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The nature of quality of life in residential care facilities: the case of White older South Africans

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This study describes the nature of quality of life (QoL) from the perspective of older South Africans ($n = 41$) in residential care facilities (female = 75%; age range 62–95 years). The residents participated in individual in-depth interviews and focus groups. They also set down their narrative reflections on their QoL in journals. Data were analysed by means of interpretative phenomenological analysis. Findings reveal the resident older South Africans regard QoL as a spiritually informed worldview of life events, coping with challenges and being mindful of others. The residents perceived QoL to include proximity and quality and reciprocity with others. QoL among older people is context and people specific.

Keywords: Older South African people, lifespan, qualitative enquiry, quality of life, relationships, residential care facilities

Introduction

QoL is an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL, 1993). Farquhar (1995) identified three broad domains of QoL: social interaction, health and material well-being. Cummins (1996) considered QoL to include emotional well-being, health, intimacy, material well-being, productivity, safety and community as prominent domains. Baltes and Smith (2003) maintain that understanding QoL at various stages of development, and especially in old age, remains a neglected but increasingly important area for research (Baltes & Smith, 2003; Bowling, 2001; Bowling & Gabriel, 2004; Cummins, 1997). Accordingly, this study sets out to obtain a better understanding of the nature of QoL for a group of older people in South Africa, in the social context of a residential care facility.

The South African life situation for the elderly

The current population figures of South Africa indicate that the country has a growing young black population and an ageing and shrinking white population (Stats SA, 2011). According to the most recent population statistics (Stats SA, 2011) the South African population increased from 40.5 million in 1996 to 51.7 million in 2011 (of whom 41 million are Black, 4.6 million are Coloured, 4.6 million are White and 1.5 million are Asian/Indian). However, the number of White South Africans as a subpopulation has decreased (from 10% of the total population to 8.9%) due to low fertility and emigration.

A visible discrepancy in service provision, access to health care and socio-economic status of the various ethnic groups of South Africa was evident for many years before and during the Apartheid era (Westaway, Olorunju, & Rai, 2007). In particular, access to residential care facilities was permitted exclusively to White older people at the time. This changed in 1994 when Apartheid ended and the Transformation Act made access to facilities possible for all race groups. Nonetheless, older people of other racial groups are more inclined and culturally accustomed to remain part of their communities or to reside with

children or extended family members. White South Africans represent 90% of all older people in residential care facilities (Department of Social Development, 2010). Furthermore, white older South Africans appear to prefer to be cared for in residential care facilities because of their deteriorating health, loose social/cultural ties, the emigration of children and grandchildren, and limited financial resources in their later years (Joubert & Bradshaw, 2006). Apart from White older people, those of other race groups in South Africa are rarely found to reside and be cared for in facilities.

Residential care

The Older Persons Act of South Africa, Act 13 of 2006 (Department of Social Development, 2006) specified three categories of residential care facilities exist in terms of, namely: Category A (independent living), Category B (assisted living) and Category C (frail care). A combination of these categories was relevant to this enquiry. The South African government subsidises some facilities to provide for the basic housing, healthcare and nutritional needs of older people (Van der Walt, 2011). The majority of well-functioning facilities are run independently, as a business or non-government organisation where residents either buy life rights to the premises (which enables buyers to stay there for the rest of their lives) or rent the accommodation and pay for services.

Older people who live in residential care facilities are more likely to experience reduced QoL, according to Kane and Kane (2001). These authors found that diminishing physical abilities, changes in the living environment, rigid daily routines and altered social interactional patterns exercise a negative impact on QoL. A good physical environment and the availability of formal (health) care in care facilities are found to be significant predictors of mortality, physical dependence and service utilisation among older people (Dorr et al., 2006). However, Spirduso, Francis, and MacRae (2005) state that merely extending the lives of people is of no value unless QoL can be maintained for the individual concerned. Only a limited number of international and local sources were identified which employed a more person-oriented and qualitative

approach in studying the multi-dimensional nature of QoL in the contexts of residential care facilities (Clark & Bowling, 1989; Farquhar, 1995; Fry, 2000).

Aim of the study

This study aimed to explore QoL as perceived by older people residing in residential care facilities in South Africa. The following broad question guided the study: What is the nature of QoL according to the perceptions of older people in residential care facilities? The study findings hope to report to care providers and others who offer support to older people in residential and similar care settings.

Method

Participants and setting

A convenience sample of 41 older White, Afrikaans and English-speaking South Africans (female, $n = 31$; age range 62 to 95) living in residential care facilities in the Free State and North West Provinces of South Africa participated in the research. None of the participants were frail and all enjoyed moderate socio-economic circumstances. Four independent residential care facilities situated in urban areas in these two provinces of South Africa formed the basis for participant recruitment and data collection. These facilities were similar in terms of care provisioning and living conditions, although the availability of organised activities in which older people were able to participate varied according to the facility.

The accommodation in the facilities was arranged so that older people either lived in small apartments on the premises or in ensuite bedrooms. Residents shared communal areas such as the lounge, dining hall and gardens. Most of the participants in the study resided in one-bedroom apartments or ensuite bedrooms. The motivation for drawing participants from more than one site was to obtain data from older people who resided in

multiple contexts with relatively similar circumstances in order to avoid biased perceptions of QoL (Mouton, 2009). The historical and current position of many older White South Africans affords them good living conditions compared with the other population groups, and this, according to Staehelin (2005), contributes to an increased life expectancy.

Data collection and procedure

Ethical approval to conduct the research was obtained from the Health Research Ethics Committee of the North-West University, under the title: *Exploring enabling contexts* (Ref. O5K14). Permission was also obtained from the managers of all four facilities to conduct the research on their premises. Participants volunteered for the study. The participants were informed of the time needed for each of the various data-collection activities. They were reassured that they could withdraw from the study at any time and were not obliged to give an account of life experiences they did not feel comfortable sharing. Counselling was offered in the event of emotional discomfort experienced following participation. The privacy, anonymity and confidentiality of all information obtained from the participants were assured. The participants gave written informed consent and gave the researchers the right to use the results for publication in scientific journals as well as in conference presentations.

Data were collected by the investigators assisted by three fieldworkers. Appointments for interviews and focus groups were scheduled with the participants at convenient times. The researcher and fieldworkers coordinated all appointments with the managers at each facility. These appointments were usually scheduled for the mornings, when the older people still had sufficient energy, and so as not to prevent them from having their afternoon rest. At the initial meeting, journals were distributed to older

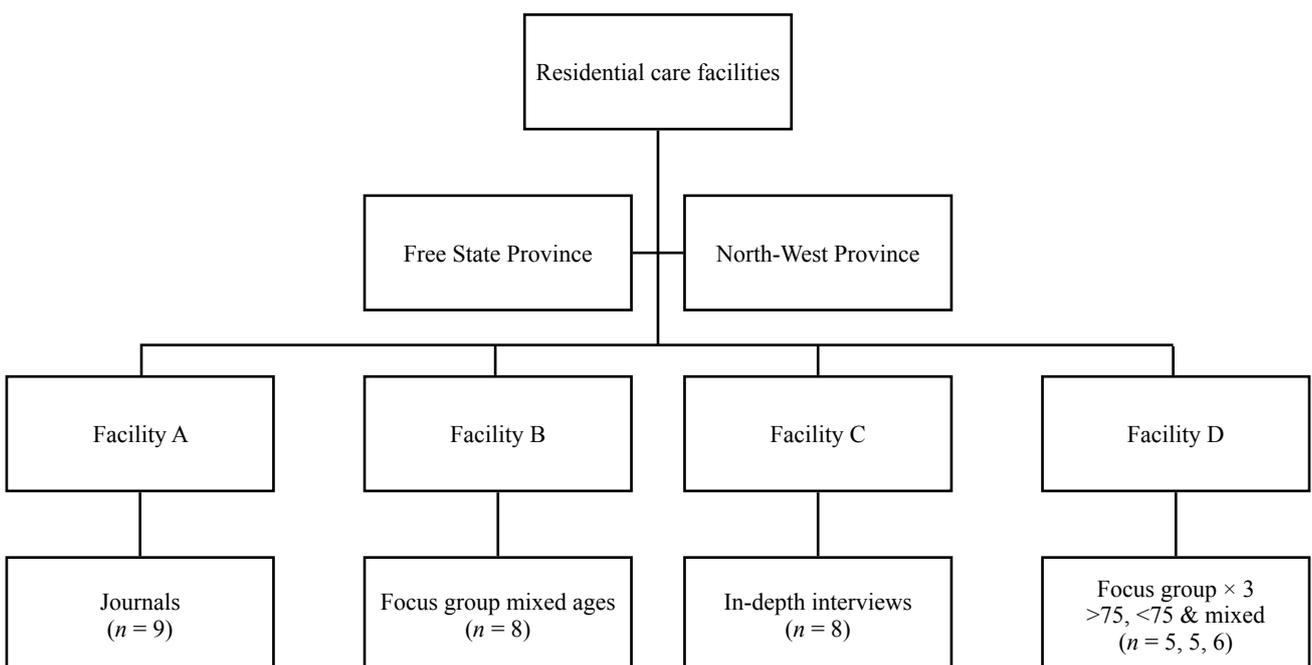


Figure 1. Layout of data-collection procedures

persons who were prepared to use them and collected after two weeks.

Data collection

Qualitative research was used for this study to explore and describe participants' understanding and interpretation of QoL (Ritchie, 2009). Figure 1 presents the layout of the data-collection procedures.

The study drew data from the collective pool of qualitative information obtained from the participants in the various settings. Specific data collection techniques will be discussed briefly.

Semi-structured interviews

Semi-structured interviews were used to obtain eight participants' ($n = 8$) perceptions and to gain insight into the nature of QoL as they see and experience it (Creswell, 2003). The questions posed to participants included: "Please share your perceptions on the nature of QoL"; "How would you define QoL?"; "How did you formerly view and experience QoL?"; and, "How do you experience it now?" These questions correspond to the work of Farquhar (1995), who conducted a similar qualitative study among older people in England. The duration of the interviews varied between 30 and 90 minutes, according to the participant.

Focus groups

The aim of the focus group was to encourage self-disclosure. Four focus groups consisting of an older group (>75 years, $n = 5$), a younger group (<75 years, $n = 5$) and two mixed age groups ($n = 6$; $n = 8$) were conducted. Age-specific groups were conducted to control for ageing effects. Altogether 24 older people formed part of the focus groups. The same questions that were asked in individual interviews were explored in the focus groups. The focus group session conducted with the younger group lasted 45 minutes, whereas the older group members spent half an hour sharing their views. The mixed groups gave their opinions in 49 minutes ($n = 6$) and 33 minutes ($n = 8$) respectively.

Journals

Participants voiced their experiences and opinions of QoL in their journal entries and narrative storytelling (Alaszewski, 2006). Journalising is ideal in situations in which individuals prefer to express themselves in writing rather than in conversation face-to-face. The instructions for journal use and specific open-ended questions were pre-printed in the journals, which were collected after two weeks. Questions included: "Please define QoL in your own words"; "What are the things that currently provide you with QoL?"; "What are the things that previously gave you QoL?"; and, "Please feel welcome to share any additional thoughts on QoL". Nine participants reflected and narrated their accounts of QoL in journal entries ($n = 9$). This method proved to be extremely valuable because the participants not only answered specific questions of interest to the research but also often provided supplementary data.

Trustworthiness

The integrity of the study was facilitated by following the guidelines suggested by Tracy (2010), including obtaining data-complementary qualitative methods to describe the complexity of QoL. Quotes are also included to provide rich and bountiful descriptions.

Data analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the data (Willig, 2001; Smith, Flowers, & Larkin, 2009). IPA emphasises interpretation of individuals' perceptions of the topic of study and how these are reflected in themes and patterns in the data. Line-by-line analysis of the interview transcripts produced a set of themes embracing the reflections of the participants. Additional extracts, from focus group discussions and the narratives in the journals, were checked against the themes that emerged from the interviews to ensure relevance of the analytic framework and to identify new themes. This developed a 'dialogue' between the researcher, coded data and the psychological knowledge that applied to the patterns that emerged. Lines of argument were identified in terms of the relationship of patterns to each other and verified against further extracts. Emerging themes were revised until the analytic framework usefully accounted for the participants' understandings and no further themes could be identified. The main themes are discussed below.

Results

Table 1 presents the themes and subthemes as described by older people.

Facilitating role of spirituality

In the opinion of many participants, spirituality informed their QoL and enforced functional coping strategies in terms of dealing with adversities in their present circumstances. Their spiritual worldview also influenced them to be mindful of others.

Spiritual worldview informs QoL

Spirituality provided the participants with a sense of purpose as they had something to live for. One older person explained: "QoL for me is to be able to get up

Table 1. Themes and subthemes informing the nature of QoL

Themes	Subthemes
Facilitating role of spirituality	<ul style="list-style-type: none"> • Spiritual worldview informs QoL • Coping with adversity • Mindfulness towards others
QoL in interpersonal contexts	<ul style="list-style-type: none"> • Quality relationships with family and close friends • Proximity of relationships • Reciprocal caring relationships
Self-regulation	<ul style="list-style-type: none"> • Health • Finances • Behaviour
Transitional nature of QoL	<ul style="list-style-type: none"> • Former QoL: 'Doing' things to have things • Current QoL: 'Being' content in current circumstances

every morning, and to know that He will help me in every situation and make my path straight” (Participant 13, 78 year old male – journal).

Coping with adversity

Participants reported that their spirituality helped them to cope with adversity. This is reflected in the following quotation: “When I was pushed [wheeled] into the theatre I made right with Him. I told Him that I would accept whatever the results turned out to be” (Participant 17, 65 year old female – interview). In a focus group discussion participants reflected on how they felt greatly comforted by “having God” and knowing that “He will help” them and “always be with them”.

Mindfulness towards others

For some their spiritually-informed approach to life made them more mindful of others, in or outside the facility. A participant reflected (Participant 7, 71 year old female – journal): “Because of Him I still feel I want to do more for others, the sick, old people like myself and little children and babies.” Aspects of providing financial support to those less fortunate were also discussed in the focus group. One participant explained that “we should give to others what they DO NOT deserve, because that is what God gave to us” (Participant 31, 76 year old male – focus group). For many of these participants their spirituality inspired them to be good to other older people and people in general.

QoL in interpersonal contexts

Participants emphasised the importance of relationships in a variety of interpersonal contexts. Social rapport can be described as the web of social relationships that surrounds an individual and varies from person to person depending on family size, frequency of interpersonal contact and living arrangements.

Quality relationships with family and close friends

Some of the participants drew a distinction between knowing people and having a relationship with them. Consider the following quotation from an interview (Participant 12, 64 year old female): “I have my close friends, many of them do not live here [in the facility]. We have known each other for a long time and went through many things together”. From a focus group discussion it also emerged that “it’s difficult to make good friends here” [in the facility] and that residents “keep to themselves”, “stay in their rooms” and “value privacy”. Quality relationships in the facilities were mostly formed with neighbours or other residents whom participants had known for a long time or those with whom they have something in common (belonging to the same church, reading groups, or walking groups).

Participants viewed their relationships with children and other close family members such as grandchildren or siblings (where applicable) as very important. They regarded relational ties with their families as a large component of their QoL in later years. A participant wrote (Participant 9, 74 year old male – journal): “The privilege of healthy family relationships and the relationship with our children that often visit affords us QoL now.” The data

revealed further that older people attach even more value to interaction with family in their later years than earlier on, as noted in the following quotation: “The opportunities that we now get to visit our children are becoming more and more precious as this keeps us going” (Participant 4, 73 year old female – interview).

Some participants expressed relationship quality in terms of nurturing: the older people felt that their family still cared for them and wanted to spend time with them. In this particular discussion a participant stated that “It is always nice when my daughter and the children [referring to grandchildren] come to visit me here... When I go to visit them she is always busy with the kids and their sport and we rarely sit down together, but when they come here, they spend time with me” (Participant 5, 69 year old female – focus group).

Proximity of relationships

Participants who reported on the quality of relationships related the *quality* to the *proximity* of relationships and the opportunity of frequent interaction. Some participants, whose children lived far away or in other countries, attached greater value to friendships and were closer to others in their immediate environment. A quote from a focus group discussion revealed that “many people’s children live far away” (Participant 8, 72 year old female), implying that interaction was limited (e.g. “We see them once or twice a year”). Quality relationships with friends outside the facility were also valued. A female participant stated in one of the interviews that “I have a friend, a man who doesn’t live here [in the facility]. We go to the movies together and have coffee. This is precious to me at our age” (Participant 23, 74 year old female – interview).

Reciprocal caring relationships

Participants expressed a need for reciprocal caring relationships in which they felt highly valued: “I feel happy when I am able to help other people...there are always others here that also help me” (Participant 8, 72 year old female – focus group). The importance of reciprocity was highly evident from participants who felt that they did not receive friendship or support (depending on the nature of the relationship) to the same extent as they were willing to extend it. This is evident from the following quote: “In this facility many people come across your path, some of them have been broken down by the years and they only want to talk about themselves and their own past” (Participant 21, 75 year old female – journal).

Self-regulation

Self-regulation was found to be an important component towards understanding the nature of QoL. Many responsibilities are taken away from older people when they go to live in residential care facilities. Behavioural aspects, health and finances were specifically mentioned as areas participants were prone to regulate themselves. The importance of regulating behavioural aspects is reflected in the following: “I know I have to change my attitude toward the people here” (Participant 6, 62 year old female – journal), and “quality of life is a mind-set... you choose if you are happy or not” (Participant 25, 83 year old female

– focus group]. Self-regulation in terms of health aspects may be noted from the following quotations: “*I believe that I have to manage my health, to rest enough and relax, control my appetite and do some exercise*” (Participant 7, 71 year old female – journal). With regards to financial regulation a participant stated: “*Things are getting more and more expensive, as also the cost of living here, and it’s difficult to save but I try to do it every month*” (Participant 31, 76 year old male – focus group).

Transitional nature of QoL

Participants perceived QoL to have transitional properties. When the participants were younger, domains such as spirituality, health and nurturing relationships were seldom mentioned as being important for QoL, whereas they were now deemed vital.

Former QoL: ‘Doing’ things to have things

Participants explained how QoL had formerly been experienced in terms of the ability to do things in order to have things. The domains of importance to former QoL were expressed as marital life, family life, career success, social engagements and financial success. For instance, a male participant wrote: “*My intellect, choice of friends and socio-economic status all contributed to my quality of life. It was important to have a tertiary education and a good job. The choice of life partner and wealth was also very important*” (Participant 13, 78 year old male – journal).

Men were mostly focused on career, money and self-attainment: “*I enjoyed being a teacher, keeping fit and expressing myself through sport*” (Participant 31, 76 year old male – focus group), and “*Everything revolved around money and being able to provide for my family; because of this it was essential to have a good job*” (Participant 9, 74 year old male – journal). On the other hand, women attributed their QoL to the success of their family life, self-image, home and to raising their children: “*I always wanted to look nice and be thin then, I enjoyed keeping a house and building new friendships*” (Participant 7, 71 year old female – journal).

Current QoL: ‘Being’ content in current circumstances

Participants used words which focused on ‘being’ than on doing many things. For instance, a participant described his current view of QoL as follows: “*Things which now define my QoL are to live in peace with my wife, using the abundance of time that I have to explore spiritual things, good relations with our children and others, and good health is also essential*” (Participant 13, 78 year old male – journal). Current QoL seemed to be largely informed by acts that gave meaning to their lives, such as relaxing, having a good time with loved ones and being considerate of others. One older person wrote (Participant 27, 69 year old female – journal): “*It is important to me that my daily activities should count for eternity, and that I don’t merely stay busy just to pass time but will do things that will have a positive influence in my own and other’s lives*”. The transcendent nature of QoL can also be seen in the following quotation in which a participant emphasised the constant need for new experiences and challenges: “*New challenges are essential for QoL. One has to try new things*

never yet experienced for the sake of your body and spirit, or just new things in the place of things that you are no longer able to do because of age. I easily get depressed if I don’t practise these principles” (Participant 27, 69 year old female – journal).

Discussion

Participants described QoL in terms of the facilitating role of a spiritually-informed worldview, relationships with people, as self-regulation and as a transitional phenomenon. Their spiritual worldview laid emphasis on sense of purpose in life. A purposeful life is associated with meaningfulness, which contributes to people’s QoL. The role of spirituality in the lives of older persons is confirmed in findings similar to that of related studies (e.g., Roos, 2013; Roos, Chigeza, & Van Niekerk, 2013). Spirituality as a QoL indicator included downward self-comparison with others in less fortunate circumstances.

Participants considered QoL to be characterised by available satisfying relationships, which offered social support, security and mutual affection or reciprocity. This is consistent with Farquhar’s (1995) findings who reported QoL of older people as revolving around family, social activities and other social contacts. Specifically, proximity and regular contact with children and other relatives, as well as contact with friends in and outside of the facility, were important for older people’s sense of belongingness (Victor, Scambler, & Bond, 2009). Reciprocity in relationships, which refers to the give-and-take of assistance from one person to another (Antonucci, 2001), may not be balanced; many participants in this study confirmed that giving support does not always translate into receiving support. Reciprocity within the residential halls was not equitable for newcomers, who experienced their relational interactions as “difficult”, with limited social access to other residents.

The transition from community living to a residential care facility has the effect that residents have fewer responsibilities in terms of an occupation, family life roles and responsibilities (Kane & Kane, 2001). Residential living also decreases the availability of choices (Kane & Kane, 2001). Self-regulation was important to the residents’ QoL because it awarded them with a sense of control over at least some aspects of their lives. Brown and Ryan (2004) found that the perceived ability of older people to change or influence a situation affected their behaviour, as well as their physical and mental well-being. Consequently, their ability to regulate certain areas in their lives and seeing the results keeps them motivated. The importance of being able to regulate behavioural aspects, health and finances was particularly important to the residents’ sense of autonomy. Autonomy is one of the key aspects that promote the well-being of people and is not age specific (Prilleltensky & Prilleltensky, 2003).

QoL is also considered a transitional experience in that it changed over participants’ lifetimes. Moreover, divergent approaches to QoL were noted between men and women in their younger years. In reflecting back on their lives, older male participants reportedly experienced QoL in terms of achievements that were translated to their own sense of value, while women’s previous experience of QoL was

related to their ideal self-image and family and home life. This agreed with the findings of Baltes and Smith (1999), who stated that younger persons see their lives largely as lying ahead of them. They are inclined to engage in things that permit them to develop a life that reflects their aspirations and abilities. For both genders, following Arber, Davidson, and Ginn (2003), these divergent approaches from men and women have been said to converge in later life. In this study, older people are more inclined to associate QoL with a sense of 'being' and not so much as with a sense of 'having'. Fromm (1993) regards the freedom from possession-centredness as an inner liberation and progress in becoming more fully human.

Implications for research and practice

QoL is a socio-culturally informed construct. For the group of older people studied, the domains they associate with their QoL may differ from that of people in other settings. Managers in residential facilities are in a position to promote older people's QoL by assessing the domains older residents value, not only by means of quantitative instruments, but also by involving people in expressing the subjective meanings they attach to contributors to their QoL. It is therefore suggested that qualitative assessments be included to determine older people's QoL when they enter a residential care facility.

QoL is dynamic rather than static. It cannot therefore be assumed that the domains of QoL will remain static throughout people's lives. In following the notion that well-being is optimised when there is a fit between people's needs and the environment, it is suggested that residential facilities adopt a flexible approach in planning programmes and structuring the social and physical environment. The aim should be to provide older residents with different options to exercise choices and opportunities to regulate themselves in the environment because autonomy and self-determination are two of the most important contributors to QoL, albeit threatened in a facilitated care setting.

QoL research may benefit from qualitative findings obtained from interviews, focus groups and journals. The journals provided particularly useful data about older people's QoL experiences and are recommended as a useful tool for collecting detailed data.

Limitations

This exploratory study was limited in scope by convenience sampling rather than probabilistic sampling. As a result findings could not be generalised to other older South Africans in same or different settings. The reliance only on self-reported qualitative data that were collected in a group rather than observations or using visual data with projective potential has the limitation that participants could present 'socially acceptable' responses. It is recommended that research in future might include older populations in different settings. In the context of South Africa, many older persons of colour find themselves in deprived facilitated care settings or multi-generational community settings. Since they constitute proportionally the biggest group of older persons, exploring what they regard as QoL would yield interesting findings and inform service providers about what is required to optimise the

life of a marginalised group of people. It would also be interesting to conduct a longitudinal study across the life course of how QoL domains change and why people attach different values to different domains as they age.

Conclusion

The present study revealed QoL for older people in South African residential care facilities to be defined by a spiritually-informed view of life and coping with everyday challenges. QoL is about the importance of relationships in terms of quality proximity and reciprocity. It is also associated with navigating and achievement of personal goals in a context in which older residents in a residential care facility have lost control over many aspects that impact their lives. Older persons' understanding of QoL appears to change from an activity-orientated, self-serving focus, to a transcendental and other-centered focus, emphasising meaningful encounters with people.

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