Home from home: residents' opinions of nursing homes and long-stay wards

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Abstract

Objective: to compare the levels of satisfaction expressed by residents of nursing homes with those of patients in geriatric long-stay wards.

Design: a structured satisfaction questionnaire containing 37 closed and two open questions was used to elicit responses from residents of nursing homes in the former South West Thames Regional Health Authority area. This was compared with a similar survey using the same questionnaire among patients in geriatric long-stay wards surveyed in 1989.

Setting: respondents came from a sample of nursing homes chosen to be representative of both size and geographical location. Nursing homes were stratified by number of beds (1-19, 20-29, 30+) and clustered by location (to reflect the urban, semi-rural and coastal nature of the region).

Subjects: a random sample was drawn from each grouping (size and location) to yield a resident sample of 850 in 36 nursing homes. This figure was similar to the number of patients (808) in geriatric long-stay wards surveyed in 1989. All eligible nursing home patients were assessed for physical dependency. Mental confusion was ascertained by the Abbreviated Mental Test Score (AMTS). Patients who scored three or less on the AMTS (indicative of severe confusion) or had dysphasia, profound deafness or concurrent serious illness were excluded from further study.

Results: 377 nursing home residents were able to complete the questionnaire and their answers were compared with those of 291 long-stay geriatric patients. The responses to the five themes—relations with staff, autonomy, amenities, privacy and social environment—show some minor differences between the two groups but what is more noticeable is the similarity of their views. This is important as much social policy assumes that the more 'homely' atmosphere of the nursing home should elicit higher levels of satisfaction than the 'institutional' setting of the hospital ward.

Conclusion: we conclude that the difference between nursing homes and hospital wards in terms of their institutionalizing capacities is not as profound as policy-makers believe.

Keywords: institutionalization, nursing homes, residents' opinions, social policy

Introduction

The idea of 'home' has become a central issue in discussions about community care policies for older people. The notion encapsulates many positive elements such as independence, security, choice and privacy. This contrasts with the notion of 'institution', where many of these elements appear to be difficult to find or are non-existent. However, the meaning of 'home' is more complicated than much writing about community care would indicate [1].

The complex nature of the debate is illustrated by those who point out the varied social processes going on in residential homes [2] and those who note that even the domestic household has the potential to be an institution [3]. This issue becomes more complicated in many highly dependent older people, for whom 'home' has become equated with the home-like setting of a nursing home [4]. This reorientation of the location of 'home' is justified on the grounds that it recreates many of the features of the resident's own home and therefore provides an acceptable alternative to institutional care [5].

By contrast, community care policy does not seem
able to embrace the legacy of National Health Service (NHS) long-stay wards. These hospital-based health care resources are seen as embodying most if not all the negative features of the 'institution' [6, 7].

Background

In the UK, the provision of institutional care to highly dependent older people has changed dramatically in the 1980s and 1990s [4, 8-10]. The relaxing by the Government of rules affecting the funding of places in privately owned nursing homes in 1984 led to a marked increase in the numbers of homes and beds. Similarly, the reform of the NHS in 1991 created circumstances in which the number of hospital beds available for the long-stay care rapidly contracted. The consequence of these two processes became apparent with the introduction of a third piece of Government policy—community care—in 1993.

Before the NHS and Community Care Act of 1990, local authorities had a limited statutory responsibility to ensure the provision of services for people in their locality, with the result that there was widespread variation in what services were provided and to whom. The Act, in contrast, gave them explicit responsibilities for the assessment and arrangement of appropriate services based on the identification of need. Unfortunately, the effect of these changes was to point policy in different directions at the same time. The desire to allow people the choice to live at home where possible was sometimes in contradiction with other objectives such as controlling financial resources. The assessment procedure that was supposed to lead to needs being identified and appropriate services provided has often become a rationing device [11].

While there is debate about the effect of these changes on users and providers [12], there has been implicit acceptance that the move away from the institution has been a positive one. The policy of community care has had a long gestation, becoming formalized in the desire to close the large Victorian-era asylums in the 1960s [13]. Representations of 'institutionalization' in such films as 'One Flew Over the Cuckoo's Nest' provided popular support for the arguments of Townsend [14] and Goffman [15]. Some empirical research has also supported the contention that institutional—and particularly hospital-based—long-stay facilities are inimical to the independence and self-worth of patients [6]. The processes whereby such institutionalization occurs are thought to be located in the position of the patients and the interactions that occur between them and the staff. The asymmetry of power and the effects of block living are said to produce a compliant and unassertive population.

This common-sense conclusion, along with the legacy of a previous era of punitive poorhouses, has left important questions about the nature of institutional living largely unresearched. Instead, we have an implicit ranking of options that owes as much to social principles (such as individual autonomy) as it does to practical considerations. In his review of chronic illness, Bury makes the point that sociologists have put too much emphasis on the nature of the difficulties and disadvantages that accompany such conditions rather than studying the responses and positive actions of those affected [16]. Perhaps the same issue applies to highly physically dependent older people.

The most striking feature of most elderly people in institutional care is their extremely high levels of physical dependency [8]; most routine activities of daily living are beyond their capacities. Often the only task that they are able to undertake independently is eating [10]. While levels of physical dependency are slightly lower in nursing homes than in long-stay wards [9], many residents are dependent on others for self-care.

In an earlier report [17] we argued that these constraints acted as the real basis for long-stay NHS patients' assessments of satisfaction with their care. Given that residents of nursing homes may comprise a very similar group of elderly patients, we would anticipate similar assessments.

We report a survey of the views of a representative section of nursing home residents in the former South West Thames health region which gauged levels of satisfaction with accommodation and treatment. We have also been able to compare these results with our previous study of NHS long-stay patients [9, 1]. We chose not to include any assessment of the physical environment as this was felt to be too subjective.

Methods

In 1992, there were 302 private or voluntary registered nursing homes in the South West Thames Region of the National Health Service [excluding homes registered specifically for mentally disordered patients, exclusively for patients with a particular illness (e.g. multiple sclerosis) or solely for terminal care]. After excluding those residents with a proposed stay of less than 3 months, there were 7826 nursing home places for those aged 65 and over.

Nursing homes were stratified by number of beds (1-19, 20-29, 30+) and clustered by location (to reflect the urban, semi-rural and coastal nature of the region). A random sample was drawn from each grouping to yield a resident sample of 850 in 36 nursing homes. Research interviewers then visited each home by appointment to identify eligible residents and to carry out assessments.

For comparative purposes, the methods and assessment instruments developed for the previous study [17] were replicated in the present study. All eligible
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nursing home residents were assessed for physical dependency using the Katz and Barthel indices [18, 19]. These are validated measures that are easy to administer and provide simple measures of levels of dependency in different homes. Mental confusion was rated by the Abbreviated Mental Test Score (AMTS) [20]. Residents who scored three or less on the AMTS (indicative of severe confusion) or who had dysphasia, profound deafness or concurrent serious illness were excluded. Neither residents nor long-stay patients were classified as needing psycho-geriatric care.

Remaining residents were interviewed about their satisfaction using a validated 36 item closed question interview schedule [21]. The questions covered five themes: relations with staff; autonomy; amenities; privacy; and social environment. There were two further semi-structured questions asking the respondent to list the best and worst features of their nursing home.

Results

Of the 850 eligible nursing home residents, 163 were excluded from further assessment because of profound deafness, dysphasia or concurrent serious illness as were 293 who scored less than four on the AMTS. A total of 377 residents were interviewed: 143 in small homes (1-19 beds), 225 in medium-sized homes (20-29 beds) and 302 in large homes (30 beds or more).

Relations with staff

Responses to questions about relations with staff indicated a very high level of satisfaction among both nursing home and NHS patients (Table 1). The item about whether staff took notice of residents' complaints received the fewest positive responses among both groups. There were 58 (15%) non-responses to this item in nursing home residents. There were no percentage differences by size of home. Fewer residents in smaller nursing homes were frightened of staff than those in larger homes (1% vs 10%), but the differences were not statistically significant.

Autonomy

There were many positive responses to questions about autonomy (Table 2). There was little variation by size of nursing home, except that 95% of residents in small homes vs 85% in medium sized homes said they could choose the clothes they wore, while 8% in small homes vs 26% in large homes wanted more say in the way their homes were run. Being able to sit at table with whom you pleased scored 45% among nursing home residents. Among NHS patients, the positive response was 80%. However, NHS patients were less satisfied that they could wear their own clothes and choose what to wear each day.

Amenities

Upwards of four-fifths of all residents were satisfied with the amenities (Table 3). Nursing home residents and NHS patients expressed similar views except in respect to visiting times—only 10% of NHS patients felt that visiting was unrestricted. There were few variations among nursing home residents by size of home, except that residents from the larger homes were slightly more likely to claim that they could not get a good night's sleep (13%) compared with those in the smallest homes (7%).

Privacy

Privacy items produced very high positive scores among nursing home residents. Residents in smaller homes were on average more satisfied than those in medium sized and large homes by about 10 percentage points. Items about being able to see visitors privately and having somewhere to go when residents wanted to be alone scored considerably higher among nursing home residents than among NHS patients (Table 4).

| Table 1. Relations with staff |
|-----------------------------|----------------|----------------|
| Item                        | % positive, by home type |
|                             | Nursing (n = 377) | NHS (n = 291) |
| Staff kind                  | 94              | 96             |
| Staff make fun of residents*| 92              | 87             |
| Frightened of staff*        | 91              | 90             |
| Staff polite                | 91              | 93             |
| See doctor when wish        | 89              | 82             |
| Staff take notice of complaints | 78          | 82             |

NHS, National Health Service.
*Negative response indicates satisfaction.
Table 2. Autonomy

<table>
<thead>
<tr>
<th>Item</th>
<th>% positive, by home type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing 377</td>
</tr>
<tr>
<td>Kept busy when you want to relax*</td>
<td>96</td>
</tr>
<tr>
<td>Wear your own clothes</td>
<td>96</td>
</tr>
<tr>
<td>Choose own clothes</td>
<td>90</td>
</tr>
<tr>
<td>Rest on bed when wish</td>
<td>88</td>
</tr>
<tr>
<td>Own possessions with you</td>
<td>88</td>
</tr>
<tr>
<td>Made to do things you do not wish to*</td>
<td>85</td>
</tr>
<tr>
<td>Go to bed when wish</td>
<td>85</td>
</tr>
<tr>
<td>Want more say in how home/ward is run*</td>
<td>85</td>
</tr>
<tr>
<td>Spend money as wish</td>
<td>80</td>
</tr>
<tr>
<td>Any spending money</td>
<td>72</td>
</tr>
<tr>
<td>Sit at table with whom you wish</td>
<td>45</td>
</tr>
</tbody>
</table>

NHS, National Health Service.

*Negative response indicates satisfaction.

Social environment

Items about the social environment scored somewhat less positively among both nursing home and NHS patients. Residents seemed to prefer the social environment of small nursing homes. About 10% more residents in small nursing homes were satisfied about thinking of the institution as home, liking the decor and finding the atmosphere cheerful. About 10% more residents in smaller homes felt that they did as much as they were able to do and about 10% fewer thought that they had to sit around with nothing to do.

Time passed more slowly for NHS patients, but they were considerably more satisfied about the number of activities provided and getting to go out as much as they wished (Table 3).

Best things, worst things

Residents were asked about the best and worst things about their situation. Those that were mentioned most frequently by nursing home and NHS patients alike were 'being looked after' 'kindness of the staff', 'friendship and company of other residents ', being 'safe' and being 'happy and contented'.

Worst things included 'unable to be at home' and 'loss of independence' In both groups 7% mentioned being institutionalized and 5% felt resigned, isolated or lonely.

Discussion

Four conclusions emerge from these findings. First, in terms of levels of satisfaction as measured by our questionnaire, residents in nursing homes and patients in long-stay NHS hospital wards had similar high levels of satisfaction. Secondly, where there was some expressed variation between the two patient groups,
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Table 4. Privacy

<table>
<thead>
<tr>
<th>Item</th>
<th>% positive, by home type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing (n = 377)</td>
</tr>
<tr>
<td>Privacy using toilet</td>
<td>91</td>
</tr>
<tr>
<td>Privacy when bathing</td>
<td>91</td>
</tr>
<tr>
<td>See visitors privately</td>
<td>84</td>
</tr>
<tr>
<td>Somewhere to go to be alone</td>
<td>81</td>
</tr>
</tbody>
</table>

NHS, National Health Service.

The difference was related to some of the obvious dissimilarities between nursing homes and hospitals in regard to their organization and facilities. Thirdly, residents of different-sized nursing homes can experience different conditions and have different opinions about the nature of their environment. Finally, the nature of institutional care, whether it is in a nursing home or in a long-stay ward, seem to lead to similar responses because they are predicated on the same issues of physical dependency. Consequently, the emphasis on 'homely' environments seems, in part, misplaced.

The similarities between both groups of respondents in terms of satisfaction seem perplexing, at least from the point of view of those arguing from a non-institutional perspective. One response would be to reject the findings because they are based on answers from a group who either cannot discriminate or are unprepared to be critical. Certainly it would be wrong to ignore these criticisms. There is a wealth of research evidence that points to high positive responses among older people to questions regarding their health care [22]. However, would it be as appropriate to disregard these responses if they were overwhelmingly critical? Much research in this area seems to suffer from a desire to see older people as powerless and more or less determined by the structures in which they find themselves. The theory of institutionalization posits institutionalized individuals and finds them. Other explanations are ruled out by this circular logic which tries to make up for the deficiencies of the institution by putting the emphasis on choice, autonomy and privacy [17].

Our research suggests taking a different direction; namely that older people in both nursing homes and long-stay NHS wards have remarkably similar levels of satisfaction because their situations are very similar. The practicalities of being physically dependent circumscribe most of their assessments. For example, both groups reported very high levels of satisfaction with the care they received. This is not surprising because these patients are very dependent on the care provided and, as the responses to open-ended questions showed, they are appreciative of the care. On issues relating to satisfaction with privacy when using the toilet or when bathing the figures are almost

Table 5. Social environment

<table>
<thead>
<tr>
<th>Item</th>
<th>% positive, by home type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing (n = 377)</td>
</tr>
<tr>
<td>Decor pleasant</td>
<td>88</td>
</tr>
<tr>
<td>Cheerful atmosphere</td>
<td>80</td>
</tr>
<tr>
<td>Do as much as you can</td>
<td>75</td>
</tr>
<tr>
<td>This is my home</td>
<td>68</td>
</tr>
<tr>
<td>Feel lonely*</td>
<td>67</td>
</tr>
<tr>
<td>Time passes slowly*</td>
<td>56</td>
</tr>
<tr>
<td>Plenty of activities</td>
<td>48</td>
</tr>
<tr>
<td>Sit around with nothing to do*</td>
<td>42</td>
</tr>
<tr>
<td>Go out as much as would like</td>
<td>39</td>
</tr>
<tr>
<td>Do as much as would like</td>
<td>29</td>
</tr>
</tbody>
</table>

NHS, National Health Service.
a Negative response indicates satisfaction.
b Not asked.
identical (91 and 92%) for the two groups. Even on questions where the different approaches of the nursing home and the hospital might produce different results (such as whether the respondents felt that where they were was home) produced similar percentages—68% from the nursing homes and 62% from the long-stay wards. While the two groups had similar levels of satisfaction to specific questions, the level of that satisfaction varied in relation to the question put. On questions relating to choosing who to sit with when eating, it could be the case that a form of ‘double communication’ is occurring. Low levels of satisfaction might indicate a negative evaluation of a social environment, where it was impossible to get away from residents who were more heavily mentally impaired (in this case the spatially restricted nursing homes). This suggests that some residents in nursing homes and NHS facilities were able to discriminate between those things that they perceived as good and those they perceived as less good. These results are consistent with others showing that people living in communal care could assess the level of their own satisfaction with their circumstances [23] and with studies that have argued that there are few differences to be found in the social environments of hospital wards and nursing homes [24].

Where nursing home and NHS patients differed in their levels of satisfaction, this could be related to obvious differences between the type of establishment. These differences did not, however, indicate the superiority of one form of care. For example, nearly all nursing home residents could wear their own clothes compared with only two-thirds of NHS patients. However, less than half of nursing home residents could choose their table partners compared with four-fifths of NHS patients. Similarly, although a higher proportion of nursing home residents could see visitors privately, NHS patients reported a higher level of activities than those in nursing homes. Surprisingly, issues such as food did not provide a basis for discrimination between nursing homes and NHS long-stay wards.

These differences can also be seen in relation to the size of the nursing home, but smaller establishments did not always provide more resident satisfaction than larger ones. Often, there was no discernible difference in satisfaction levels among residents in nursing homes of different sizes. This would seem to indicate some degree of consistency between residents on issues relating to satisfaction with their environments. However, where differences did exist, they concerned issues such as thinking of the nursing home as ‘home’ and being able to choose their own clothes. Also, fewer residents in smaller nursing homes wanted more say in the way their homes were run than did those in larger facilities. These findings suggest that there is some truth in the assertion that nursing homes do provide a more homely environment, particularly if they are small. It is difficult to argue, however, that these small differences justify the whole emphasis of community care policy.

Finally, many assumptions have been made about the limitations on the lives of physically dependent older people. In contrast, we would argue that these people may still remain capable of being agents in relation to their own circumstances and can assess their own limitations and their origins. Thus, it is possible to separate the meanings of ‘house’ and ‘home’ [1]. Many older people have an attachment to a particular house, often because of the length of time that they have lived in it and because it provides a sense of security. Moving can disrupt this and it is unlikely that providing a home-like environment in a nursing home can recreate these attachments. More important are the social relations that can emerge from a change in environment. The social and emotional life created by the institution can be as rich if not richer than that experienced previously by the older person. This aspect, allied to the high level of acceptance of the need for institutional care among older people themselves [25] suggests a different framework for the understanding of institutional care.

The analysis of the position of highly physically dependent older people should start from the position that they find themselves in: unable to carry out most of the ordinary functions of everyday life without help [10, 16]. While this dependency presents opportunities for control by those providing care, to maintain that this is what always occurs is wrong. Such an approach reduces older people to the position of cyphers. Older people in such situations are aware of their need for help. They may be grateful (but it seems no less grateful in nursing homes where they are paying), but they know that their physical limitations would place them in these circumstances no matter where they were being cared for. The more disabled over-90s in the community exhibit noticeable anxieties about isolation and loneliness [23]. Consequently, it is not surprising that regardless of the type of facility, our sample of elderly and dependent residents have high levels of satisfaction with institutional care because, here, at least they are receiving care.

Conclusion

Community care policy is predicated on an idea that long-term care should be provided at home or in a ‘homely’ atmosphere wherever possible. This is assumed to be better because it militates against the effects of institutionalization. We have shown that nursing home residents demonstrate remarkably similar levels of satisfaction to NHS long-stay patients. This suggests that the differences between the two groups of patients are not as large as it might seem. In this light, it seems that the policy of allowing NHS long-stay
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provision to diminish may not have been a positive step.

The notion of homely settings is much less important than has previously been argued. The concepts of 'home' and 'institution' have had more symbolic importance than serving as concrete bases in the construction of policy for older dependent people. If policy is to achieve its objective of improving the lives of this group of people, then it needs to correct this bias.

Key points

• The UK's community care policy sees institutional care in hospital as inferior to nursing home care.
• Patients and residents have similar levels of dependency and needs.
• Both groups have the same level of satisfaction with form of care.
• Policy options favouring nursing homes over hospital provision are not justified on basis of patient satisfaction.

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References


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Phyllis Gledhill age 101. Born 1896, Bradford: "I started work in the Spekes Mills when I was 12. The noise of looms was terrible but I soon learnt to lip-read. We had no running water, we had to collect it from a local spring." © Ian Beesley.