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The development of the 'Nursing home/hostel - Quality Of Life Index': A tool to measure the quality of life of permanent residents in geriatric care institutions

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USE OF THESIS

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THE DEVELOPMENT OF THE 'NURSING HOME/HOSTEL: QUALITY OF LIFE INDEX'.

A tool to measure the quality of life of permanent residents in

geriatric care institutions

by

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ABSTRACT

The purpose of this study was to develop the 'Nursing Home/Hostel: Quality of Life Index' (NH/H:QLI). This was to be a tool which would indicate the 'quality of life' of elderly residents in geriatric care institutions, such as nursing homes and hostels.

Several means were employed to establish the validity of the tool. These were: consultation with experienced geriatric nurses, an examination of similar types of tools and correlation with another already established tool; Bigot's Life Satisfaction Index. The reliability of the NH/H:QLI was established by determining how well the scores correlated on a test re-test format. Kendall's Tau was used for this purpose. Alpha had been set at 0.05.

The tool itself consisted of two parts. Part one examined seven major categories. These were; autonomy, life satisfaction, self-esteem, recreation, health, interpersonal relationships and the care institution. Each category had four items related to it. This resulted in there being twenty eight items in part one. Part two consisted of only three items. These were general in nature.

The study was conducted in a single hostel for the aged. There was a small pilot study. Nine subjects took part in the study itself; 1 male and 8 females. Their ages ranged from 81 to 98 years. The length of stay varied from 1 to 13 years. Care was taken to exclude subjects suffering from any intellectual impairment as they would invalidate the data.

The results proved to be encouraging, but not conclusive. With the exception of one group, the various correlations of the test and re-test were significant at the 0.05 level. However, the results of the NH/H:QLI did not correlate with the Bigot's Life Satisfaction Index.

Of the two sub-problems; the NH/H: QLI was able to indicate how the general quality of life of those in the sample population fared. The NH/H:QLI was also able to indicate which of the seven major categories were acting to improve the quality of life and which were acting to decrease it.

DECLARATION

I certify that this theisis does not incorporate without
acknowledgement any material previously submitted for a degree
or diploma in any institution of higher education: and that to
the best of my knowledge and belief it does not contain any material
previously published or written by another person except where
due reference is made in the text.

Linda Pettit

ACKNOWLEDGEMENTS

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INTRODUCTION

The population of Australia is ageing. In 1981, 14% of the population was 60 years and older. The Australian Bureau of Statistics predict that by the year 2021, 22% of the total population will be over 60 years of age. (Kendig & McCallum, 1986;4)

This will create many problems, one of which will be the need to provide suitable accommodation for those who, with advancing age, become frail or debilitated. Such accommodation must be cost effective, yet still protect the quality of residents lives. Studies which evaluate the quality of life in various settings are necessary to help identify which areas are deficient and therefore, where improvements can be made.

The purpose of this study was to develop a tool which measured the Quality of Life of elderly people who live in nursing homes and hostels. The tool took the form of a questionnaire which the respondents were asked to answer themselves. The tool was called the 'Nursing Home/Hostel : Quality of Life Index' (NH/H:QLI).

REVIEW OF LITERATURE

The importance of having a good quality of life or 'Life Satisfaction' as it is sometimes called, has been well recognised in the literature over recent years (Calman 1984, Pearlman & John 1985). However, some difficulty lies with its precise definition. The general consensus, however, appears to be that the quality of life is a subjective experience that can only be truly evaluated by the individual concerned. It is a multi dimensional concept that involves many factors including one's material comfort, state

of health, interpersonal relationship and satisfaction with one's achievements. Furthermore, the quality of life is a dynamic phenomenon which changes over time; being better during some periods of a persons life, and worse during others. A good quality of life is best achieved when an individual's hopes and aspirations are most closely matched with their real situation (Najman & Levine 1981, Calman 1984).

The 'quality of life' is an important concept to study because technology has now progressed to the point where it is possible to prolong life, even though a terminal condition may exist. Such a wonderful achievement, however, may be of little real value if the quality of that extra time is poor (Schipper 1983, Hollandsworth 1988).

The first attempts to describe and define the 'quality of life' concentrated on objective physical criteria. The 'Karnofsky Scale' is one such tool and it has often been used. It has the advantage that a large body of normative data are now available. Unfortunately it has two major limitations. Firstly, it only measures the patient's functional ability. Secondly, it is scaled by the attending physician and so does not reflect the patient's own perspective (Frank-Stromborg 1984, Padilla & Grant 1985). Moreover, such early attempts did not contribute to the understanding of how these physical indicators were experienced by the person concerned.

Later studies began to identify indicators that were more subjective in nature. It would seem in fact that subjective indicators are a more accruate measure of the quality of life and

that they remain more stable over time (Najman & Levine 1981; 108).

The point has now been reached where many authors have developed tools which attempt to quantify various aspects of the quality of life, including its subjective indicators. Some tools examine it in global terms. Examples of this include Priestman and Baums 'Linear Analogue Self Assessment' (Frank-Stromborg 1984), Bigot's 'Life Satisfaction Index' (Snowdon & Manicavasager 1985, Gilleard Willmott & Vadaddi 1981) and Markides & Martins 'Path Model' (Osberg. et al 1987). Many authors have also developed tools which are specific to certain diseases. Examples of these include the 'Quality of Life Index' for colostomy patients (Padilla & Grant 1985) and the 'Quality of Life Questionnaire' for cancer patients (Young & Longman 1983). It is perhaps quite reasonable to have a variety of different tools available as the concerns of a colostomy patient may be quite different from those of a heart attack victim.

Also found in the literature are many articles which explore the impact of various types of housing and care setting on the elderly. Horsnell and Fopp (1988; 30) list several reasons why the elderly leave their established homes and move into a residential care setting. Often they suffer from a physical illness or impaired mobility which makes the daily activities of self care and house maintenance very difficult. Other reasons included feeling lonely or vulnerable, perhaps after the death of a spouse. Also a cause was not wanting to 'be a burden' on their families. Some doctors may also encourage their elderly patients to enter care settings where emergency assistance is readily available.

Whatever the reason for the move, it has several profound consequences. The individual must leave behind their familiar home and many of their most cherished possessions. The move will also take the person away from local social networks which may have taken years to develop. However, Hinrichsen (1985) found that a major advantage of moving into 'age concentrated housing' was that it did facilitate social interaction with peers.

Lemke and Moos (1986) conducted an extensive study which evaluated the 'quality of residential settings' for the elderly. They divided the various aspects of these residential settings into two groups. 'Structural features' included building design and location. 'Process features' included such elements as the quality of nursing care. They found that, some aspects such as safety and cleanliness were always perceived by the residents as being beneficial. However, other aspects such as the opportunity to participate in decision making depended on individual preference. It appears therefore, that there must be some variety in the types of facilities provided to house the elderly in order to cater for the differing needs of each individual.

At present, the official policy of the Australian Government is to provide a variety of care settings. However, the major emphasis is to maintain people in their own homes wherever possible. This is encouraged by the provision of alternative services such as home nursing and community care (Commonwealth/State Working Party on Nursing Home Standards, 1987; vii). Both nursing homes and hostels are expected to provide "conditions approaching as nearly as possible normal domestic life" (Hotel Standards Committee

1982;2). Previously (i.e prior to the late 1970's) nursing homes were classified as "C-Class Hospitals". As a consequence, many observers (the writer included) felt that the atmosphere in these institutions was clinical and detached. It is hoped that by providing a more 'home like' environment and allowing the residents greater autonomy, that the quality of their lives will be maintained at the highest level possible.

In order to achieve these goals, official guidelines have already been set down for nursing homes (Commonwealth/State Working Party on Nursing Home Standards 1987). Guidelines for hostels are currently being drafted (Hostel Standards Committee, June 1987). In future, Government funding for these institutions will be dependent upon their adherence to these guidelines.

In summary therefore, it can be seen that the body of knowledge pertaining to the concept of 'a good quality of life' has grown considerably over the past few years. Research has shifted from mere quantification of strictly physical criteria to the understanding and appreciation of more subjective aspects. Much work has already been done in developing tools which measure the quality of life in a variety of situations. In fact, this accumulated body of knowledge is now being used in very practical ways, especially in relation to the provision of services for the elderly.

FRAME OF REFERENCE

The Question For Study

The original intention of the researcher was to measure the quality of life of elderly people in care institutions using an

established tool. However, none of the tools available were found to be specific enough to this purpose. The many tools which had been developed tended to concentrate either on a general index of life satisfaction, or on specific diseases. No tool was found which examined how an elderly person's quality of life was influenced by their place of residence. To this end, the major objective of this study became the development of a tool to measure the quality of life of elderly Australians who reside permanently in geriatric care institutions such as nursing homes and hostels.

There were two sub-problems related to this question. Firstly, what was the overall quality of these peoples' lives? Could it be considered generally good or generally poor? The second sub-problem was to determine which factors, if any, were lowering their quality of life. Answers to questions such as these are important to care-givers who may be in a position to improve the situation.

For the purposes of this study, a nursing home was defined as 'hospital like' accommodation where several residents may share the same room. The residents are moderately to severely debilitated and require assistance with most activities of daily living. Registered nurses are available at all times. By contrast, a hostel was defined as providing single room accommodation. The residents here usually care for themselves but limited assistance is available when needed. Meals and room cleaning are provided. Hostels are often supervised by people with little or no nursing experience.

As this was a preliminary study, only hostel residents were included. This was because they were likely to be more mentally and physically capable than nursing home residents. Therefore,

they would be able to provide more accurate and reliable feedback as the tool was developed. It was anticipated however, that the finished tool would also be suitable for use in a nursing home.

Conceptual Framework

From the review of literature, the term 'quality of life' can be defined as an individual's own perception of how good or how bad their life is. It is a phenomenon that changes over time, becoming greater or lesser, depending upon the influence of various aspects of one's life. It was from the review of literature that seven major factors which had a considerable impact on the quality of life was formulated. These factors were; interpersonal relationships, state of health, life satisfaction, self esteem, financial security, recreation and autonomy. These factors formed the foundation of the conceptual framework. With the exception of 'financial security',these factors became the major categories from which the individual items of the NH/H:QLI were derived. Financial security was not included because the researcher would be unlikely to have access to files where this information would be kept. For the purposes of this study, these factors or categories are defined and discussed below.

Interpersonal relationships. This involves contact with and support from one's family and friends. It implies a degree of emotional satisfaction and perhaps even material support from such contact. Moving into an institution can have a tremendous impact upon a person's level of social contact. The individual may lose

touch with old friends simply by moving too far away. It has also been the writer's experience that some relatives feel uncomfortable in geriatric institutions and so tend not to visit. On the other hand, new friendships can certainly develop amongst residents of such institutions. On rare occasions residents have even married each other.

State of health. Osberg et al. (1987) assert that a good state of health does not guarantee a good quality of life, but rather, those who suffer poor health experience a lower quality of life. By their very nature, nursing home residents have poor health;otherwise they would not be there. In some cases health care workers can ease the situation by providing adequate pain relief, for example. But, overall, the health of each resident would be expected to decline.

Life satisfaction. This encompasses the satisfaction one has with past achievements, the level of contentment perceived in relation to others in a similar situation as well as one's outlook for the future. The degree of satisfaction experienced depends to a large extent on the personality of the individual. It may also depend on how well things have turned out in life.

Self esteem. This is the belief that one is an important individual who is able to contribute in a meaningful way both to one's own life and to society as a whole. It is how good one feels about oneself. An elderly person's self esteem can be eroded by the fact that they can no longer care for themselves and so must

rely on others for assistance with their most basic needs. It is also important for a person to feel that their opinions and experiences are still of value to society.

Financial security. Money may not make a person happy by itself, but it certainly provides material comforts. At the very least, an income which is sufficient to provide adequate food and shelter will help to maintain a reasonable state of health. Any disposable income could then facilitate the pursuit of leisure activities. The implications for an elderly person are obvious. The more money a person has, the more able they are to afford good quality care.

Recreation. This involves the ability to pursue activities and interests that one enjoys. Although it usually refers to leisure activities, some people enjoy their work sufficiently to consider it recreation. Very often an elderly person is robbed of his or her ability to enjoy leisure activities by failing health. This may also result in a reduction of social contact.

Autonomy. This is the right to make decisions about one's own activities, or to have power and control over one's own life. Definite moves are now being made to include the residents in the decision-making processes of the institutions. This is often done by way of regular meetings with administrative and nursing staff

The quality of life of an individual therefore can become greater or lesser depending upon the input from the various factors. For example, good health and high self esteem would be acting to increase the quality of life where as poor health and low esteem

would be acting to decrease it. At any given point in time, the actual quality of life experienced by an individual would depend on the balance between those factors which are acting to decrease it and those which are acting to improve it. Figure one provides a diagrammatic representation of this concept.

Interpersonal Relationships **Recreation**

Autonomy **State of Health**

Quality

of

Life

Self-Esteem **Life Satisfaction**

Financial Security

Figure 1. <u>Factors which influence the quality of life</u>

None of these factors operate in isolation. They can in fact combine to have a considerable impact on the quality of life. For example, a person who had no money might not be able to afford

adequate food and shelter, this could lead to a decline in health. That same person would have no resources with which to pursue leisure activities and so might suffer social isolation (a lack of interpersonal relationships) and reduced self esteem as a result. It is important to note that although relationships exist between the various factors, it is not within the scope of this study to examine such relationships. Furthermore, no attempt is made to measure the specific contribution of each factor on the quality of life. Rather, this study attempted to describe the quality of life using the NH/H:QLI, a new instrument which is based on this original conceptual framework.

As this study was concerned with the quality of life of geriatrics in care institutions, then one more category needed to be included. It was the :

Care institution.This is defined as the nursing home or hostel itself. It involves both the physical structure; its design and ambience as well as 'process' factors. Process factors include things like the attitude of the staff towards the residents and the adequacy of services such as meals and entertainment.

METHODS AND PROCEDURES OF THE STUDY

Design

This study followed a methodological design in which the validity and reliability of a tool, the 'Nursing Home/Hostel:Quality of Life Index' (NH/H:QLI) was to be established.

Several steps were taken to ensure the validity of the questionnaire. They were as follows:

i) Each item in the questionnaire fell into one of the seven major categories. Six of these categories (autonomy, state of health, life satisfaction, self esteem, recreation and interpersonal relationships) were drawn up from the general literature on the quality of life.

ii) The researcher herself was able to draw on her own broad experience of working with the elderly in a variety of settings. This enabled her to make an informed judgement as to which items might be the most appropriate in this instance. This was of particular help when developing items which pertained to the seventh major category; the care institution.

iii) Many of the items were adapted from existing questionnaires. Sources included both the 'Hospitalized Patient Decision-Making' and the 'Health Illness, Powerlessness Questionnaire' by Sr Callista Roy (US Department of Health, Education and Welfare, 1979; 150-153 and 172-175 respectively). Also included was the 'Twenty-three Item Quality of Life Index for Colostomy Patients' by Padilla and Grant (1985; 59-60).

iv) The draft copy of the NH/H:QLI was distributed to two registered general nurses who were working in a nursing home at the time. They were asked for their appraisal.

v)   Lastly the results of the NH/H:QLI were to be correlated with those from an already established tool; 'Bigot's Life Satisfaction Index' (Gilleard, Willmott & Vaddadi 1981; 234). Bigot's tool was completed at the same time as the NH/H:QLI, on each and every occasion during this study.

The reliability of the NH/H:QLI was to be established using the test re-test format. This was achieved in the following manner.

The subjects were divided into two groups; Group A and Group B. Every subject was administered the same questionnaire twice. In the case of Group A, the two tests were about 24 hours (1 day) apart. It was anticipated that there should be no significant change in each subject's quality of life over such a short period, thus establishing the consistency of the responses. The time interval between the two tests for Group B was 10 days. This longer period was needed to establish how stable the test was over time. Had the time interval been much longer than 10 days, then there may well have been a real alteration in the quality of the subjects lives, particularly with regard to their state of health. This would have given erroneous results. For the NH/H:QLI to be deemed reliable, there needed to be a significant correlation of results between the two tests.

Description of Population, Sample and Setting

The target population for this study consists of all geriatrics who reside in nursing homes and hostels throughout Australia. From this large group, a small sample was to be studied.

Strict criteria were set for entry into the study. They are as follows:

i)   Each subject must be a permanent resident of the hostel and to have resided there for at least three months. This ensures that they have had a chance to settle in.

ii)   Subjects must be over 55 years of age. This is an arbitrary point chosen because the subjects must fit into the category of being 'elderly', yet the limits must not be set so high that there are insufficient numbers of potential subjects.

iii)   Each subject may have any number of physical disabilities such as arthritis or diabetes but may not have intellectual impairment, such as Alzheimer's disease, as the latter would have difficulty answering the questions. It is noted that their quality of life, however, is just as important.

iv)   To control ethnic factors subjects must be English speaking white Australian natives. Alternaitvely, they may have come from a similar culture such as Britain, North America or South Africa and to have resided here for at least ten years.

In order to control for extraneous variables it was decided to conduct the study in one and only one care institution. Extraneous variables were considered to be those aspects which would vary between institutions. They included:

i)   Staffing levels

ii)   Staff attitudes towards their clients

iii)   Convenience or otherwise of building design

iv)   Adequacy of cleaning and laundry facilities

v)   Standard of meal service

vi)   Provision of recreational facilities

vii)   Proximity to transport and shops

viii)   The type of client in residence. That is, some institutions

tend to care for those who are physically disabled whilst others care for more mentally impaired residents.

As a result of adherence to the above sets of criteria and a restricted time span to conduct the study a serious limitation emerged. In the chosen institution there were only twelve residents identified as suitable subjects.

Each of those twelve residents were invited to participate in the study. Only one refused. Of the remainder, two subjects participated in the pilot study. This left only nine subjects for the study itself. The characteristics of those nine were as follows:

i)   There were 8 females and 1 male

ii)   Ages ranged from 81 to 98 years

iii)   Length of stay varied from 1 year to 13 years

iv)   Each subject had more than one physical complaint. These conditions included osteoporosis, rheumatoid arthritis, vertigo, congestive cardiac failure, gout, diabetes, blindness, hypertension and unilateral above knee amputations.

Within certain constraints, the hostel was chosen at random. That is, a list of all suitable hostels in the northern suburbs of the Perth metropolitan area was drawn up. These names were placed in a hat and then drawn out one at a time. Their Directors of Nursing were then contacted. This study was performed at the first hostel that granted permission.

The result was that the study was conducted in a large, non profit, church run care institution. The hostel formed part of a residential complex which also included self-contained 'pensioner flats' as well as a nursing home.

In the hostel there were thirty two permanent residents. Each had their own room but had to share adjoining bathroom with their neighbour. Space was limited but each resident was allowed some of their own furniture. A small fridge was provided and many residents had installed their own telephone and television. Each group of rooms were situated around a small courtyard. Communal areas included a lounge area, a dining area, a day room and barbecue facilities. Also located on the premises were a library and a tuck shop. A hairdresser visited regularly. Once a day residents were able to catch public transport which took them to a nearby major shopping complex. Various activities were arranged daily and all elderly members of the local community were encouraged to attend. In order to provide a 'normal domestic setting' relatives of the residents were encouraged to visit and the staff were not required to wear uniform. The residents had recently been given the option of forming a 'residents committee'. They declined, opting for less formal regular meetings instead. In

addition to the above, workers stated that the staffing levels were adequate. Lastly, although meals were freshly prepared on site, choice was limited.

In conclusion, this was found to be a highly reputable and progressive institution. Care had been taken to maintain the variety, dignity and autonomy in the residents' lives. These observations should be reflected as favourable outcomes in the NH/H:QLI, especially on items from the categories of autonomy, recreation and the care institution. It is important to note also that this hostel was located in a higher socio-economic area. This may have indicated a greater level of financial security for the residents. However, this stduy specifically precludes examination of this point.

Ethical Considerations

This study was explained to potential subjects. They were invited to join but informed that they were under no obligation. To maintain confidentiality no names appeared on the questionnaires. Each subject was assigned an identification number.

The Pilot Study

A small pilot study with two subjects was conducted to check the clarity of the questions and the effectiveness of the instructions. No apparent difficulties were encountered. The subjects were able to complete the questionnaire alone. It took them about twenty minutes.

Data Collection Procedures

There were 9 subjects in the sample. Each subject was to answer the questionnaire on two occasions. Therefore, the questionnaire was administered on a total of 18 separate occasions. All data were collected by the one researcher.

Subjects were randomly assigned to groups in the following manner:

i)   An equal number of coloured stickers (5 green and 5 yellow) were placed in a paper bag

ii)   As each questionnaire was answered one sticker was drawn out of the bag and stuck onto the questionnaire

iii)   It had been pre-determined that those with a yellow sticker would belong to Group A and those with a green sticker would belong to Group B.

Group A was to complete the re-test the next day. Group B was to complete the re-test ten days later.

The Content and Format of the Questionnaire

Part one of the tool. The NH/H:QLI examined seven major categories. Four items were formulated for each category. This made a total of twenty eight items in part one. Each item consisted of a statement followed by a choice of responses. See Appendix A.

In an effort to eliminate bias, the order of the items was mixed. Therefore, all items pertaining to the one category were scattered throughout the questionnaire. However, if very sensitive or personal items were placed near the front, there was a greater chance that the subject would fail to complete the tool once these items were encountered. Therefore, those items which were considered to be more intimate were placed towards the back. Another means of eliminating bias was to express half the statements in a positive form and half in a negative form. This was done for each category so that of all the four items, two were positive and two were negative. An example of positive and negative statements is :

Item 15 - a positive statement

"I still get as much satisfaction out of life as I used to".

Item 2 - a negative statement

"I feel rejected by my friends and family".

A subject who indicated 'strong agreement' with a positive statement would be indicating a better quality of life and so would receive a high score, whilst 'strong agreement' with a negative statement would indicate a lower quality of life which resulted in a low score.

The questionnaire itself is located in Appendix A. A marking guide is located in Appendix B.

The response format consisted of a 'forced choice' Likert scale. This was a somewhat controversial decision. A forced choice scale means that the subject must indicate that they are either for or against the statement. There is no middle ground where they can register an 'uncertain' or 'undecided' opinion. This could be frustrating for those respondents who genuinely were undecided. On the other hand, having too many subjects who chose the 'undecided' option could invalidate the data (Burns & Grove, 1987; 316). For the purpose of this study the forced choice version was retained. Particularly in view of the fact that there were only a few subjects and the researcher did not want to lose any data. This position was confirmed when those who took part in the pilot study had no dificulty with the forced choice version.

Part two of the tool. This section consisted of only three questions. As a general comparison with part one subjects were asked to rate the quality of their lives at present. They were also asked to indicate if it had improved or declined since entering the hostel. In this section, space was provided for comments.

RESULTS

The items in the NH/H:QLI measured subject's attitudes on a Likert scale of 1 to 4. A score of one indicated a low quality of life whilst a score of 4 indicated a high quality of life. The data, therefore, are ordinal. There appears to be strong debate over which level of statistical analysis is appropriate for ordinal data. Should one use parametric or non-parametric statistics? The purists claim that the use of parametric statistics for ordinal data will result in production of meaningless figures. This is

because the exact amount of difference between one score and the next is unknown. Fundamentalists (and many social scientists) do use parametrics statistics for ordinal data. These people claim that accurate comparisons can still be made even though some of the assumptions of parametric analysis have been violated (Burns & Grove, 1987; 476).

For the purpose of this study it was decided that it would be more correct to side with the purists, particularly in view of the small sample size. Kendall's Tau was chosen as the most suitable non parametric measure of correlation. Tau is considered the analysis of choice when there are large numbers of tied scores. It can be used when both variables are ordinal and it is suitable for small samples (Burns & Grove, 1987; 476). Table 1 shows the results of these correlations.

TABLE 1

THE DEGREE OF CORRELATION BETWEEN GROUPS

alpha = 0.05

Variables for Correlation	Tau	Level of Significance
NH/H:QLI:		
Group A		
test to re-test	1	0.02
Group B		
test to re-test	0.53	0.09
All Groups Combined		
test to re-test	0.9	0.004
NH/H:QLI		
to		
Bigot's LSI	0.49	0.5

The nest task was to determine how consistent the responses were for each item between the test and the re-test. Table 2 provides this information. The column headed: 'Number of Identical Responses' indicates the number of subjects who chose exactly the same response between the test and the re-test. The Column headed 'Number of Opposite Responses' indicates the number of subjects who changed from agreement with an item to disagreement with it (or vice versa). This table gives only a crude guide to the internal consistency of each item. Those items listed above item 27 on the table appear to evoke fairly consistent responses. Those

items listed below item 17 appear to be fairly inconsistent. This
indicates that the content of these items may need to be reviewed.

TABLE 2

CONSISTENCY OF RESPONSES BETWEEN THE TEST AND THE RE-TEST

Item Number	No of Identical Responses	No of Opposite Responses
28	9	0
1	8	0
10	8	0
16	8	0
6	8	1
3	7	0
4	7	0
9	7	0
11	7	0
23	7	0
22	7	1
7	7	2
27	7	2
8	6	0
18	6	0
19	6	0
13	6	1
12	5	1
14	5	1
25	5	1
2	5	2
15	5	2
20	5	2
24	5	2
17	4	0
5	4	1
26	4	3
21	3	2

Where: Total No of responses per item = No of subjects = 9

The maximum possible score for each subject on Part One of the tool was 112. The actual scores obtained ranged from 66 to 85 with a mean of **76.78.**

Item 29 of Part Two of the tool asked the subjects to indicate what they perceived their quality of life to be. Table 3 shows the results.

TABLE 3

SUBJECTS OWN PERCEPTION OF THEIR QUALITY OF LIFE

Level	Number of Occasions	Percentage of Total
Very Good	4	22.22
Good	11	61.12
Poor	3	16.66
Very Poor	Nil	—
Total =	18 =	Number of occasions on which test was administered

It can be seen from Table 3 that subjects rated their quality of life as either good or very good on the majority of occasions. These responses were compared to the scores obtained on Part One of the test:

i)   100% of those who scored 83 or above on Part One rated their quality of life as very good on question 29.

ii)   90% of those who scored between 74 and 81 rated their quality of life as good.

iii)   60% of those who scored 73 or below rated their quality of life as poor.

iv)   No subject rated their quality of life as very poor.

This would indicate that on the NH/H:QLI, the cut-off point between a good quality of life and a poor quality of life is around 73. From these results, one could conclude that, with a few exceptions, the subjects in this study generally experience a fairly good quality of life.

In item 30, subjects were asked how their quality of life had fared since entering the hostel:

i)   On 8 occasions (45%) subjects rated their quality of life as having declined since entering the hostel

ii)   On 9 occasions (50%) subjects rated their quality of life as having stayed the same

iii)   On 1 occasion (5%) the subject indicated that their quality of life had improved. The subject gave a reason for this, stating that "I couldn't get around at home."

The last item (number 31) gave subjects the opportunity to comment on things that could be done to improve their quality of life. Of the 9 subjects, there was only one written comment. This comment stated that the bathrooms needed to be bigger to allow wheelchairs to fit in. However, several subjects stated verbally,

words to the effect that the staff working at the hostel were nice and that this "made all the difference".

The final task was to examine the influence of each category on the quality of life. Table 4 ranks these categories in order, from those which obtained the highest scores to those which obtained the lowest scores.

TABLE 4

CATEGORY ANALYSIS

Category	Mode per item	Mean per category
Autonomy	3	12.67
Interpersonal Relationships	3	11.61
Care Institution	3	11.61
Self Esteem	3	11.44
Life Satisfaction	2	10.39
Recreation	2	10.06
Health	2	8.89

Where the maximum possible score per category = 16

DISCUSSION

Limitations Of The Study

The most obvious limitation of this study was the fact that there were too few subjects. This of course means that any

conclusions drawn from the results must be viewed with caution. It also means that it is not feasible to generalize from this small sample to the target population. The small sample size can be attributed directly to two factors. One was the need to control extraneous variables. The other was the need to set rigid criteria for entry which would ensure that the sample studied was relatively homogeneous.

Another major limitation of this study was that it left out some important sub-groups of the nursing home and hostel population. A large proportion of residents in care institutions have some degree of intellectual impairment. These include victims of cerebro vascular accidents or Alzheimer's disease for example. This group was not studied because they would be unable to answer the questionnaire reliably. Residents who came from different ethnic backgrounds were also excluded. Not only might there have been language difficulties, but each ethnic group may experience its own particular type of problems and this could cloud the issue at hand. An often forgotten group is those who live in country areas. These people tend not to be studied because of restrictions on time and budget. However, these people face many extra hurdles which would alter their quality of life. Allied health professionals such as podiatrists or physiotherapists may simply not be available and a visit to the 'specialist' may require a long and expensive journey.

How Well Was The Tool Developed

The main objective of this study was to develop a tool to measure the quality of life of elderly Australians living in care institutions. It would be fair to say that the results are encouraging but by no means conclusive. Alpha had been set at 0.05. When looking at Table 1, it can be seen that the best correlation occurred when all groups, both A and B were combined and their initial tests compared with their re-tests. The most disappointing result was the correlation between the NH/H:QLI and the already established 'Bigot's Life Satisfaction Index'. Upon reflection, this may be a result of the fact that Bigot's tool only measured one aspect of the quality of life, that being life satisfaction. The NH/H:QLI however had a much more comprehensive approach and looked at several areas of influence. As a result of the above, it is plain that the NH/H:QLI needs to be administered on many occasions and compared to a variety of already established tools in order to conclusively establish its reliability and validity. The results of this study do provide some encouragement. Particularly in view of the fact that overall, between all groups (Table 1) the level of correlation was quite high and very statistically significant.

Consideration Of The Sub-Problem

The first sub-problem was to determine just how good the quality of life of the subjects was overall. The NH/H:QLI did indicate that it tended to be fairly good in general. The scores obtained on part one were compared to the subjects' own perception of their quality of life (item 29) and this supported the view

that most subjects experienced a reasonably good quality of life.

The second sub-problem was to determine how the various categories were acting to influence the quality of life. The results of this analysis were found in Table 4.

Autonomy. Subjects rated the category of autonomy the most highly. This would indicate that the efforts of the hostel to respect their clients privacy, to give them some power over their daily activities and to have a say in decisions which would affect them, were having the desired effect.

Interpersonal Relationships. These also fared well. Interpersonal relationships occur on several levels. It was plain that subjects had not lost contact with all their relatives and former friends. Furthermore, the subjects had developed some friendships within the hostel. They had developed relationships not only with the other residents, but with the staff as well. The importance of this last comment was made plain by the frequent comments as to how important it was to have friendly staff.

The Care Institution. There were some aspects of the structure of this care institution which caused problems. Particularly the small bathrooms which had to be shared. However, there appeared to be general satisfaction with various process factors. Even item 3 which asked about the food enjoyed some success even though the menu was limited.

Self-esteem. The level of self esteem is a function of how good or how bad one feels about oneself. In a practical way, self esteem can be improved by a supportive environment. However, in the elderly, the level of self esteem may be falling due to the inability to perform tasks that were previously simple. Some people may also be beginning to feel that they have out-lived their usefulness.

Recreation. It is interesting that recreation came so far down the list even though considerable effort had been made by the hostel management to provide a variety of activities. One explanation may be that subjects were prevented from persuing their favourite activities by lack of physical ability rather than lack of opportunity.

Health. The category of health received the lowest scores. This is perhaps not surprising considering that poor health is the most likely reason for entering a hostel in the first place. This factor alone did the most to reduce the residents quality of life.

Implications For Nurses

Overall, this study provided support for government initiatives which were aimed at improving the quality of life of nursing home and hostel residents. Nurses should, therefore, aim to maintain their clients' privacy, dignity and autonomy. The development and maintenance of interpersonal relationships was very important. Nurses can help make relatives feel at ease in the hostel environment and encourage their participation in various activities.

They can also assist the relatives to take residents on outings by simple activities such as arranging appropriate transport or allowing clients to borrow a wheelchair for the day. Interpersonal relationships can be fostered within the nursing home by encouraging certain members of the general community to visit. This would help to reduce the isolation experienced by some hostel residents. Lastly, the provision of staff who are friendly, sympathetic and stable can go a long way towards improving the quality of life.

Studies such as this may also indicate areas where nurses think they are achieving a goal but may in fact not be. Perhaps the provision of recreational activities needs to be re-assessed in this case.

Recommendations For Further Research

This study in fact poses several problems which require further research. Most obviously the NH/H:QLI needs further development and refinement.

Also in need of research are the various implications of the guidelines set down by Government. Some of these guidelines may in fact require additional staff and funding which were not immediately apparent. Also some measures may in fact not have the desired effect. For example, the practice of staff not wearing uniforms may be seen as a step towards 'normalization', but for elderly residents it may cause confusion instead. Without uniforms, it can be difficult to determine who is a staff member and who is a visitor.

Studies need to be done to determine what the quality of life is for people of various ethnic backgrounds. Is it appropriate to have people from a variety of cultures residing in the one institution or should there be a variety of institutions to cater for different cultures?

The Government's goal of maintaining people in their own homes is commendable in that it keeps people in familiar surroundings. However, this policy is also encouraged because it costs less. The danger is that there may be many people who actually require nursing home care but can not get it. The Staff at the particular care institution in which this study was conducted report that they have a long waiting list of needy people. Research needs to be done to determine just how well the available services are meeting the needs of the community.

Lastly, studies need to be done into the particular problems of country residents. The tyrany of distance presents many problems. Not only is it difficult for clients to obtain specialist care but it is also difficult, sometimes almost impossible, for staff to further their education.

CONCLUSION

This study only partially achieved its main objective of developing the NH/H:QLI as a tool for measuring the quality of life of residents in permanent care institutions. However, it was found that the general quality of life in the care institution

studied tended to be reasonably good. This reflected in part the recent Government guidelines as well as the compassion and initiative of the staff.

APPENDIX A

NURSING HOME/HOSTEL: QUALITY OF LIFE INDEX

Part One

This section contains several statements. You are asked to rate each one according to how well you agree or disagree with it.

For example:

The sun always sets in the west.

    __X__ Strongly Agree

    _____ Agree

    _____ Disagree

    _____ Strongly Disagree

We are asking for your opinion only, there are no right or wrong answers. Mark only one space per question. Good luck.

1   I enjoy participating in the recreational activities provided by the hostel.

    _____ Strongly Agree

    _____ Agree

    _____ Disagree

    _____ Strongly Disagree

2   I am unable to persue my old interests and activities because the facilities are not available here.

     _____ Strongly Agree

     _____ Agree

     _____ Disagree

     _____ Strongly Disagree

3   I enjoy the food here very much

     _____ Strongly Agree

     _____ Agree

     _____ Disagree

     _____ Strongly Disagree

4   I am given no choice about every day matters, such as what time to get out of bed or when to have a shower

     _____ Strongly Agree

     _____ Agree

     _____ Disagree

     _____ Strongly Disagree

5   I feel that I am still a useful member of society

     _____ Strongly Agree

     _____ Agree

     _____ Disagree

     _____ Strongly Disagree

6   I still peruse all the old hobbies and interests that I

enjoyed before coming here to live

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

7   I feel that I am not given enough privacy by the staff here

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

8   This building is well designed. For example: the rooms are

big enough, the toilet facilities are convenient and the

decor is pleasant

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

9   I have no physical impairments

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

10 I decide which activities I will or will not attend

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

11 Since coming here to live, I have lost contact with most

of my old friends

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

12 I am still able to perform daily activities such as dressing

and bathing without help from anyone

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

13 I tire much more easily these days

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

14   I am expected to do as I am told by the staff

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

15   I still get as much satisfaction out of life as I used to

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

16   On the whole, I feel that I am worse off than other people
in a similar situation

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

17   When I say that I don't want to do something, the staff
respect my decision

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

18 I am constantly made miserable by poor health

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

19 I feel rejected by my friends and family

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

20 During my life I have achieved everything that was important to me

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

21 I have developed satisfying friendships with some of the other residents here

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

22   I feel totally useless

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

23   One of the benefits of moving to a hostel is the opportunity to meet new people and make new friends

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

24   I feel very discouraged about what the future holds for me

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

25   My family does not visit me as often as I would like

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

26 None of the recreational activities provided here are to my liking

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

27 I have much knowledge and experience that could be of value to younger people

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

28 I would like to have more say as to how this hostel is run

_____ Strongly Agree

_____ Agree

_____ Disagree

_____ Strongly Disagree

Part Two

29 How would you rate the quality of your life at present

_____ Very Good

_____ Good

_____ Poor

_____ Very Poor

30   In general, would you say that the quality of your life has improved or declined since coming here to live?

        _____ Improved

        _____ Stayed The Same

        _____ Declined

Can you give any reasons?_____

_____

_____

31   Can you think of anything that could be done to improve the quality of your life?

_____

_____

_____

_____

APPENDIX B

MARKING KEY FOR PART ONE OF THE NH/H:QLI

Scores for positive items		Scores for negative items	
<u>4</u>	Strongly Agree	<u>1</u>	Strongly Agree
<u>3</u>	Agree	<u>2</u>	Agree
<u>2</u>	Disagree	<u>3</u>	Disagree
<u>1</u>	Strongly Disagree	<u>4</u>	Strongly Disagree

Category	Item Number			
	Positive items		Negative items	
Self Esteem	5	27	19	22
The Care Institution	3	8	7	28
Interpersonal Relationships	21	23	11	25
Health	9	12	13	18
Recreation	1	6	2	26
Life Satisfaction	15	20	16	24
Autonomy	10	17	4	14

N.B.   No scores awarded for Part Two.

APPENDIX C

BIGOT'S LIFE SATISFACTION INDEX

		Scores		
		T	U	F
1	I am as happy now as when I was younger	2	1	0
2	Compared to others, I get down in the dumps too often	0	1	2
3	The things I do are as interesting to me as they ever were	2	1	0
4	When I look back on my life, I didn't get most of the important things I wanted	0	1	2
5	These are the best years of my life	2	1	0
6	Compared to others my age, I've made a lot of foolish decisions	0	1	2
7	I would not change my past life if I could	0	1	2
8	My life could be happier than it is now	0	1	2

(Gilleard, Willmott & Vaddadi, 1981; 234)

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