The Chinese University of Hong Kong
The Nethersole School of Nursing

Cadenza Training Programme

CTP005: Community and Residential Care for Older People

Chapter 6:

Living in Residential Care: impacts on older people and families

Cadenza 溢金頌

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Chapter Outline

- Brief introduction and general views towards residential placement.
- Impacts on older people and families after placement
- Introduction of adjustment processes and coping strategies

Introduction

- Relocation is one of the major life events in later life for older people. (Armer, 1996).

- Transition to a residential home has been identified as the most stressful relocation affecting older people.

1. Residential care placements are often associated with a crisis:
   - acute illness
   - hospitalisation
   - widowhood
   - changes in physical condition, social support and coping skills

(Brearley, 1980; Chenitz, 1983; Willcocks, Peace & Keller, 1987; Johnson, 1990; Retsinas, 1991; Reinardy, 1992;Johnson & Hlava, 1994; Dellasega & Mastrian, 1995; Reed & Roskell Payton, 1996)

2. Admission to a residential home leads to many discontinuities in relation to personal lifestyle.

3. Older people are confronted with the following changes:

- physical location
- daily life patterns
- social networks and support

(Johnson, 1996)

GENERAL VIEWS OF RESIDENTIAL CARE

Views from society:

- Residential care placement has become a social stigma.
  (Qureshi & Walker, 1989; Higgs& Victor, 1993)

- Negative perception due to media reports of neglect or abuse, under-trained staff and profit-making. (Lee, 1997)

Views from older people:

- Rather negative perceptions of living in residential care.

- Often regarded by older people as the 'final sign of failure' and give rise to feelings of abandonment.

(Victor, 1992)

DECISION MAKING PROCESS IN RESIDENTIAL CARE

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Personnel involved

Older people:

- Inclusion of older people is important as their involvement helps to preserve their sense of control, minimises resentment and improves cooperation.
- There are important differences between residential care and acute care and family members should be more involved in decision making.

TRIGGERS FOR MAKING A DECISION ON RESIDENTIAL CARE HOME ADMISSION

The final decision usually comes from family caregivers.

Trigger points are as follows:

1. *Singularity*
2. *Crisis escalation*
3. *Conforming to the idealised caregiver*
4. *Peer validation*
5. *Emotional turmoil*
6. *Ambivalence*
7. *Role redefinition*

(Dellasega & Mastrian,1995)

1. Singularity

Isolated decision making:

Research shows that most relatives see themselves as singular decision makers and feel they are solely responsible for the placement decision.

(Dellasega & Mastrian,1995)

2. Crisis Escalation

- Occurs in families providing informal care to older people who are in need of long-term care services.

- Their burden would be exacerbated by an episode of the older person's physical deterioration or hospitalisation, resulting in a decision of residential care home admission.

(Dellasega & Mastrian,1995)

3. Conforming to the Idealised Caregiver

- Older people's relatives participate in some form of caregiving.

- The caregiving arrangements vary from living with the older person and providing day-to-day care, to taking responsibility for money management and living situations, and by extension, all decisions.

(Dellasega & Mastrian,1995)

4. Peer Validation

- Friends play a critical role before and after the placement decision has been made.
- Friends serve the function of validation.
- The older person's relatives use peer validation to recognise the correctness of the placement decision for the older person.

(Dellasega & Mastrian,1995)

5. Emotional Turmoil

- Carers experience emotional turmoil relating to the placement of the older person.

- Emotions include sadness, loneliness, anger, resentment, relief.

(Dellasega & Mastrian,1995)

6. *Ambivalence*

" Carers may feel ambivalent and uncertain about the permanence of the placement and often experience conflicting emotions.

(Dellasega & Mastrian,1995)

7. Role Redefinition

- Caregivers experience the need to redefine and change roles as a consequence of residential care home placement.

(Dellasega & Mastrian,1995)

EXPERIENCES OF OLDER PEOPLE AFTER ADMITTANCE TO RESIDENTIAL CARE HOMES

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There are four kinds of placement experiences they may encounter:

1. Feelings of loss and suffering
2. Sense of relief and security
3. Reduction in privacy
4. Change of role in their relationships (Nay,1995)

1. Feelings of loss and suffering

- Older people experience insecurity and a devalued sense of self
- Losses can be classified as:
  - *abstract*
  - *material*
  - *social*
- Negative feelings

(Nay, 1995)

Losses : Abstract loss

- Loss of role, lifestyle, freedom, autonomy and privacy.
  (Ryen, 1984; Brooke, 1987; Faucett et al., 1990; Learman et al., 1990; Peisah, 1991; Pearson et al. ,1993; Nay, 1995; Brubaker; 1996, Iwasiw et al., 1996; Wilson, 1997; Fiveash, 1998).

- Loss of autonomy and privacy related to group living and regimentation, which hinders the residential care adjustment.

- Loss of privacy and control over daily living leads to anxiety and stress (Thomasma, Yeaworth & McCabe 1990) and a devalued sense of identity and self-determination.
  (Kahn, 1990; Nay, 1995)

Losses : Material loss

- Including the loss of:
  - home
  - personal belongings.
  - memories attached to homes
- Material losses affect one's sense of security, control and personal identity.

(McCracken, 1987; Thomasma et al., 1990; Nay, 1995)

Losses : Social loss

- Social losses include the loss of family, friends, and even pets.

(Brooke, 1987; Nay, 1995; Patterson, 1995; Iwasiw, Goldenberg, MacMaster, McCutcheon & Bol,1996; Wilson, 1997)

Negative Feelings

The older people may consider themselves unproductive, incompetent and a great burden to others.

- Sense of devalued self
- Powerlessness

Older people may display the following negative emotions and feelings after placement:

- sadness
- depression
- anger
- betrayal

(Tobin & Lieberman, 1976; Chenitz, 1983; Wilkins & Hughes, 1987; Nay, 1995; Gormn, 1996, Iwasiw et al., 1996; Reed & Roskell Payton, 1996)

2. Sense of relief and security

- Sense of relief: no longer alone
- Receive more physical care and feel physically safe
- No need to manage household
- More social stimulation than at home and able to meet new friends

3. Reduction of Privacy

- Privacy consists of the ability of an individual to maintain and control access to him/herself. (Beauchamp & Childress 1989, Childress 1982)

- Attaining privacy is more difficult in respect to the close quarters and the communal areas of eating, watching TV, and talking.

- The demands of nursing care may also lead to decreased emphasis on privacy.

4. Role Relationship

Once older people are admitted to nursing homes, roles and relationships between the health care professionals and the older people will change as follows:

- The health care professionals' role is to maximise the older people's health, and in particular, physical well-being.

- The older people are expected to get better lifestyles by complying with health care professionals' recommendations.

EXPERIENCES OF FAMILIES AFTER THE OLDER PEOPLE ENTERED RESIDENTIAL CARE HOMES

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1. A relief of caregiving burden and stress

- The residential care home admission reduces the caregiving burden and stress associated with taking both physical and psychological care of the older person.

2. Facing challenges of new stressors

- Facing greater financial worries.

- Feeling of guilt as they are unable to take care of the older family members (role failure disruption).

- Feeling of stress when negotiating relationships with staff in residential care homes, *e.g., conflicts arise concerning the family's role in medical decision-making; different expectations of responsibilities between family and staff.*

FAMILY INVOLVEMENT

Family Involvement

Family involvement is considered an effective means for promoting a positive experience for family caregivers.

What is Family Involvement?

The extent to which a family/ family caregiver is involved in taking care of an older person admitted to a residential care home.

Determinants of Family Involvement

Frequency of visits is the main indicator when measuring family involvement. Determinants of frequency include:

1. kinship
2. length of stay
3. cognitive function
4. geographic distance between family and residential care home
5. relationship between family and staff of residential care home

1. Kinship: first-degree kin and those living closer to the residential home visit more frequently.

2. Length of stay: evidence shows that family involvement declines with increasing duration of stay.
(Bitzan & Kruzich, 1990; Yamamoto- Mitani, Aneshensel, Levy-Storms, 2002)

3. Cognitive function:
   - a study found that residents without dementia received more contacts from family compared to residents with dementia. (Port & Clinton, 2001)

- caregiver-resident relationship is affected by the depressed mood and agitation of the resident, and this reduces the number and duration of visits.

4. Distance: transportation is the determinant of family caregiver visits.

5. Relationship with staff: tense relationship with staff may make visits distressing.

Positive Effects of Family Involvement

Greater family involvement has been found to promote elder communication and interaction with staff in residential care homes and resulted in better coping with post-placement stress such as role disruption, guilt and uncertainty about future.

ADJUSTMENT PROCESS

Four processes surrounding placement that influence adjustment

1. Anticipation
2. Participation
3. Exploration
4. Information

(Nolan, Walker,Nolan, Williams, Poland, Curran & Kent ,1996)

1. Anticipation

- The extent to which the residential home arrangement was planned for in a rational and proactive manner. This includes involvement in exploration and providing information.

(Nolan et al., 1996)

2. Participation

- The degree to which there was active involvement in choosing a home.

(Nolan et al., 1996)

3. Exploration

- The degree to which there had been a thorough

  consideration of all the alternatives to residential care, the scope of possible homes and the feelings and reactions to the expected placement.

(*Nolan et al., 1996)*

4. Information

The degree to which comprehensive and clear information was provided on which to base informed choice.

(Nolan et al., 1996)

THE PHASES OF ADJUSTMENT

Using grounded theory approach, Wilson ,1997 developed three phases of the initial process from admission to residential home life within the first month:

1. the overwhelmed phase
2. the adjustment phase
3. the initial acceptance phase

(Wilson, 1997)

1. The overwhelmed phase

- Emotional response to the placement is the dominant in this phase
- Emotional responses include:
  - feelings of loneliness, sadness and loss
  - crying
  - expression of being afraid

(Wilson, 1997)

2. The adjustment phase

- Begins to internalise the negative emotions
- Develops a positive attitude towards the future and everyday living
- Starts to establish new networks
- Addresses problems relating to control and autonomy

(Wilson, 1997)

3. The initial acceptance phase

- Working on acceptance is the goal of this phase
- Starts to get involved in activities and makes new friends
- Self-confidence increases
- Realisation that he/she has a future in his/her new home

FOUR PHASES OF PROGRESSION

Brooke (1987) developed a further process of adjustment within the first eight months after the older people's placement.

1. Disorganisation
2. Reorganisation
3. Relationship building
4. Stabilisation

(Wilson, 1997)

1. Disorganisation

- Happens in newly admitted older residents during the first two months

- The characteristics of disorganisation are:
  - negative feelings associated with the loss of significant others, physical or mental abilities and valued possessions
  - feelings of displacement, vulnerability and being abandoned
  - inward and self-centred behaviour

(Brooke,1987)

2. Reorganisation

- Happens by the third month after placement

- Problem-solving abilities improve:
  - finding the meaning of living in a residential care home,
  - adapting to the routine
  - defining and directing care needs
  - developing goals

(Brooke,1987)

3. Relationship Building

- Occurs during the third and fourth month
- Characterised by developing relationships with other residents and staff

(Brooke,1987)

4. Stabilisation

- Occurs between the fourth and sixth month
- Becoming established in the residential home environment
- Taking others into their world
- More easily accepting of new experiences

(Brooke,1987)

ADJUSTMENT STRATEGIES

Dealing with the placement experience

1. Passive acceptance
2. Making the best of available choices
3. Reframing

1. Passive acceptance

- Conforms with the norms and routine of residential life.

- Porter and Clinton (1992) identified the following common strategies to deal with the changes imposed by residential living:
  - "getting used to living here"
  - "going along with what takes place there"
  - "fitting in through meshing oneself with the circumstances of residential home life"
  - "obeying"
  - "keeping quiet"

(Porter and Clinton ,1992)

2. Making the best of available choices

- Older people focus on those aspects of life in the home that they can still control.

- Engaging in personal characteristics or other familiar, self-oriented activities.

- Exercising control in areas:
  - when to go to bed
  - whether to participate in the home's activities

(Porter & Clinton, 1992)

- Engaging in self-care in areas:
  -managing and stocking up on their favorite food

- Maintaining previous relationships with family and close friends in which the older person still felt in control and able to retain their identity.

(Kahn, 1990; Iwasiw et al., 1996)

3. Reframing

- Reframing the perception that they are “useless” compared to other residents.

- Areas for comparison:
  - physical and cognitive health
  - social status
  - family involvement
  - financial situations

- To enable them to cope with the depersonalisation of the home’s regimen

(Kahn, 1990)

Types of Placement

- Older people have different perceptions towards placement.
- Different processes during placement could result in different adjustment experiences.

Based on the above variables, Nolan et al (1996) classified four different types of placement.

(Nolan et al. ,1996)

Four Different Types of Placement

- Positive choice
- Rationalised alternative
- Discredited option
- “Fait accompli”

(Nolan et al., 1996)

1. **Positive choice:**
   - the most desirable type
   - consideration of when and where to enter care
   - alternatives and feelings about the placement were explored
   - opportunities to maintain a sense of continuity

(Nolan et al., 1996)

2. Rationalised alternative:

- less anticipation, participation, exploration or information was involved
- not desirable
- older people create a perception that the placement was legitimate and / or reversible

(Nolan et al., 1996)

3. Discredited option

began shortly after admission when the situation was not as that perceived before

(Nolan et al., 1996)

4. “Fait accompli”

- described as the worst type when no basic conditions for an acceptable placement were present

- entirely negative

(Nolan et al., 1996)

Conclusion

- The choice of residential home is subject to a decision making process and the outcome will have great impact on both the older person and the family members.

- The elderly take time to adjust to life in a residential home. Feelings, lifestyle patterns, roles and relationships between family members, home staff and the older people are all disrupted by the new environment.

- Family support has been proven to have a positive influence on adjustment and acceptance.

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