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# Quality of Life Indicators: The Objective-Subjective Interrelationship That Exists within One's 'Place of Residence' in Old Age

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**Abstract**

Using a largely qualitative research design, this study originally explored how a small cohort of aged clients and human service workers assessed and measured Quality of Life (QOL) amongst older people. A literature review was undertaken and interviews were conducted with participants from Community Vision Incorporated (CVI) and other key informants from separate human service agencies. The findings suggested that there was a dichotomous relationship between the perceived affects that in-home care and aged care facilities had on the QOL of older people. A number of participants suggested that in-home care and aged care facilities were disempowering and overall, impacted negatively on the Objective QOL (O-QOL) and Subjective QOL (S-QOL) of older people. This paper will outline these complexities and further discuss related themes, issues and new insights into the relationship between an older person's 'place of residence' and other O & S-QOL indicators.

**Keywords:** Qualitative research design, Quality of life indicators, Older people, Community vision incorporated, In home care, Residential Aged care facilities, Subjective and objective quality of life, Place of residence

## 1. Introduction

This research paper is based on the greater findings of a Post Graduate Honours Research Degree, conducted in the School of Psychology and Social Science (SPSS), at Edith Cowan University (ECU) (see Georgiou, 2008). The study focused on the qualitative responses of a small cohort of aged clients, staff members and managers from CVI, as well as number of key informants from three other large, Western Australian aged care service providers. CVI is a peak Non-Government Organisation (NGO) operating throughout the northern suburbs of Perth, the capital city of Western Australia. The agency provides various community, care and support services to older people and people with disabilities. The original study had three main components of inquiry, each exploring issues related to QOL amongst older people; particularly within an Australian context.

The research was designed to qualitatively study the ways in which participants perceived and understood QOL and thereby identify new insights or measures that could be used to inform future research into QOL amongst older people. This involved the collection of primary data, as well as a review of relevant academic literature and Australian

Government documents. This created an understanding of existing QOL indicators or frameworks and also explored the ways they are generally utilised by aged care service providers.

The secondary aim of the research was to find possible weaknesses in existing QOL measures or instruments and suggest new ways to understand and assess the QOL of older people. Although not an evaluation of the agency per se, *CVI's Referral and Assessment Form* (this form being a standardised instrument adopted from Department of Health *pro formas*) was used as the theoretical foundation of this analysis (Aged Care Team Leader, 2007). The concept of an ageing society was also explored through primary and secondary inquiry. The phenomenon's potential impact on the Australian aged care industry and the future QOL of older people was considered to be a significant issue that warranted further investigation (See Table 1 for a list of the five fundamental research questions used to shape the original study).

The research concluded that home care and aged care facilities, should be a critical component in the assessment and referral process of aged clients. However, it would appear that to date, they are not. Regardless of whether the clients live in private residences and received in-home care, or reside in dedicated aged care homes, the data was constant. 'Residential'-based indicators of QOL were extremely important in understanding how participants perceived and understood their QOL.

These same 'Residential' themes and sub-themes also suggested new ways in which QOL indicators should be developed in the future. For example, the theme 'Residential' was found to be a multi-faceted QOL indicator that needed to be further broken down into smaller measures. These areas included 'place of residence', 'in-home care' and 'age-friendly design' and each was identified with having a significant bearing on the QOL experiences of older people. However, an older person's subjective 'Perception' of their place of residence appeared to impact on QOL more than the purported physical benefits of their residential environment. This led the Researcher to conclude that referral and assessment protocols (which tend to be closed ended in Australian contexts) need to be far more subjective and qualitative in nature to ensure QOL indicators (based on subjective perceptions) and others mentioned below, are captured and implemented.

## 2. Background to the Original Study - QOL Paradigms and CVI's Referral and Assessment Form

The original study found that QOL paradigms can be narrow or broad. The vast number of QOL indicators identified in the literature review, were multi-dimensional and tended to employ, to varying degrees, a combination of both O-QOL and S-QOL indicators. There were considerable similarities in the frameworks studied *vis-à-vis* O & S-QOL indicators. Furthermore, an O-S QOL interrelationship was evident even in the primary data.

However, the literature review also suggested that many of the existing referral and assessment instruments (utilised by aged care providers and related government agencies) used 'closed' instruments when assessing aged clients. 'Closed' refers to the fact that the instruments did not allow the older people (and indeed staff and management) to 'speak for themselves'. CVI's *Referral and Assessment Form*, did not accommodate for a O-S overlap, tending to be 'closed' and focusing on four broad O-QOL indicators; 'physical', 'intellectual', 'sensory' and 'social' QOL indicators (Aged Care Team Leader, 2007).

The literature showed that there has been a strong momentum in the QOL debate for the individuation of QOL Frameworks (see Bowling, 2005). As a result, the original research focused on this issue; transferred 'individualised' dimensions into the methodology; and encouraged respondents to identify themes they perceived as personally significant to the measurement of QOL. Ultimately, the original Honours Research suggested that CVI could further amend and improve their *Referral and Assessment Form* to better accommodate S-QOL indicators and include open ended questions.

## 3. Literature Review -QOL Frameworks

As previously stated, QOL Frameworks have generally been constructed with either a narrow focus or based on a broader understanding of an individual's well-being (Gerritsen, Steverink, Ooms & Ribbe, 2004). According to Gerritsen *et al.* (2004), models based on health-related QOL fall into the first category (narrow). Hunt (1999) stipulated that health-related QOL can be regarded as synonymous with one's 'physical functioning'. Opponents of such a view have argued that although a person with physical debility may be limited in their mobility, it does not necessarily demonstrate that they have a poorer QOL than a physically healthy individual (Hunt, 1999). It was suggested that such a "narrow" correlation discriminated against older people, people with disabilities and those with long term diseases (Hunt, 1999, p. 229). Therefore, this narrow approach to measuring QOL was not applied in this Honours study.

Health-related QOL indicators and frameworks can also be separated into "holistic" measures (such as 'social, emotional and physical well-being') or more limited definitions that focus on a person's life in general (Carr, Gibson and Robinson, 2001, p. 1240). Hunt (1999) posited that QOL should not be evaluated purely on an individual's health. In order to maximise one's life status, societal, monetary and cultural dimensions of wellbeing need to be addressed in conjunction with a person's physical state. Coming from a health-related background, Lacasse, Wong and Guyatt (1999) stipulated that QOL is commonly comprised of four recurring themes. These included 'bodily functioning',

'psychological wellbeing', 'socialisation' and 'physical sensation'. Although not ideal, this approach more closely related to the QOL measurement paradigms ultimately utilised as part of the original Honours study.

Community indicators of QOL have also been divided into narrow and broad categories, ranging from countrywide measures to local service delivery and individual QOL instruments (Zagon & Shookner, 2002). Bowling (2005) argued that there are fundamental QOL indicators that permeate the greater population. These included 'mental', 'physiological' and 'emotional' health (Bowling, 2005). Also important were social and familial networks, civic participation, as well as maintaining physical and financial security (Bowling, 2005). However Bowling (2005) also discussed various subjective dimensions of QOL, further suggesting that 'autonomy' was a distinct measure of one's QOL.

In Bowling's (2005) review of Individual QOL Frameworks she discussed the *Schedule for the Evaluation of Individual QOL.* The schedule requires older people to describe five issues that are personally significant to their own wellbeing (Bowling, 2005). The *Quality of Life Index* is a tool for self-assessment (Browne, 1999). As in the schedule discussed above, individuals using this index elect QOL indicators that they feel are significant to their personal wellbeing. They then relay whether they have positive life experiences in each of these indicators (Browne, 1999). A similar procedure was used in this research methodology, where participants were asked to define what QOL meant to them, as well as describe any issues or advantages that they or older people in general experienced in relation to QOL.

According to Browne's (1999) *Goal Attainment Measures,* QOL is determined by comparing one's actual state of being, with what they desire for themselves. Aiming for desired outcomes and actually attaining these goals are related to positive experiences of QOL (Browne, 1999). Such measures are subjectively individualised and not subject to standardisation – desires being highly personal in nature.

Another Individualised Framework discussed by Browne (1999), was the *Subjective QOL Profile.* This model encompassed four indicators of QOL. The first indicator includes physical, physiological, psychological and sexual ability under the banner of 'functional life'. The next objective indicator, 'social life', is comprised of 'networks, social engagement and participation'. Monetary and housing concerns come under the objective indicator 'material life'. The last is the subjective indicator 'spiritual life' which involves religious views, faith and personal activities such as "reflection" "reading" or "meditation' (Browne, 1999, p. 165). These QOL frameworks discussed above provides a realistic insight into the subjective QOL needs of the aged, however, these discussions are only available in academic literature and only a handful of QOL frameworks can be said to have adopted the most positive aspects of these frameworks.

Although CVI's multi-dimensional *Referral and Assessment Form* focused on four broad categories - 'physical', 'intellectual', 'sensory' and 'social' - the ways in which their clients were asked and their QOL assessed, denied their 'subjective' input. Despite this, the *Referral and Assessment Form* still closely related an eclectic approach to measuring QOL and was used as the theoretical foundation of the original research. To add a subjective dimension to the study, the researchers asked more general, open-ended questions that queried the perceptions participants held regarding QOL issues. For a discussion about the methodology employed in this research please refer to section 4.2 below (for an outline of the question guide please see Table 2).

*3.1 Literature Review - Objective and Subjective Dimensions of QOL*

According to Lebowitx (2000) QOL is an extensive topic. There is little agreement as to its theoretical foundations, what indicators exist or how QOL frameworks should be utilised (Lebowitz, 2000). Although there appears to be no universal definition of the concept of QOL, it is usually measured in terms of 'objective' and 'subjective' indicators (O-QOL and S-QOL indicators). "Quality of Life is both objective and subjective, so its measurement should include how people think about their lives" (Eckersley, 1999, p. ix).

O-QOL indicators involve tangible objects such as finances, employment, place of residence (home ownership), education levels and one's social or physical environment (Bowling, 2005). S-QOL indicators include one's contextual understanding of QOL based on personal history, future prospects and attitudes, life history and emotional and physical well-being, as well as 'depression', 'anxiety', 'bereavement', 'adaptability' and 'reminiscence' (Bowling, 2005). According to Roche (1990), QOL is subjectively measured by personal opinion and objectively defined in terms of standardised measures. Objective and subjective indicators appear to be interlinked, but a contradiction arises in the assessment process when subjective indicators are assessed using a closed instrument (see Roche, 1990).

As outlined by Bowling (2005, p. 148) conventional QOL measurement devices have been *"ad hoc"*, with no uniform structure. Again, although QOL itself appears to have no agreed upon classification (Bowling, 2005), the importance of perception and one's outlook on life have been recognised and there has been a recent trend to add subjective dimensions to pre-existing, traditional O-QOL frameworks to enhance the scope of QOL inquiry (Bowling, 2005). However, it would seem that widespread acceptance of these trends has not occurred.

Subjective wellbeing, as defined by Glicksman (2000), is related to positive feelings and mental states. According to Bowling (2005) S-QOL is synonymous with how positive one's life is. Subjective wellbeing is an assessment of an individual's mental, physical, economic and social status (Glicksman, 2000). It involves a comparison between one's current life and their prior experiences (Glicksman, 2000). Subjective wellbeing is further influenced by events in one's life and how one reacts to 'life's events'.

A further S-QOL indicator identified in the literature was depression. Universally, the largest sources of depression amongst older people are consequences of physical disorders, pain, loss and diminished social support (Richardson & Barusch, 2006. Another important S-QOL indicator discovered in this research and related literature is 'Reminiscence'. Reminiscing is not solely about remembering events, but portraying one's life experiences from a highly subjective perspective (Tilki, 2000). According to Tilki (2000), older people should have the opportunity to reminisce in both formal and informal environments. "*Reminiscence affords a rich seam of information which has the potential to enhance the quality of life for older people by enabling professionals to listen to the real needs of clients*" (Tilki, 2000 p. 107).

S-QOL indicators are wide-reaching and influenced by many intrinsic, cognitive, emotional and contextual factors. In addition to the substantive themes discussed here, it was found that subjective dimensions are closely interrelated with objective indicators of QOL. The indicators identified in the literature correlated with those recognised in the primary data of this research study. These O-QOL and S-QOL are listed in Table 1 below, and whilst they are not the major focus of this paper, they form the basis upon which its arguments are based. The indicators listed in Table 3 come from the analysis of primary data and many have been supported by the relevant QOL literature.

## 4. Research Design – Ethical Considerations

Initially, a brief proposal outlining the purpose and ethical considerations of this research was submitted to CVI's Board of Executives early in 2008. The original study was completed under the auspices of ECU research guidelines and data collection commenced after National Health and Medical Research Committee (NHMRC) ethics approval was obtained from ECU in June 2008. Ultimately, CVI accepted the research proposal, upon receiving said ECU ethics approval. Informal discussions about the study took place with prospective clients, staff and key informants prior to the formal face-to-face interviews taking place. *Information Letters* and *Ethics Consent Forms* (based on ECU and NHMRC guidelines) were presented or sent to all participants. Due to ECU's ethical guidelines, the *Information Letter* and *Ethics Consent* forms were disseminated as hard copy documents with the University's Banner included in the letter head. However, in some cases these were read to clients with poor vision.

In 2007 the researcher was completing a Bachelor of Social Science at Edith Cowan University with a Double Major in Community Studies and Welfare and Community Work. Practicum's were an essential part of this degree. As part of a Third Year Practicum Unit, the researcher completed two hundred hours of a student work placement at CVI. As a result, the researcher worked closely with clients and staff at the *Adult Day Care Centre* as well as CVI's Administrative Offices in Joondalup, in late 2007. This created a pre-existing relationship of trust between the researcher and participants, thereby unintentionally aiding the data collection process undertaken in June 2008.

The face-to-face interviews with client and staff participants from CVI took place at the Woodvale Community Centre in the northern suburbs of Perth. As it was the location of the *Adult Day Care Program*, it was a secure setting that both the researcher and participants were familiar and comfortable with. Interviews with key informants were undertaken at their own place of work. All interviews were conducted individually and in a private room; ensuring full confidentiality. At the end of each interview, participants were asked to choose a fictitious name. Participants selected their own pseudonyms to protect their anonymity and to further secure their confidentiality. By including them in part of the decision-making process it also ensured that the research design was collaborative. These pseudonyms have also been used in this paper and have been combined with their status as an aged client, day care staff worker, manager or key informant (so as to easily identify them as belonging to a specific demographic group).

*4.1 Research Design – Sampling Frame*

The total number of participants recruited for this study was sixteen. A small group of six aged clients from the *Adult Day Centre* were the central focus of this study. A further five staff members from the *Adult Day Centre* were interviewed and two managers from the CVI's Administrative Offices undertook the electronic survey. In addition to this, three key informants from three separate Western Australian aged service delivery organisations were also recruited.

The process of recruitment was non-random and true generalisation to the greater population of older people outside the Day Centre was not feasible (Walliman, 2004). A combination of Theoretical Sampling, Convenience Sampling, the Snowball Sampling technique and Opportunity Sampling was employed to recruit participants (see Bell, 2005; see Walliman, 2004). Limitations of the research could be related to the small sample size, however the study was able to draw indicative and valid conclusions that could inform policy and research. Although not based on empirical fact, due

to the in-depth nature of the study (using both primary and secondary resources to support any data), the findings might be useful to health care workers, researchers and policy-makers concerned with the maintenance of positive QOL experiences among older people.

*4.2 Research Design – The Data Collection Process*

Unlike the quantification of interview responses that takes place in traditional experimental research designs, the questions used as part of this research focused on the respondents' personal and professional views on QOL amongst older people. In quantitative research designs, set answers are assigned a pre-determined value and the "meaning" behind what is said is only considered after an analysis of the content (Rubinstein, 2002, p. 137). Conversely, interviews used as part of qualitative research design (such as in this study) encourage respondents to provide an in-depth account of their personal experiences; thereby establishing the meaning behind one's responses (Rubinstein, 2002).

The research design was made up of a series of semi-structured interviews and survey interviews. By using a semi-structured instrument, the researcher was in a position to ask respondents to expand on matters of interest or concern to the study; according to Bell (2005) this is a strength of qualitative research. At the beginning of each in interview, respondents were asked probing questions relating to their personal and conceptual understanding of QOL. The question guide also included questions that were based on the four fundamental themes in *CVI's Referral and Assessment Form*; 'physical', 'intellectual', 'sensory' and 'social' QOL indicators (Aged Care Team Leader, 2007). Further information was gathered concerning 'service delivery' and the QOL of older people in an 'ageing society' and how Australian aged care services could meet the demands of an ageing society. All interviews closed with an open-ended question that allowed respondents to discuss matters personally significant to them.

The majority of questions relating to the four main QOL themes were asked of all participants but these universal questions were modified to suit the separate sample groups and individuals therein. As stipulated by DETWA (2005) the questions were shaped to cater to the individual participant giving their response. For example -

> *"In your opinion, do older people…"* – for staff
>
> *"In your experience, do you ever…"* – for clients

A number of questions were relevant only to clients, staff, managers or key informants; they were specific to these respondent groups' Subjective opinions or expertise (for the questions list posed to staff members see Table 2). Overall, the question guide was not prescriptive and conversations were flexible. Even in the survey interviews, respondents were encouraged to provide in-depth accounts of their personal experiences; thereby allowing the researcher to establish the meaning behind their responses (Rubinstein, 2002).

*4.3 Research Design – Analytical Framework and Data Analysis*

In the original study, the Analytical Framework involved identifying QOL indicators through the literature review and interview processes; data analysis had three phases. The first phase, the literature review, listed several existing QOL Frameworks and QOL indicators, as well information regarding ageing populations. One of the aims of this review was to establish whether the CVI *Referral and Assessment Form* required amendments (Aged Care Leader, 2007). Another aim was to establish what changes might occur as part of an ageing society and how this could impact on the QOL of older people in Australia.

The interview process was the second phase of the Analytical Framework. As previously stated, the question guide developed for the interviews and survey interviews was based on the four themes of the Referral and Assessment Form (Aged Team Leader, 2007). As in the literature review, a purpose of the interviews was to assess whether these themes were adequate measures of QOL amongst older people or if the instrument should be further developed to include new or alternative QOL indicators. The interviews also aimed to ascertain other pertinent information about the QOL of older people in an ageing society and how aged service delivery may evolve to meet the demands of an ageing population. These qualitatively based interviews were transcribed; the content analysed; and then reviewed, using thematic analysis techniques whereby verbatim quotes were grouped into themed categories. Historically, 'themes' have been described as recurrent subject areas that are identified by participants as areas of great significance to their lives. As purported by Rubinstein (2002), in the original study themes were interpreted during interview's (detailed in the field notes) and again as part of the analysis process.

*NVivo Version 7,* a post-positivist software tool for qualitative analysis, was used for content analysis purposes. The researcher input verbatim quotes from field notes and survey interview data into *NVivo*, which was then used to develop substantive codes and nodes; from this it was determined what initial themes appeared to be emerging from the primary data relating to old age and QOL indicators. Using these substantive codes as a foundation, further data analysis involved the categorisation of full interview and survey content by constructing themed tables on *Microsoft Word*. These themes and quotes were then used as part of the thesis findings and were used to explore and discuss any new or alternative QOL indicators.

In the third analytical process, comparisons were made between select QOL Frameworks that were analysed in the literature review (see section 3.1 above); the QOL indicators identified through an analysis of the participant data; and the QOL themes that emerged from further analysis of the CVI QOL indicator, the *Referral and Assessment Form*. The data analysis was based on a triangulation of data from these three separate, qualitative sources. Ultimately, the themes and quotes identified in the primary data were used to add context to the secondary data (see Table 4). Furthermore, responses concerning QOL were used to explore, develop and discuss any new or alternative QOL indicators (as outlined in Table 3). The original research was able to identify strengths and weaknesses in the current CVI and other QOL indicators. This further contributed to the discussion of QOL issues experienced by older people - within an Australian context.

*4.4 Research Design - Limitations and Strengths of this Research*

Mirrored in this study, Rubinstein (2002) suggested that in most research designs, participants are encouraged to provide responses based on their subjective experiences. As in this study, the analyst then investigates all responses as a group and recurring themes are identified. Despite this, Rubinstein (2002) argued that although shared experiences may become apparent to the researcher, the history of individuals is highly personal and the experiences of 'one' cannot be directly generalised to other people. He further stipulated that analysts usually present an individual response as indicative of the sample population's experiences (Rubinstein, 2002). In this study, verbatim responses were analysed, compared and quotes deemed the best examples of a particular theme, were used to represent recurrent themes. As the format described by Rubinstein (2002) is similar to the data collection and analysis phases of this study (see section 4.3 above), the original research's Methodology and Analytical Framework could be viewed as limited.

Conversely, Rubinstein (2002) discussed an interview where a proxy informant (a carer or support worker answering on behalf of their client) not only described her own interpretation of events, but how her aging mother felt and her own perception of her mother's later life. This phenomenon was apparent in this study. Members of the staff, manager and key informant participant groups all drew from their own experiences with older family members, clients and dealings with older people in the community. It was important to the service providers that they be able to empathise with older people and particularly in conversations about QOL, hypothetically view situations from the perspective of older people. Although responses were grouped into broad thematic categories, it seems that the opinions of human service workers may have been shaped by empathy; thereby closely reflecting the views expressed by aged clients. Thus, it could be argued that generalisations made about the findings were warranted and in fact, not a weakness of this study.

Rubinstein (2002) described power relationships that can exist between the interviewer and the participant. He identified a correlation between the length of an interview and the nature of the interviewer-participant relationship. Short, structured interviews afford greater authority to the interviewer due to the narrow, pre-determined content. Therefore, brief interviews may be limited as tools for data collection because the items may not be personally relevant to the participant. As such, a strength of this study was that the majority of semi-structured interviews were conducted between 15 and 50 minutes in length. The purpose of this research was to collect participants' qualitative responses and establish meaning. Therefore, using Rubinstein's reasoning, this study was successful. Participants were encouraged to talk freely (about matters significant to them) and without a perception of time constraint.

According to Rubinstein (2002) a 'child-parent' power relationship may develop in the course of interviews conducted with a younger interviewer and an older participant. Although there was a 'child parent' power relationship between the researcher and respondents, it did not impact negatively on the data collection process. Again, due to the length of interviews, familiarity was fostered between the researcher and participants. This prompted the older respondents to divulge more information; in fact members from all participant populations elected to provide information about ageing and growing older in the form of advice – as a parent would to a child.

In this study a small sample was utilised for interviews and surveys. In most research designs, questionnaires are usually applied to small cross-sections of a population and results are not easily generalised to the greater global community. As such, a small sample group might be a possible limitation of such research designs. However, the findings of this study were never intended to be generalised to the greater population and therefore sample size was not a weakness of this research design. The purpose of the study was to convey the interview data as indicative of other aged clients in similar NGO settings. Hunt (1999) stipulated that data acquired through research using a cross-section of a population is generally presented as indicative of other populations and situations. However, a possible limitation of this study was that conclusions derived from such data can be erroneous. Hunt (1999) stated that there are extreme variations between separate demographic populations based on culture, ethnicity, gender, social status and nationality.

**5. Findings - General QOL Indicators and Sub-Themes**

Respondents interpreted the concept of QOL using similar Objective-Subjective parameters identified in the literature review (see section 3.1 above). This prominent interrelationship was best encapsulated in the following quote -

> *QOL is both subjective and objective. There are things "out there" such as housing, getting food, the weather, all sorts of quite objective things, which of course, affect how I feel, but how I choose to respond is up to me* (Eddie, Key Informant from a Peak WA Aged Service Delivery Organisation, Personal Communication, July 24th, 2008).

Certain tangible indicators were identified to be universally important in predicting whether an older person's QOL was adequate. However, it was widely posited that the intrinsic nature of older people (or being aged) also influenced an individual's level of QOL. In addition to this, Objective and Subjective indicators were found to be intrinsically linked.

The Objective indicator 'physical wellbeing' was further subdivided into one's ability to carry out 'daily tasks and routines' as well as maintaining their 'personal hygiene'. The Objective indicator 'sensory' referred to 'hearing' and 'sight'. Participants measured older people's 'intellectual' QOL in terms of their 'cognitive functioning' and the Subjective measure of one's mental 'attitude'. Although largely Objective in nature 'technological aids and human support' were highly influenced by the Subjective QOL indicators of 'resistance' and 'adaptability'. That is, learning how to cope with an age-related impairment and thereby changing their lifestyle accordingly.

The Objective QOL measure, 'service delivery' was subdivided into 'care and support services', as well as 'medical services'. 'Residential' indicators of QOL were subdivided into 'place', 'in-home care' and 'age-friendly cities' (all primarily Objective in nature). Participants measured the Objective indicator 'financial' QOL, in terms of 'government pension' and how they perceived '3rd party assistance'. That is, whether they were willing to give up their financial independence or if this constituted a decline in their QOL. The broad area of 'social' was related to the areas of 'service delivery', one's Objective ability to 'communicate' and how this impacted on them personally. 'Social' was further subdivided into feelings of 'isolation', 'depression' and 'one's autonomy of choice' and how this influenced their QOL.

The Subjective indicator 'anxiety' was strongly related with experiences of 'bereavement' and feelings of 'loss'. Similarly, the Subjective theme of 'reminiscence' was also related to participants' feelings of 'loss'. Particularly when comparing one's past accomplishments or position in society to their current life style. For a full list of these Objective and Subjective QOL indicators (as well as their sub-themes) please see Table 1.

To summarise, Roche (1990) portrayed QOL as a multi-dimensional concept that is viewed and measured in different ways. Roche (1990) identified many societal facets of QOL, including age, culture, ethnicity, politics, economy and the current trends in human service delivery. The latter facet is discussed further below in terms of quality of care (QOC), particularly in terms of residential aged care facilities. The main focus of the discussion below is the impact that one's 'place of residence' has on the QOL of older people; as identified in the primary and secondary data collated during the original Honours study. Please refer to Table 1 below, for an outline of the research questions and subsequent recommendations made in the original research.

## 6. Discussion - Defining Residential-Related QOL Indicators

In their discussion concerning 'old age' and 'environment', Weisman, Chaundhury and Moore (2000) described several places that older people live. These included private residences, day centres, retirement villages, nursing homes and special care units. It was their opinion that "place" was more appropriate a term than traditional titles such as "building" or "setting" that denoted only the physical dimensions of such old age environments (Weisman et al., 2000, p. 3). The authors felt 'place' better reflected the mental, societal, structural and physical dimensions of an older person's environments.

Generally speaking, there were three facets of 'place' as defined by Weisman *et al.*, (2000); 'subjective', 'objective' and 'consensual' indicators. 'Subjective' indicators of place are the personal interpretations individuals hold concerning their environments. 'Objective' indicators are the contextual influences that shape environment. 'Consensual' indictors involve societal limitations imposed by community values and expectations. Therefore the latter constitute options that are available or acceptable to an individual operating within an environment, thereby determining their actions or overall perception (Weisman et al., 2000). In fact, the primary data further suggested that autonomy of choice was a strong predictive factor in determining the level of QOL experienced by older people in any residence.

Respondents reported that generally, older people lived in two kinds of environments; private residences and residential care facilities (such as retirement villages or nursing homes). A major issue to arise in the primary data was the relationship between in home care and aged care residences, including the ways in which these impacted upon individual QOL. Furthermore, these factors were found to be related to both O & S-QOL and that they indeed overlapped; rather than being separate phenomena. For example, the broad O-QOL indicator of 'Residential' listed in Table 1, was closely interlinked to the S-QOL indicator identified as 'Autonomy' (also see Table 1) –

> *Depends on the individual. Many people prefer to live at home, even if it poses difficulties for them… If a person is living in a place where they do not wish to be, then this will have a negative impact of their QOL* (Fay, manager, personal communication, July 28, 2005).

From the primary data, it would appear that an older person's subjective perception of their place of residence played a larger role in indicating their QOL than the actual objective physical benefits of the environment they were living in. Furthermore, there was a dichotomy between the types of responses provided by different participant groups in the study. This dichotomous relationship was apparent throughout the entire research project and was most likely shaped by each participant's subjective experiences. The various opinions related to 'residential' indicators of QOL identified in the primary data, will be discussed in greater detail below.

*6.1 Discussion - Private Residences and In-Home Care*

Most aged care respondents viewed private living as an indicator that an older person's subjective QOL was high – *"I think if you're living in your own home you've got all your memories around you, you've got everything you've built up throughout your life"* (Joan, day care staff member, personal communication, July 24, 2007). In the literature, "continuance of self" was thought be a determinant of QOL in old age (Gitlin, 2000). Specifically, it was argued that remaining in one's own residence represented safety, familiarity and relative independence for an older person experiencing functional debility. In short, private homes are environments that foster adaptability in old age (Gitlin, 2000).

It was also opined by a member of staff that granny flats were advantageous to one's QOL (Dorothy, day care staff member, personal communication, July 16, 2008). One client resided in a granny-flat, attached to her son's private property. She considered herself to be *"lucky"* and described various in-home conveniences that allowed her to remain relatively independent (Mary-Jones, aged client, personal communication, July 24, 2008).

However, staff also tended to argue that living privately could have a potentially negative impact on both O & S-QOL – *"a lot of people might live in a private big old house, but they can be very lonely… We've had cases where they've actually fallen and nobody's found them* (Dorothy, day care staff member, personal communication, July 16, 2008). Therefore, it was suggested that having support staff 'on call' was an objective benefit of residential accommodation.

> *These services are in place to keep them as independent as possible in their own home… Some require a little assistance and some a bit more. These people, without the assistance, would either be struggling terribly or end up in permanent care… QOL is improved*
>
> –   Anne, Manager, personal communication, July 24, 2008
>
> –

Both CVI managers believed that access to in-home care was essential to the QOL of older people. It was argued that older people required greater support to remain living independently in their own private residences Maintaining one's autonomy has been described as a universal desire – as such, Australian community care services have been centred on sustaining older people's independence and remaining private residences (Australian Government Department of Health and Ageing, 2006).

Despite this, Anne suggested that West Australian *"personal care services only provide for a fraction of what is needed"* and that *"if the situation becomes unhygienic, it usually ends up with the client entering permanent care as in-home services won't assist due to OHS issues"* – thereby forcing that older person to relinquish their independence (Anne, Manager, personal communication, August 25, 2008). It was posited that in-home services needed to be individualised to meet client's needs and not based solely on governmental standards of care (Anne, Manager, personal communication, August 25, 2008).

There was a clear dichotomy between the positive and negative influences that private residences have on the QOL of older people. Although clients perceived their own homes as places of safety and independence, members of staff believed that some older people might benefit from constant care and supervision. Moreover, the managers suggested that the presence of support services should be decided on a contextual basis; whether an individual remains independent, receives in-home care or enters into residential care would depend on the individual QOL needs of that older person.

*6.2 Discussion - Residential Care Facilities*

Some respondents maintained that older people living in *"residences or retirement villages have got a very good QOL. They're kept warm, there's food, they do activities and that with them"* (Dorothy, day care staff member, personal communication, July 16, 2008). However, it was suggested by several respondents, and supported in the secondary data, that it was not enough to just have social contact, but that older people needed to value that contact in order for it to benefit one's QOL (see Gerritsen et al., 2004) –

> *I think that all depends on the person. I think you may find somebody who finds it incredibly lonely who would actually benefit from a hostel type of residence. Most of the population I feel, would think they are losing their freedom*

– Regina, Staff Member from the Day Centre, July 31, 2008

One manager also suggested that moving into a retirement village meant older people lost their independence and were giving up a 'place' that held intrinsic value.

In fact, relocation to residential care was sometimes perceived as an indication that an older person's QOL was depreciating -

> *Our client base has shown that remaining as independent as possible in their own home or retirement village has a positive effect on their quality of life…. In most of the circumstances we have seen, entering permanent care is usually a necessity due to the client becoming a danger to themselves by living in their own home* (Anne, manager, personal communication, August 25, 2008).

In terms of maintaining an older person's independence, Roche (1990) found that permanent care often resulted in a reduced freedom of choice for older people. This was despite the fact that aged-care facilities 'theoretically' maintained one's O-QOL. Reduced freedom was perceived to be a result of a lack of collaboration between staff and clients in terms of decision-making (Roche, 1990). Privacy was thought to be best maintained by giving clients their own living spaces (including personal hygiene facilities); however, Roche (1990) argued that this was not feasible in all institutions (sometimes for the protection of clients). These QOL themes are reiterated in Table 1.

In respect to losing items of intrinsic value, Roche (1990) argued that facilities could be made more 'homely' by allowing aged clients to keep their material possessions (Roche, 1990). In addition, that by modifying the structure and shape of residential care buildings to appear more like a house and allowing clients to have opportunities to prepare meals, also fostered feelings likened to a continuance of self amongst older people (see Gitlin, 2000). Similarly, Roche (1990) found that an older person's perception of social independence was sustained if one's social connections outside the care facility were maintained – thereby enhancing the overall QOL of older people. Client Jane-Davies suggested that when she entered care, she experienced social marginalisation and therefore, her QOL had depreciated – *"we do have a hall in our village, which I don't go to because I feel shut out"* (aged client, personal communication, July 31, 2008).

Staff and managers also suggested that social advantages and disadvantages of residential care are influenced by the subjective nature and experiences of individuals - *"Everybody's different, a lot of people go and live in these places because it's company for them and they want to interact with other people and they've got the time because they're retired"* (Margo, day care staff member, personal communication. July 15, 2008). Conversely, one manager suggested that on the whole – *"from the many clients we have seen enter permanent care, it is rarely a positive experience for either the client or their family"* (Anne, manager, personal communication, July 25, 2008). Furthermore, the key informants stipulated that individuals evaluated their lives along a continuum that consisted of positive, negative, objective and subjective dimensions. This implies that simply assessing an aged client when they enter a service is insufficient, and multiple assessments are needed to address this 'continuum'.

Some day care staff members claimed that aged care facilities led to negative QOL outcomes, stating that the QOL of older people living in old age homes was poor. Participants from the staff population suggested that individuals can become totally dependent on support workers, because in some residential care facilities, such services are available at all times (Joan, day care staff, personal communication, July 24, 2008). This was seen as detrimental to older people's QOL because it indicated that the older person had developed a high degree of dependence on support services. In addition to this, it was stipulated that the quality of care (QOC) in many institutions was inadequate and therefore identified as an undesirable places to live in now or in the future (Andy, day care staff member, personal communication, July 16, 2008).

At the time of Roche's study, the Australian government focused on only eight paradigms which centred on maximising the effectiveness of services for older people (Roche, 1990). The quality measures were used to evaluate care standards across various departments and community agencies (Roche, 1990). These included 'health care', 'social independence', 'freedom of choice', 'individual rights'; 'provision of a home-like environment', 'variety of experience', 'privacy and dignity' and 'safety' (Roche, 1990). These indicators were seen as universal needs and designed to be individualised for clients based on their care requirements (Roche, 1990). At the time, it was Roche's opinion that aged individuals in nursing homes, hostels and residential care may not be receiving optimum services, with many of these measures not being recognised as relevant to older people.

A 2008 news article supported much of the fears expressed by the participants in this study; it outlined recent negative events surrounding a residential care facility in Australia (ABC, 2008). According to the source, a great number of older residents were adversely affected by a stomach virus in a short period of time. A representative from *Aged and Community Services Australia* was quoted as saying - "things that would make a younger, fitter person unwell for a couple of days can be terminal for older people in residential care" (ABC, 2008, p. 1). At the time of the article, the facility was being investigated and there was a proposal that all aged care settings be evaluated for poor QOC. When

compared to the issues raised by Roche (1990), it would appear that sub-standard QOC in residential care facilities has been a constant concern for the maintenance of QOL amongst aged clients for the past twenty years.

Based on the primary data, although clearly divided, many members of the Day Care staff tended to view residential aged care homes as a positive intervention, whilst most managers and aged care clients held the opposite opinion. Similarly, key informants viewed aged care homes as being potentially negative living environments for older people. Staff who viewed residential aged homes as being beneficial may have been influenced by their own personal concerns about aged clients. Having worked closely with older people on a daily basis, they would have observed the struggles of clients trying to live independently first hand. Conversely, based on their experiences in the administrative side of the Aged Care Sector, managers may have had a broader understanding of the limitations of such services and therefore, this shaped their negative perception of residential facilities.

*6.3 Discussion - Adult Day Care Services*

Despite the negative aspects of residential aged care facilities identified above, day care staff argued that there were significant benefits to specific aged care programs. It was found that in old age, QOL meant having access to emotional support and services delivered by centre-based care organisations where social participation was facilitated (Jane-Davies, aged client, personal communication, July 31, 2008). In the primary data, the QOL benefits of Centre-based care were recognised as being largely subjective in nature. Although 'Social' contact was perceived as a universal indicator of O-QOL (see Table 1) it had a strong subjective dimension. The individual personalities of older people not only determined whether they chose to enter the social environment of centre-based care, but whether it was a positive experience. For example, Dorothy stipulated that the older people from the *Adult Day Care Centre* were *"all go- getter types"* and that certain individuals felt it was *"their right to have"* assistance.

Acceptance of one's circumstances as an older person, who may be in need of support, was thought to play a large part in an individual's decision to enter centre-based day care (Dorothy, day care staff member, personal communication, July 16, 2008) –

> they're not prepared to just sit back and let life pass them by, they want to be part of life. They want to be part
> of the society and they're still interested in politics and sport and they don't care that they're recipients
> (Dorothy, day care staff member, personal communication, July 16, 2008).

In fact, a benefit of Day Centre services was to older people's social independence – *"they're still making a life for themselves. So they're not as reliant on contact with their family"* (Regina, day care staff member, personal communication, July 31, 2008).

Many staff believed that the services offered by the *Adult Day Care Centre* maintained older people's engagement in society and thereby enhanced their QOL. Similarly, there was a strong belief that the subjective natures of individual older people determined whether *Adult Day Care Centres* would be beneficial to their QOL. It must be said however, that the participants' perceptions of such services may have been biased by their connection to CVI's own Day Centre program.

*6.4 Discussion - Age-Friendly Designs*

In light of the possible benefits of staying at home (rather than entering into poor quality care facilities) the concept of 'Universal Design or Age Friendly Design' was considered by key informants. In both the primary and secondary data it was found that older people's QOL would objectively benefit from more age-friendly residential designs (WHO, 2007). These included; doorways being made accessible to people with wheelchairs or walking frames; whether the bathroom or toilet was easily accessible; the inclusion of floor surfaces or hand rails that limited one's propensity to fall; and whether the garden was modifiable to suit the changing needs or limitations of an older person.

The WHO's (2007, p. 32) global study into age-friendly cities found that in Melbourne, Australia - "assistance equipment for the aged is not used because it does not fit into the home and many care-givers are unable to afford the necessary renovations". Giltin (2000) discussed the concept of designing an age-friendly residence through home modification.

> We must be able to identify characteristics of homes that are desirable, or that maximise independence,
> individual choice, and autonomy. Also, we must develop a measurement approach that is reliable and
> ecologically valid, e.g., one that accounts for the person as a contextual factor. These represent difficult
> methodological tasks, given the extreme variation in the physical arrangements of homes, the differentiated
> relationship between persons and household characteristics, and the highly individualized needs and task
> preferences demonstrated by older adults. (Giltin, 2000, p. 48).

Key informant Eddie (personal communication, August 28, 2008), argued that if it became normal practice to include settings for hand rails, or if door frames were made larger, modifications could be completed quickly and inexpensively and stigma would be reduced. Eddie suggested that there was a subjective dimension to the concept of age-friendly

design – *"people are very short-sighted about their future needs"* (Eddie, key informant, personal communication, August 28, 2008). He stipulated that many retirement villages do not include such technology as standard when marketing to buyers, as older people do not believe they are warranted.

It would appear that 'Autonomy of Choice' was viewed as an important aspect of 'Residential' indicators of QOL. Further, the subjective indicator of 'Independence' was an important facet of QOL for older people. As supported in the primary data, older people may be able to maintain their independence by remaining at home. However, if inadequate in-home services take this control (independence and choice) out of their hands, older people may be forced to relocate to a poor quality residential care facility and become increasingly dependent on aged services. Age-friendly designs were believed to enhance the level of control experienced by older people in both the home and in residential care; and thereby, improve their overall QOL.

*6.5 Discussion - Aged Care in an Ageing Society*

One of the major issues raised about human service delivery in the future, concerned recruitment rates. In order to keep up with the growing number of aged clients and maintain their QOL, it was opined that – *"they're going to have to have an awful lot more volunteers and community centres"* (Margo, day care staff member, personal communication, July 15, 2008). It was further stated that a *"lack of future generations entering this industry will affect QOL"*, it was further conveyed that *"the work is not valued or recognized"* and that *"the younger generations lean towards greater earning potential industries"* (Anne, personal communication, August 25, 2008). Similarly, Tilki (2000) opined that the free market economy under values the aged care sector and this in turn adversely affects the wellbeing of older people.

Manager Anne also suggested that a lack of skilled and committed aged care workers would lead to the structure of aged services changing –*"the time support workers spend with clients will decrease with just the most essential tasks being provided"* (Anne, personal communication, August 25, 2008. It was also suggested that *"services in the future will be reduced, not only by lack of appropriate workers but also due to inadequate funding"* (Anne, personal communication, August 25, 2008). Similarly, staff member Dorothy (personal communication, July 16, 2008) feared that a withdrawal of funds in the human service sector and a lack of workers would severely limit the services available to older people in the future and change the dynamic of existing health services.

CVI Manager Anne also posited that a lack in trained human service workers would mean that the QOL of older people would decline without additional family support (personal communication, August 28, 2008). However, day care staff member Andy believed that the financial stresses of the future would lead to younger generations focusing on maintaining their own QOL and thus be unable to provide care or support to older people (personal communication, July 16, 2008). Andy further suggested that relatively independent and healthy older people would need to look after the needs of other frailer older people. This can be evidenced by the case of the 70 year old woman who worked as a carer at a retirement village looking *"after people the same age"* (Gibson, 2008, p. 18). As such, inter-dependence already appears to be a reality for current older people living in Western Australia. However, one possible problem with this solution was identified by key informant Danni (personal communication, September 4, 2008). She suggested that despite meaning well, aged volunteers might actually reduce other older people's independence by taking responsibility away from clients who could be encouraged to function for themselves.

Overall, members from all participant groups agreed that the aged service delivery sector may be adversely affected by poor recruitment rates, universally high costs and a greater demand for services. In turn, this may limit the number of services available to older people and impinge on the QOC aged clients receive; therefore diminishing their overall QOL. Furthermore, the negative effects identified as being synonymous with an ageing society, appear to be a reality in Australian society at the present.

**7. Conclusion**

'Residential' indicators of QOL were originally included as a singular component of the methodology, based on the 'physical' or objective component of the *Referral and Assessment Form* (Aged Care Team Leader, 2007). However, due to the large amount of significant data that 'Residential' and in-home care generated, combined with its apparent subjective importance to QOL, it was discussed in isolation from physical wellbeing. There appeared to be a strong correlation between O-QOL indicators and how these personally impacted on the individual, thus indicating a subjective dimension to all QOL paradigms.

In the primary and secondary data, the objective indicator of QOL, 'Residential", was presented as a multi-faceted indicator that needed to be further broken down into the smaller objective themes; 'place of residence', 'in-home care' and 'age-friendly design'. However, it would appear that an older person's subjective 'perception' of their place of residence and their level of 'autonomy of choice', had a greater impact on QOL than the physical benefits of one's environment. This was conclusion was compounded by the fact that clients, staff, key informants and managers were at times, 'divided' on issues regarding 'Residential' indicators of QOL. Based on the area's objective and subjective

implications on older people's QOL, 'Residential' issues warrant further attention by researchers and aged-care stakeholders.

Complexity is an essential component of the human condition. As humans age these complexities appear to become interwoven, increasingly complex and difficult to master. QOL is a condition that is different for each individual and requires deeper qualitative inquiry; particularly as it relates to referral and assessment instruments for the aged, which based on our research, tend to be closed-ended and based predominantly on O-QOL or physical indicators. The 'one size fits all' approach to understanding S & O-QOL needs to be unravelled and pulled apart. This can only be achieved through the individualization of instruments and using a continuum of assessments (rather than one at entry and one at exit). We suggest that the concept of QOL amongst older people be viewed as a multi-dimensional construct composed of both objective and subjective indicators. However, overall subjective indicators appear to be more significant and can have the ability to negate any improvements in O-QOL. 'Perception' is a powerful force and one that is dynamic, ever-changing and warrants greater research.

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Table 1. Research Questions and Recommendations

1) *How does a small cohort of aged clients, staff members and managers from CVI and key informants representing peak WA aged services, perceive QOL amongst older people?*

- That the concept of QOL amongst older people be viewed as a multi-dimensional construct composed of both Objective and Subjective indicators.

- That the existing interrelationship between Objective and Subjective dimensions be recognised by academics, service providers and policy makers when evaluating the QOL of aged clients, aged care services and facilities and older people in Australia.

- That older people in Australia be viewed as a heterogeneous population with individual needs and QOL requirements.

- That older people in Australia be viewed as cognisant individuals and active participants in decisions relating to aged care interventions.

2) *To what extent is the current QOL indicator used by CVI, the Referral and Assessment Form, applicable to the group being studied?*

- That the *Referral and Assessment Form* retain part of its original thematic structure and therefore ensure that the Objective indicators of QOL are applied to the aged client group under study.

- That it be recognised the *Referral and Assessment Form* is missing a crucial Subjective dimension to its composition and therefore not fully applicable to the aged client group under study.

3) *Does the QOL indicator used by CVI need to be refined and further developed to incorporate additional QOL indicators?*

- Refine and further develop the *Referral and Assessment Form* to include further Subjective and Objective QOL indicators that provide a holistic view of QOL. Refer above for discussion about these additional QOL indicators. This would be necessary for assessors to accommodate the level of individuality amongst older people in Australia.

- Refine and further develop the *Referral and Assessment Form* to include open-ended questions thereby allow aged client to describe issues significant to their QOL or discuss interrelationships between Objective and Subjective indicators of QOL.

- In light of the strong Objective-Subjective relationship that exists within the concept of QOL, refine and further develop the *Referral and Assessment Form* to include dimensions from *Individualised QOL Frameworks*, the *Wellness Approach* and the Subjective concept of reminiscence.

4) *How can the results of this project be used to better inform policy-makers and service delivery practices related to aged care?*

- That older people, academics, aged service providers and policy-makers work collaboratively to produce new approaches to practice in order to meet the demands of an ageing society and provide individualised interventions.

- To consider implementing the Wellness Approach which would help to ensure the independence of aged clients and provide care, based on an ongoing assessment of older people's level of need.

- To implement reminiscence wherever possible which would help to account for aged clients' physical and social histories during the assessment phase; thereby allowing assessors to have a full account of aged clients' individual needs and indicating that the assessors have an interest in their clients. This in turn could potentially maximise the feelings of worth amongst older people.

5) *In light of Australia's rapidly 'ageing society', will older people require greater input from policy-makers and service providers to ensure their QOL is considered, debated and maintained?*

- Increased input from Australian policy-makers and service providers to ensure the QOL of older people is considered, debated and maintained in an ageing society.

- Greater government funding to policy-makers and service providers in order to attract more human service workers, thus ensuring that the level of QOC is maintained in Australian service delivery.

- An increase in the future services available to older people in order to cope with an increase in demand as part of an ageing society in Australia; centre-based care and in-home-care were identified as strong predictors of a positive QOL amongst older people.

Source: Georgiou (2008) Research Questions and Recommendations

Table 2. Interview Questions for Staff (FIELD NOTES)

SECTION A: PRELIMINARY

1) What do you feel are the most significant issues that affect older people in Australia today?

2) What are the advantages of being an older person in Australia today?

3) Australia has been described as a rapidly ageing population.

What implications do you believe an ageing society will have on older people's QOL in the future?

Do you believe older people's QOL will change as a result of a rapidly ageing population?

SECTION B: PHYSICAL INDICATORS OF QOL

4) How is type of residence an indicator of an older person's QOL? (private residence, hostel, retirement village)

5) In what specific circumstances does an older person require a care or support worker and what does this indicate about an older person's QOL?

6) What does reliance upon a medical professional or medication indicate about an older person's QOL?

7) How would physical issues (mobility) affect an older person's ability to complete daily tasks or routines? (housework or catching public transport) Would this impact on a person's QOL?

8) How would physical issues (mobility) affect an older person's ability to care for themselves? (personal hygiene) Would this impact on a person's QOL?

SECTION C: INTELLECTUAL / SENSORY INDICATORS OF QOL

9) What impact does getting older have on older people's mental abilities and subsequent QOL?

10) How important is vision and hearing to an older person's QOL? In what way?

11) If an older person requires technological aids or human assistance to perform tasks (routine or otherwise), how would this impact on their QOL?

12) Is the ability to communicate well with others an indication of an older person's QOL? In what way?

13) Would outside control of finances affect an older person's QOL? (bank, lawyer, family)

SECTION D: SOCIAL INDICATORS OF QOL

14) How important is social contact in terms of an older person's QOL?

15) Can isolation or feelings of depression have an impact on an older person's QOL? In what way?

SECTION E: QUESTIONS RELATED TO SERVICE DELIVERY

16) What can be inferred about an older person's QOL if they are a recipient of services provided by a community service agency or Government body?

17) In light of Australia's Ageing population, how do you believe your role as a HSW will change?

Particularly in terms of ensuring that QOL issues for the elderly are met?

SECTION F: FINAL

18) Is there anything further you would like to add or discuss?

(old age, growing older, an ageing society or QOL amongst older people)

Source: Georgiou (2008) Semi Structured and Survey Interview Question Guide

Table 3. Main QOL Indicators and their Sub-Themes

| *Objective QOL Indicators (Main)* | *Interconnected Sub-Themes of QOL* |
|---|---|
| Physical Wellbeing | Mobility (Objective) |
| | Daily Tasks (Objective) |
| | Personal Hygiene (Objective) |
| | Intrinsic Importance (Subjective) |
| | Autonomy of Choice (Subjective) |
| | Attitude (Subjective) |
| | Contextual Situation (Subjective) |
| Sensory | Hearing (Objective) |
| | Vision (Objective) |
| | Intrinsic Importance (Subjective) |
| Intellectual | Cognitive Functioning (Objective) |
| | Attitude (Subjective) |
| Technological Aids and Human Support | Resistance (Subjective) |
| | Adaptability (Subjective) |
| Service Delivery | Care and Support (Objective) |
| | Medical (Objective) |
| | Autonomy of Choice (Subjective) |
| | Adaptability (Subjective) |
| | Intrinsic Beliefs (Subjective) |
| | Resistance (Subjective) |
| | Feelings of Loss (Subjective) |
| Residential | Private Residences (Objective) |
| | Villages (Objective) |
| | In-Home Care (Objective) |
| | Age Friendly Cities (Objective) |
| | Perception (Subjective) |
| | Autonomy of Choice (Subjective) |
| Financial | Government Pension Rates (Objective) |
| | Third Party Assistance (Objective) |
| | Attitude (Subjective) |
| | Autonomy of Choice (Subjective) |
| Social | Contact (Objective) |
| | Service Delivery (Objective) |
| | The Ability to Communicate (Objective) |
| | Isolation (Objective) |
| | Depression (Subjective) |
| | Autonomy of Choice (Subjective) |
| | Access to Transport (Objective) |
| | Age Friendly Cities (Objective) |
| | Value and Worth (Subjective) |
| | Intrinsic Importance (Subjective) |
| | Personality (Subjective) |

| Geographical Location and Climate | |
|---|---|
| *Subjective QOL Indicators (Main)* | *Interconnected Sub-Themes of QOL* |
| Anxiety | Bereavement (Subjective) |
| | Feelings of Loss (Subjective) |
| Reminiscence | Growing Older (Objective) |
| | Life Review (Subjective) |
| Autonomy of Choice | (See above) |
| Attitude | (See above) |
| Resistance | (See above) |
| Adaptability | (See above) |
| Depression | (See above) |
| Bereavement | (See above) |
| Feelings of Loss | (See above) |
| Resilience | |
| Wisdom | |

Source: Georgiou (2008) Semi Structured and Survey Interview Data

| Table 4. Research Questions and Analytical Framework | | | |
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| Research Question | Literature. Review | Interviews and Surveys | CVI QOL Indicator |
| *1) How does a small cohort of aged clients, staff members and managers from CVI and key informants representing peak WA aged services, perceive QOL amongst older people?* | Use the Literature Review Data (QOL Paradigms, Gerontological and Sociological Perspectives, Government Practices and Ageing Society Issues) as supporting evidence for findings extrapolated from the Primary Data. | Conduct Interviews and Survey Interviews with Participants – exploring how they view QOL amongst Older People. Determine how important the four major QOL themes; QOL indicators relating to service delivery and an ageing society; and other QOL indicators - are to the participants. | Utilise the CVI Referral and Assessment Form as a Theoretical Framework for the Question Guide. Determine how important the four major themes are to the participants. |
| *2) To what extent is the current QOL indicator used by CVI, the Referral and Assessment Form, applicable to the group being studied?* | Use the Literature Review Data (QOL Paradigms, Gerontological and Sociological Perspectives, Government Practices and Ageing Society Issues) as supporting evidence for the findings extrapolated from the Primary Data. | Conduct Interviews and Survey Interviews with Participants – exploring how they view QOL amongst Older People. Determine how important the four major QOL themes are to the participants. | Utilise the CVI Referral and Assessment Form as a Theoretical Framework for the Question Guide. Determine how important the four major themes are to the participants. |
| *3) Does the QOL indicator used by CVI need to be refined and further developed to incorporate additional QOL indicators?* | Compare new and alternative QOL indicators (including other existing QOL Frameworks) identified in the Literature Review to CVI's QOL Indicator and suggest amendments to the CVI Indicator accordingly. | Compare new and alternative QOL indicators identified in the interviews to CVI's Indicator and suggest amendments to the CVI Indicator accordingly. | Using the QOL Paradigms, Gerontological and Sociological Perspectives identified in the Literature Review as a comparative baseline, outline the CVI Indicator as a tool by itself and then compare it to further primary and secondary data. Suggest |

| | | | amendments to the CVI Indicator accordingly. |
|---|---|---|---|
| **4) *How can the results of this project be used to better inform policy-makers and service delivery practices related to aged care?*** | Identify Literature Review Data (QOL Paradigms, Gerontological, Sociological Perspectives, Government Practices and Ageing Society Issues). Discuss how these findings could be used as indicative data and applied to the Australian Aged Care Industry. | Identify themes in the Primary Data (QOL Indicators, Old Age, Service Delivery and an Ageing Society). Discuss how these findings could be used as indicative data and applied to the Australian Aged Care Industry. | Compare existing QOL Indicators Paradigms and new or alternative QOL indicators (from the Secondary Data); the new or alternative QOL Indicators identified in the Primary Data; and QOL themes from CVI's Referral and Assessment Form. Discuss how findings relating to QOL Indicators, Old Age and Service Delivery could be used as indicative data and applied to the Australian Aged Care Industry. |
| **5) *In light of Australia's rapidly 'ageing society', will older people require greater input from policy-makers and service providers to ensure their QOL is considered, debated and maintained?*** | Identify significant themes in the Secondary Data relating to the phenomenon of an Ageing Society (Sociological and Political) and its relationship to QOL in old age. Discuss how these findings could be used as indicative data and applied to Australian Policy Development and Service Provision (thus sustaining QOL amongst older people in the future). | Identify significant themes in the Primary Data relating to the phenomenon of an Ageing Society and its relationship to QOL in old age. Discuss how these findings could be used as indicative data and applied to Australian Policy Development and Service Provision (thus sustaining QOL amongst older people in the future). | Identify recurring themes in the Primary and Secondary data (in regards to an Ageing Society and it's subsequent impact on QOL). Compare the new or alternative QOL indicators from these findings with the existing themes in CVI's QOL Indicator. Suggest amendments to the CVI QOL Indicator accordingly. |

Source: Georgiou (2008) Research Questions and Analytical Framework