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Perceived resident–facility fit and sense of control in assisted living

Jari Pirhonen *, Ilkka Pietilä

School of Health Sciences and Gerontology Research Center, 33014 University of Tampere, Finland

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ABSTRACT

The concept of resident–facility fit has largely been used to illustrate whether a residential care facility and a resident are together able to meet requirements set by only the hampering functional abilities of the latter. The purpose of this paper is to study how assisted living residents perceive resident–facility fit. The data were gathered ethnographically from both observations and resident interviews in a sheltered home in Finland during 2013–2014. Perceived resident–facility fit is based on several relational factors that connect to both the residents as individuals and their surroundings. This fit seems also to be partly conditional and indeed depends on residents' trust in having their own potential to act. Good resident–facility fit results in feeling at home in a facility, whereas poor fit can even result in residents' feeling imprisoned. Care providers can thus utilize our results to affirm residents' quality of life in residential facilities.
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Introduction

During the last few decades, different forms of residential care have become the fastest growing form of long-term care for those growing older (Ball et al., 2004; Street, Burge, Quadagno, and Barrett, 2007; Zimmerman et al., 2003) for both economical and humane reasons (Chapin and Dobbs-Kepper, 2001). The diversity of these forms of care is vast, since residential care facilities for older people are known by nearly 20 different names in the United States alone (Mitchell and Kemp, 2000, p. 117). Indeed, the term *assisted living* (AL) has become a widely used label since it captures both the nature of residential care facilities and the philosophy of residential care (Mitchell and Kemp, 2000). According to Cutchin, Owen, and Chang (2003) AL attempts to offer a middle ground between independent living arrangements and nursing homes by combining elements of both; provision of housing combined with basic care round-the-clock. Kemp, Ball, Hollingsworth, and Perkins (2012, p. 491) hold that AL encompasses a range of settings that vary in size, service provision, regulatory standards, funding, fees, and resident characteristics.

AL does not easily surrender to strict definitions, but there are some common features regarding the policies and nature of AL care. According to Roth and Eckert (2011, p. 216), AL "emphasizes home-like environment that fosters respect for an individual's sense of autonomy, privacy, and freedom of choice". Zimmerman et al. (2005, p. 195) hold that the core idea of AL is to provide a choice of services and lifestyles to avoid the typical characteristics of an institutional setting. Key words related to AL are autonomy and choice (Ball et al., 2004; Roth and Eckert, 2011; Zimmerman et al., 2003), which refer to the goal of enabling as good a quality of life as possible for these older individuals, regardless of any hampering functional abilities. In addition to affirming the quality of life, a growing number of older people and the increasing costs of nursing care have directed the evolution of care towards AL (Zimmerman et al., 2003, p. 107). According to Chapin and Dobbs-Kepper (2001), AL is perceived as an economical way to care for low-income, frail older people in contrast to care given in the more traditional nursing homes.

* Corresponding author. Tel.: +358 50 318 7336; fax: +358 3 3641 511.
E-mail addresses: jari.pirhonen@staff.uta.fi (J. Pirhonen), ilkka.pietila@staff.uta.fi (I. Pietilä).

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There is yet another factor behind the success of AL, namely, the promise of aging in place (Zimmerman et al., 2005, p. 196). The concept aging in place originally referred to older people's possibilities to grow old in private homes without transferring to care facilities, but today it may be taken to encompass AL as well (Ball et al., 2004; Mitchell and Kemp, 2000; Roth and Eckert, 2011; Zimmerman et al., 2005). According to this philosophy, a facility adjusts its service provisions and care criteria to meet their residents' changing needs to postpone or even erase the need of high-level nursing care (Chapin and Dobbs-Kepper, 2001, p. 43). Simply put, the idea is that AL becomes the last home for older people, a home where they can spend their last years and where eventually they pass away. Indeed, as Ball et al. (2004, p. 202) remark, today AL residents are increasingly older, more functionally impaired, and have greater care needs than before, which in *de facto* terms paradoxically prevents people from aging in place. Chapin and Dobbs-Kepper (2001) reported how in particular, incontinence, behavioral problems, and lowering cognition still easily can result in a transfer from AL to a higher-level nursing facility. Service-directing policies and the business goals of care facilities may also either promote or prevent the nature of desired aging in place (Ball et al., 2004; Roth and Eckert, 2011).

Resident–facility fit

For successful aging in place, it is highly important that a person's and the environment's capabilities meet in AL. This idea can be tracked back to Lawton's (1980) pioneering work on the person–environment relationship, which gave rise to environmental gerontology (Wahl, Iwarsson, and Oswald, 2012). The concept known as *person–environment fit* was thus generated to study the possibilities for aging in place in general, including the broader phenomena that range from housing to community infrastructure. *Resident–facility fit* can thus be seen as a sub-concept of person–environment fit by focusing on factors that influence the possibilities of older persons to live in a given facility without any transfer to a higher-level care facility (Ball et al., 2004; Roth and Eckert, 2011; Zimmerman et al., 2003).

According to Morgan et al. (2014), prior research on resident–facility fit has largely focused on changes in the aging person, i.e. the challenges posed by functional decline, although resident–facility fit is also influenced by constant changes in the resident, the facility, and community factors. In addition to residents' functional decline, staff, procedures, policies, ownership of facilities, and other factors are contingent by their very nature (Ibid.). Only focusing on the hampering functional abilities of the residents, however, easily leads to just a "one way model" in AL where the environment is designed to match the individuals' competence levels (cf. Roth and Eckert, 2011, p. 216). On the other hand, focusing on the individual may result in overemphasizing residents' capabilities, such as their autonomy competences (Atkins, 2006). Ball et al. (2004) indeed hold that resident–facility fit is both an outcome and an influence on the management process of decline in which both the resident and the facility try to manage expected resident decline.

In this article, we see resident–facility fit as the resident's perception of his/her fit in the facility. We use resident–facility fit as a philosophical value judgment where the fit is good when residents feel that they have control over the environment. Thus, good resident–facility fit entails that the environment meets residents' needs and offers positive opportunities for autonomous living. The fit does not have to be constantly good or poor to have sense of control but it may differ from time to time and situation to situation. Our notion entails that resident–facility fit can be affirmed or impaired by multiple factors that relate to the residents, other people, and the surroundings. Resident–facility fit may then be seen as an outcome of the residents' chances to maintain continuity in their lives despite have moved into a care facility. Whereas the previous research sees this fit as a goal for process that aims to avoid transfers in residential care, we see fit more as a result of process that aims to achieve a residents' control over their surroundings. In this article, resident–facility fit is neither an objectively measurable phenomenon nor a subjective feeling, but rather a combination of the two; resident–facility fit is the residents' perception of their ability to manage in their new surroundings with their current capability. Thus, the idea of resident fit can be best studied by interviewing people and observing them in their daily lives.

Relational autonomy

AL and resident–facility fit both carry a promise of affirming resident autonomy. National guidelines for the care of older people in Finland, such as *The National Framework for High-quality Services for Older People* (Ministry of Social Affairs and Health, 2008), stress autonomy and the right to self-determination and making choices. It is recommended that older people be treated on the basis of informed choice and should be given both the information and other help they need to make their decisions (Ibid., p. 13). In reality, AL seems to be rather difficult surroundings in which older people can execute their right to choose, since usually these "individuals need long-term care because they suffer illnesses and incapacities that compromise their ability to function independently and choose rationally" (Agich, 2003, p. 1). According to Sherwin and Winsby (2010), resident autonomy may also be reduced by the paternalistic attitudes of staff, other people's self-interests (such as relatives), and residents' personal fear that disobedience could result in abandonment. Collopy (1988) holds that helping interventions are often judged by the motivations and goals of the helpers instead of the helped, which easily reduces the autonomy of the latter. Daily routines are still another issue that influences residents' opportunities to act freely (Eyers, Arber, Luff, Young, and Ellmers, 2012). Traditional conceptualizations of autonomy as self-determination or the right to choose seem to exclude a large group of people, namely, those older people who are residing in AL due to their hampered functional abilities.

The perception of *relational autonomy* acknowledges the situated nature of human life intertwined with facticity and connections and interactions with other people (Atkins, 2006; Christman, 2014; Sherwin and Winsby, 2010). Relational approaches to autonomy grant that individuals' actions are inevitably linked to several relational factors, such as social relationships, personal characteristics, and the affordances of the agent's environment. Human will is not free, but rather governed by reality or, in Kant's (2012, p. 486) words, human will can only be free when governed by reason. Especially, the feminist research tradition, which highlights the intersectional

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