>2. A: What do you want me to tell you, i just want GODs’ mercy, and if i just can get out of here just for one week to spend at the village and then come back.</td>
<td>Expressing desire to make choices for her life</td>
<td>Care environment</td>
<td>Autonomy/choice</td>
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<th>Focused Coding</th>
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<tbody>
<tr>
<td>1. Q: what in your current life is going well?</td>
<td></td>
<td></td>
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<tr>
<td>2. A: yes, i enjoy the picnics, i enjoy having people around, they sing and clap and dance, we listen to the radio all the road.</td>
<td>Enjoying day trips, sharing good times with other residents and caregivers.</td>
<td>Going beyond the constraint</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Almost every Thursday we go to picnic, but Ramadan (the Holy Month) is coming</td>
<td></td>
<td>In search of comfort</td>
</tr>
<tr>
<td>4.</td>
<td>so it might be the last Thursday, unless they take us to eat at a restaurant instead.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Initial Coding</td>
<td>Focused Coding</td>
<td>Theoretical Coding</td>
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</tr>
<tr>
<td>Q: If anything what could make your life feel better?</td>
<td>Struggling to remove pain</td>
<td>Not being a burden.</td>
<td>Concerns for the future</td>
</tr>
<tr>
<td>A: I told you, to have this pain relieved, and keep walking by myself to the bathroom without assistance, without needing a diaper or someone to lift me up, you know I am eighty four now, I just ask GOD to die with faith, they say it's a taboo to say that, but I say that when I die I will be relieved from this life that I reached. I used to be happy before, I had a very nice husband, GOD bless his soul, but we didn't have any children, we lived thirty years together and we were so happy, he received so many treatments, but nothing worked, it was GODS will and I was satisfied with whatever GOD blessed me with, we were blood relatives, everyone kept telling me to leave him, but I am not that kind of woman who would leave their husband, and he wasn't the kind of men who would leave their wife. He left me two rooms (a small house) so I would have a place to live in when he dies. He was scared that when he dies his nephews will force me to leave the house of their uncle, he wanted to make sure that I have a place to stay and that I won't be insulted after</td>
<td>Expressing desire to remain fit enough to retain independence, hold on to the health she still enjoyed. Expressing desire to die with faith.</td>
<td>Maintaining the body.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Had a full and rich life before coming to this nursing home.</td>
<td>Feeling uncertain about the future</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Content with God's blessing. Remembering the past</td>
<td>The lived past</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emphasizing the full and eventful life she has lived and carried with her.</td>
<td>The lived past.</td>
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</table>

**Interview**

<p>| 1. | Q: If anything what could make your life feel better? |
| 2. | A: I told you, to have this pain relieved, and keep walking by myself to the bathroom without assistance, without needing a diaper or someone to lift me up, you know I am eighty four now, I just ask GOD to die with faith, they say it's a taboo to say that, but I say that when I die I will be relieved from this life that I reached. I used to be happy before, I had a very nice husband, GOD bless his soul, but we didn't have any children, we lived thirty years together and we were so happy, he received so many treatments, but nothing worked, it was GODS will and I was satisfied with whatever GOD blessed me with, we were blood relatives, everyone kept telling me to leave him, but I am not that kind of woman who would leave their husband, and he wasn't the kind of men who would leave their wife. He left me two rooms (a small house) so I would have a place to live in when he dies. He was scared that when he dies his nephews will force me to leave the house of their uncle, he wanted to make sure that I have a place to stay and that I won’t be insulted after | Struggling to remove pain | Not being a burden. |
| 3. | | Expressing desire to remain fit enough to retain independence, hold on to the health she still enjoyed. | Maintaining the body. |
| 4. | | Expressing desire to die with faith. | Feeling uncertain about the future |
| 5. | | Had a full and rich life before coming to this nursing home. | The lived past |
| 6. | | Content with God's blessing. Remembering the past | Self assertion |
| 7. | | Emphasizing the full and eventful life she has lived and carried with her. | |
| 8. | | The lived past. | Self assertion |
| 9. | | Grieving the loss of personhood | |</p>
<table>
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<tr>
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<th>Focused Coding</th>
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<tbody>
<tr>
<td>1. his death. One of his nephews was an alcoholic, drug addict, who used to take money from us but now he is under supervision. The other one was better. When my husband died everyone started to interfere pushing me to give him the house before he takes it without my consent, so i did some thinking and i gave up on the house. At first he was very good with me and he used to give me money and check on me, but recently he had an open heart surgery and he had some financial problems so things changed. Some people said why didn’t you give the house to your niece and nephews so they would have a place to spend the summer at when they want, well it’s too late now and i can’t change things, i regret it and i know i have made the mistake of my life but regret won’t change a thing. I used to have some jewellery, part of it was stolen and the rest i sold, when my nephew came i gave him the money, you know how expensive health care related issues are, he pays a lot of money for my treatment and for my medications plus what would i need the money for!! When i receive money especially in Ramadan or from my relatives who live abroad i give it to my Consideration of the economic implications of her life in the nursing home. Adequate income relative to others</td>
<td>Not being a burden</td>
<td>Performance ability</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Adequate income relative to others</td>
<td>Financial circumstances</td>
<td>Social ability</td>
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</tbody>
</table>
1. nephew. He buys my medications
2. and never tells me how much they cost
3. and I don’t even ask.

<table>
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<tr>
<td>1. nephew. He buys my medications</td>
<td>Financial security</td>
<td>Financial circumstances</td>
<td>Social ability</td>
</tr>
<tr>
<td>2. and never tells me how much they cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. and I don’t even ask.</td>
<td></td>
<td></td>
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<tr>
<td>Interview</td>
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<tr>
<td>1. Q: What do you look forward to when you wake up in the morning?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. A: I wake up at 4 am, i wash up and i pray then i thank his almighty, i use my rosary, then i lie down either i fall asleep or stay awake until the girls wake up so we can talk.</td>
<td>Having to “fit” her life around the routine.</td>
<td>Care environment</td>
<td>The human environment</td>
</tr>
</tbody>
</table>

Having to “fit” her life around the routine.
1. Q: what would you like to happen that would make your quality of life better?

3. A: What do i want!! I have poor eyesight and i need surgery. I am receiving good medical treatment, an endocrinologist visited me, he told me i have a hypo functioning glands, but it’s not a problem, what i need is an eyesurgery because I have cataract. I will do the surgery in six months. I am receiving all the care i need by living here what else do I need, can i do if i went back to the village, in here i eat and drink, i have nothing to worry about what else do i need!!

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<th>Focused Coding</th>
<th>Theoretical Coding</th>
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<tbody>
<tr>
<td>1. Q: what would you like to happen that would make your quality of life better?</td>
<td>Receiving individualized and dependable care.</td>
<td>Being cared for</td>
<td>Ensuring physical safety</td>
</tr>
<tr>
<td>2.</td>
<td>Having nothing to worry about</td>
<td></td>
<td>Psychological well-being</td>
</tr>
<tr>
<td>3. A: What do i want!! I have poor eyesight and i need surgery. I am receiving good medical treatment, an endocrinologist visited me, he told me i have a hypo functioning glands, but it’s not a problem, what i need is an eyesurgery because I have cataract. I will do the surgery in six months. I am receiving all the care i need by living here what else do I need, can i do if i went back to the village, in here i eat and drink, i have nothing to worry about what else do i need!!</td>
<td>Freedom from stress</td>
<td></td>
<td></td>
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<tr>
<td>Interview</td>
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<td>Focused Coding</td>
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<tr>
<td>1. Q: what kind of things do you miss about your life before you moved in here?</td>
<td>Used to enjoy home. Good relationships with neighbours.</td>
<td>Home and neighbourhood The lived past</td>
<td>Self assertion</td>
</tr>
<tr>
<td>2.</td>
<td>Pleasant environment</td>
<td></td>
<td>Loss of opportunity to fulfill her roles</td>
</tr>
<tr>
<td>3. A: I used to work at home, clean, wash, do the laundry, cook, visit my neighbours, and they used to visit me in return. I had a small garden in front of my house and used to plant with different kinds of vegetables, so at any time i want i could pick up my stuff from the garden and make a delicious bowl of salad and fry some potatoes and eat. My neighbours were very good with me, they used to send me food when i couldn’t cook anymore. If i can still do these stuff then you won’t find me here, if i had the strength in my legs to walk then i wouldn’t stay in here, i am here because i have to.</td>
<td>Experiencing a loss of contact with others. Her illness has made it difficult for her to do these stuff.</td>
<td></td>
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<td>Interview</td>
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<tr>
<td>1. Q: so you were happier before?</td>
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<td>2. A: yes, i was happy in my house, taking</td>
<td></td>
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<td>3. care of myself, making my own food,</td>
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<tr>
<td>4. taking abath, doing my laundry and set it</td>
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<td>5. to dry before it’s even 7 am. My</td>
<td></td>
<td></td>
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<tr>
<td>6. neighbours used to ask me what time do</td>
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<td>7. you wake up!! Don’t you sleep at night!! I</td>
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<tr>
<td>8. used to tell them when i have things to do,</td>
<td></td>
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<tr>
<td>9. i can’t sleep until i finish what i have.</td>
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<td>10. example i used to make a kind of sweet</td>
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<td>11. named ‘ma3karun’ i used to spend all the</td>
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<td>12. night, i knead the dough, then fry it and</td>
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<tr>
<td>13. then distribute it to all my</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>14. neighbours and serve to my guests and</td>
<td></td>
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<tr>
<td>15. so...</td>
<td></td>
<td></td>
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<td></td>
<td>Loss: happiness and independence</td>
<td>The lived past</td>
<td>Self assertion</td>
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Interview

1. Q: Is there anything in this nursing home that prevents you from having a good quality of life?

4. A: what should i think, i wouldn’t be here if it weren’t because of my disease, if i weren’t in pain i would be somewhere else, but i am happy and thank GOD, i am no different than other people. There are over seventy patients in this department here, all are fine people, they have families and here we are, i am happy but i wish i could be among my family and relatives. I have a brother he is no better than me, he is sick too, he can’t walk and he has poor eyesight too and i know he wants to see me desparately but he can’t, his wife and children come and visit me and reassure me that he is fine, i just wish i could go out for one week to see my brother, so he could see me too. I told you about my sisters’ children i am like a mother to them. They love me a lot, but they live abroad, if only they live here i could but i’d stay at their place. My sister used to work here in the kitchen to help her husband, later he raise the children, GOD bless them they love me a lot, my nephew went crazy when they brought me here, he didn’t want to leave me, he

Initial Coding

The overriding reason for moving to a nursing home was for feeling safe and to have access to the assistance she needed.

Focused Coding

Concern for feeling safe

Theoretical Coding

Ensuring physical safety
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<th>Focused Coding</th>
<th>Theoretical Coding</th>
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<tr>
<td>1. kept saying what would people say “that 2. we left our aunt in a nursing home!”’, 3. but they were scared that if i stayed alone 4. In the village i might fall down and break a 5. bone and find no one to help me. Here he 6. keeps asking me if i am sad, and if i don’t 7. want to stay he will not leave me, he said 8. lets try for a week so you could receive 9. your treatment and if you are not able to 10. accommodate i will pick you up. Thank 11. God, they always check on me and get 12. me whatever i need or like. There are 13. some patients in here that no one asks 14. about, you can see my drawer, it’s full of 15. everything that you would like to have. 16. My niece always checks on me, that poor 17. girl, she is sick now and she has children, 18. and a house rent to pay. Her husband 19. GOD curse him left them, he doesn’t even 20. ask about his children, what kind of a 21. father he is!! Not even a phone call, this 22. bastard he refused to divorce her 23. because he didn’t want her to have a 24. chance to even think of marrying 25. someone else, she loved him, and now 26. she regrets but what can she do, she has 2 27. daughters to take care of, this girl 28. squeezes my heart when i see how sad 29. and unhappy she is.</td>
<td>Realizing that she could not expect the help she needed to be available in her home.</td>
<td>Moving into the nursing home was the second best solution for her because of her need for safety and security.</td>
<td>Safety and security</td>
</tr>
</tbody>
</table>
1. Q: Is there anything about quality of life that we haven’t talked about that is important to you?
2. A: No, there is nothing else left...
APPENDIX 3: Interview Guide (English)

1. Older Person – Nursing Home Resident
2. Staff Member
3. Family Carer
INTERVIEW GUIDE: OLDER PERSON

Generating a model of quality of life for older nursing home residents in the Lebanon: A grounded theory study

1) How would you describe quality of life?

2) What do you understand by the term “quality of life”?

3) What kind of things does the term quality of life make you think of?

4) Tell me what is important to you living in this nursing home?

5) What do you like most about being in this nursing home?

6) What kind of activities do you enjoy most here?

7) What are the 3 or 4 things you feel essential for having a good quality of life living in this nursing home?

8) What in your current life is going well?

9) If anything what could make your life feel better?

10) What do you look forward to in the day/week?

11) What kind of things do you miss about your life before you moved in here?
INTERVIEW GUIDE: STAFF MEMBER

Generating a model of quality of life for older nursing home residents in the Lebanon: A grounded theory study

1) What do you understand by the term “quality of life”?

2) To what extent do your residents here enjoy that sort of “quality of life”?

3) What things are important to a good quality of life for the older persons living in this nursing home?

4) How do you measure good quality care in your nursing home?

5) What do you do in your work here to ensure residents enjoy a good quality of life?

6) What mechanisms do you have in place to check that those interventions are effective?

7) What else could nurses do to help in creating a good life for older persons living in this nursing home?

8) What other things would you like to be able to do to enhance the residents’ quality of life?

9) What prevents you from being able to do those things?
INTERVIEW GUIDE: FAMILY CARER

Generating a model of quality of life for older nursing home residents in the Lebanon: A grounded theory study

1) How would you describe quality of life?

2) What is your life like now, now that your relative is in a nursing home?

3) What do you think makes a good quality of life for your relative living in this nursing home?

4) If anything, what could improve your relative’s life?

5) Can you describe your role in helping to support quality of life of your older relative?

6) Do you still think of yourself as a carer? If so, in what way?

7) What, if any, pleasure do you get from visiting your relative in the nursing home?

8) How would you describe your relationship with your older relative?

9) How much support are you given by health care professionals?

10) How often do you receive any practical support you need?

11) How satisfied are you with the treatment that your older relative receives?

12) What factors did you think about when you were choosing a suitable nursing home/helping your relative choose a suitable nursing home?
1. Older Person – Nursing Home Resident
2. Staff Member
3. Family Carer
Interview Guide: Older Person

dليل المسائلة: للمسنين

تكوين نموذج لنوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية معززة

1- كيف تصف نوعية الحياة؟

2- لماذا يعني لك التعبير "نوعية الحياة"?

3- ما هي الأمور التي يوحي لك بها التعبير "نوعية الحياة"?

4- اخبرني ما المهم لديك في حياتك في هذا الدار للعناية؟

5- ما هو أكثر ما يعجبك في سكنك في دار العناية هذا؟

6- ما هي النشاطات التي تستمتع بها كثيرا هنا؟

7- ما هي المقومات الثلاثة أو الأربعة الرئيسية التي تجعل نوعية الحياة جيدة في هذا الدار للعناية؟

8- في حياتك الحالية ما هي الأمور التي تجري بطريقة حسنة؟

9- هل هناك من شيء قد يجعل حياتك أفضل؟ ما هو؟

10- ما الأمور الذي تتطلع نحوها خلال النهار/الاسبوع؟

11- ما هي الأمور التي افتقدتها في حياتك عند انتقالك إلى هنا؟
Interview Guide: Staff Member

دليل المسئل: المشرفون على رعاية المسنين

تكوين نموذج لنوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية معززة

1- ماذا يعني لك التعبير "نوعية الحياة"?

2- إلى أي مدى يستمتع المقيمين بنوعية الحياة المتوفرة في دار العناية هذا؟

3- ما هي الأمور الملحة لنوعية حياة جيدة للمسنين القاطنين في دار العناية هذا؟

4- ما هو مقياسك للرعاية الصحية الجيدة في دار الرعاية الذي تعمل فيه؟

5- ما الذي تقوم به خلال عملك لضمان جعل المقيمين في دار العناية يستمتعون بحياة أفضل؟

6- ما هي الوسيلة التي تعتمدها لتأكيد نجاح هذا التدابير؟

7- هل من أمور أخرى تستطيع المرضة القيام بها لخلق حياة أفضل للمسنين المقيمين في دار العناية؟

8- ما هي الأمور التي ترغب بالقيام بها لتحسين نوعية الحياة لدى القاطنين في دار الرعاية؟

9- ما هي الأمور التي تعتق تنفيذ رغبتك لتحقيق هذه التحسينات؟
دليل المسائلة: الأقرباء المشرفون على العناية بالمسن

تكوين نموذج لنوعية الحياة في دور العناية للمسنين في لبنان: دراسة نظرية معززة

1- كيف تصف نوعية الحياة؟
2- كيف تجد حياتك الآن حيث أحد أقربائك يقطن في دار للعناية؟
3- باعتقادك ما قد يجعل قريبك يعني حياة كريمة في هذا الدار للعناية؟
4- هل هناك من شيء قد يجعل حياة قريبك أفضل؟ ما هو؟
5- هل تستطيع وصف دورك في تحسين نوعية حياة قريبك المسن؟
6- هل ما زلت تعتبر نفسك من يهتم بهذا المسن؟ كيف يتم ذلك ومن أي ناحية؟
7- هل هناك من أي متعة تشعر بها لدى زيارتك لقرببك في دار العناية؟ ما هي؟
8- كيف تصف علاقتك مع قريبك المسن؟
9- ما مدى الدعم والعناية التي يقدمها لك اخصائيي الرعاية الصحية؟
10- كم من المرات تلقيك دعمًا عمليًا لاحتياجاتك؟
11- كيف تصنف رضاك عن المعاملة (إكتفاكك بالمعاملة) التي يلاقيها قريبك المسن؟
12- ما هي العوامل التي اخذتها بعين الاعتبار لإختيار دار عناية مناسب/مساعدة قريبك على اختيار دار عناية مناسب؟
APPENDIX 4: Ethics Committee Approval: University of Manchester
Our Ref: HS/MH

Ms Marina Adra
Research Assistant
Rm 4.313, Jean McFarlane Building
School of Nursing, Midwifery & Social Work
University of Manchester
Oxford Road
Manchester
M13 9PL

28 October 2009

By email and internal post.

Re: Generating a model of quality of life for older nursing home residents in the Lebanon:
A grounded theory study (Resubmission)
Proposal Number: 09/1021/NMSW

Dear Ms Adra,

Thank you for the clarifications and amendments to the above study as requested by the Research Ethics Committee.

I am of the opinion that no major concerns or objections are evident of an ethical nature. Therefore on behalf of the Committee and taking Chair’s Action, I am happy to grant full ethical approval.

During the progress of the study please inform the Committee of any changes or amendments that may be necessary.

On completion of the study would you please provide the Committee with a “Completion of Study Report”.

Direct Contact: Jean McFarlane Building, University Place

Howard Shilton
Tel: +44 (0)161 306 7642 Fax: 0161 306 7707
Email: Howard.Shilton@manchester.ac.uk
In order to arrange University Insurance Cover please forward the completed Insurance Form (enclosed) along with your Research Proposal and a copy of this letter to the Purchasing Office at the address printed on the form.

Best wishes for your study.

Yours sincerely

[Signature]

Howard Shilton
Chair: School Research Ethics Committee

cc.  John Hopton
     John Keady

Direct Contact: Jean McFarlane Building, University Place

Howard Shilton
Tel:  +44 (0)161 306 7642 Fax: 0161 306 7757
Email: Howard.Shilton@manchester.ac.uk
APPENDIX 5: Institutional Review Board Approval Forms:

American University of Beirut
To: Dr. Marina Adra  
Date: June 1, 2009

Principal Investigator: Dr. Marina Adra  
American University of Beirut
Protocol Number: NUR.MA.02
Protocol Name: Quality of life for nursing home residents in Lebanon: Perceptions and perspectives

Thank you for submitting to the IRB your letter dated May 14, 2009 in response to IRB comments letter dated March 16, 2009 for review.

The IRB reviewed in an expedited manner your reply, the modified study proposal, the English & Arabic interview guides (for older person, family Carer, and Staff member), the English & Arabic informed consents (for older person, family Carer, and Staff member) (version May 13, 2009) and raised the following comment:

Since your proposal is targeting a vulnerable population (elderly), who will be probably suffering from dementia, the IRB recommends having a witness during the process of informed consent.

The signatures of both the witness & the elderly person should be secured prior to participation.

Please submit your reply & the modified informed consents for further consideration.

The membership of this Institutional Review Board complies with the membership requirements defined in the US Code of Federal Regulation (21CFR56 and 45CFR46) of the Food and Drug Administration. In addition, the IRB operates in a manner consistent with Good Clinical Practices under the ICH guidelines, with FDA and applicable national/local regulations.

Sincerely,

Ibrahim Salti, MD, PhD  
Chairperson of the IRB

cc. Dr. Ali Bazarbachi, Assistant Dean for Research, Faculty of Medicine
To: Ms. Marina Adra  
Date: June 9, 2009

Principal Investigator: Ms. Marina Adra  
American University of Beirut

Protocol Number: NUR.MA.02  
Protocol Name: Quality of life for nursing home residents in Lebanon: Perceptions and perspectives

Thank you for submitting to the IRB your letter dated June 04, 2009 in response to IRB comments letter dated June 01, 2009 for review.

The IRB reviewed in an expedited manner your letter indicating that a witness will be present in the process of getting informed consents from older persons, the modified English & Arabic informed consents (for older persons; version dated June 04, 2009).

This is to grant you approval to the study proposal, the English & Arabic interview guides (for older person, family Carer, and Staff member), the English & Arabic informed consents (for family Carer, and Staff member; version May13, 2009), the English & Arabic informed consents (for older persons; version dated June 04, 2009), the English & Arabic Quality of life index (Generic version-III), the chart review form; for a period of one year from the above date, at which time a progress report is kindly requested from you.

The membership of this Institutional Review Board complies with the membership requirements defined in the US Code of Federal Regulation (21CFR56 and 45CFR46) of the Food and Drug Administration. In addition, the IRB operates in a manner consistent with Good Clinical Practices under the ICH guidelines, with FDA and applicable national/local regulations.

Sincerely,

[Signature]

Ibrahim Salti, MD, PhD  
Chairperson of the IRB

cc. Dr. Ali Bazarbachi, Assistant Dean for Research, Faculty of Medicine
To: Ms. Marina Adra
Date: June 19, 2009

Principal Investigator: Ms. Marina Adra
American University of Beirut

Protocol Number: NUR.MA.02

Old Protocol Name: Quality of life for nursing home residents in Lebanon: Perceptions and Perspectives
New Protocol Name: Generating a Model of Quality of life for older nursing home residents in the Lebanon: A grounded Theory Study

Thank you for submitting to the IRB your letter dated June 18, 2009 for review.

The IRB reviewed in an expedited manner, and took note of your letter indicating the change of the study title from “Quality of life for nursing home residents in Lebanon: Perceptions and Perspectives” to “Generating a Model of Quality of life for older nursing home residents in the Lebanon: A grounded Theory Study”; and that no other amendments have been introduced to the study proposal.

The membership of this Institutional Review Board complies with the membership requirements defined in the US Code of Federal Regulation (21CFR56 and 45CFR46) of the Food and Drug Administration. In addition, the IRB operates in a manner consistent with Good Clinical Practices under the ICH guidelines, with FDA and applicable national/local regulations.

Sincerely,

Ibrahim Salti, MD, PhD
Chairperson of the IRB

cc: Dr. Ali Bazarbachi, Assistant Dean for Research, Faculty of Medicine