Privacy in personal Care Homes in Winnipeg, Manitoba as Experienced by Residents.

by

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Abstract

The case study examined physical and social privacy for nine residents residing in personal care homes in Winnipeg, Manitoba, Canada. The study explored how residents' well-being and quality of life was affected by the privacy afforded to them in various room accommodations. The purpose of the study was to use maximum variation of cases to examine privacy from the perspective of several residents who reside in a personal care home through in-depth data collection during a semi-structured interview process. The case study explored residents' social location, room preference, safety and security, communication with family, interaction with staff, and interaction with roommates. Resident interviews were audiotaped, transcribed, analyzed and sorted into themes.

The study found that residents benefit from having access to locks for doors; specialized units for cognitively impaired residents; private health assessment rooms; phasing out multi-bed room; use of room barriers; privacy for intimacy; access to private lounges for visiting; and private room with a public telephone. The findings aligned with the ecosystems perspective and residents taking control of their environment to improve goodness of fit. The study assists health care providers and students in health fields in becoming aware of privacy issues. The study may be useful in assisting residents to prepare for adjustment to a personal care home.

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Privacy in personal care homes in Winnipeg, Manitoba as Experienced by Residents.

Introduction 1.

Introduction

The introduction chapter reviews trends in aging in Canada. Following an overview of aging trends in Canada the Provincial requirements for privacy in personal care homes is outlined. The chapter defines the research question and ends with a brief description of the researchers interests in aging.

Canada's population is aging rapidly; according to Statistics Canada (2011) it was estimated in 2011 that 5 million Canadians were 65 years or older. It is expected by 2036 Canada's population of individuals 65 years or older will grow to 10.4 million (HRSDC calculations based on Statistics Canada, 2011). The impact of increased life expectancies and the aging post-war 'baby boomer' generation will require an increase in supports for daily living. With the life expectancy of Canadians increasing there will be an increase in demand for person care home (NACA, 2005). During 2007-2008 20.9 % of females and 30.7 % of males age 85 and older resided in a personal care home in the province of Manitoba, Canada (Doupe, M., *et al*, 2011). The demand for personal care homes will increase by 7.5 % when the oldest members of the Baby Boomer generation reach age 75 in the years 2020-2021 (Doupe, M., *et al*, 2011).

Personal care homes serve all ages however their primary residents are older adults over the age of 85 (NACA, 2005). Personal care homes provide accommodations, health care services, nursing, physician services, nutrition, medications, recreation programs, housekeeping, laundry, and allied health services for residents.

Manitoba Health cites privacy as an important requirement for residents residing in Personal Care Homes (Manitoba Health Standards Document, 2014). The requirement of privacy is of central importance under the Bill of Rights portion of the Manitoba Health Personal Care Home Standards, which all personal care homes are expected to follow. Manitoba Health Standards cites the following forms of privacy as a requirement for person care home: 1. Residents are to be treated with courtesy, respect and in a way that promotes their dignity and individuality (MB Health, 2014, p. 4); 2. Subject to safety requirements and the privacy rights of other residents, residents are to be encouraged to exercise their freedom of choice (MB Health, 2014, p. 5); 3. Residents may exercise their choice of religion, culture and language (MB Health, 2014, p. 5); 4. Residents may communicate with, have contact with and visits to and from friends, family and others in private if desired (MB Health, 2014, p. 6); 5. Residents are free to choose the personal items to be kept in their rooms when space permits (MB Health, 2014, p. 8); 6. Residents are to be afforded reasonable privacy while being treated and cared for (MB Health, 2014, p. 9); and 7. Residents may communicate and meet with their legal representative as often as necessary and in private if desired (MB Health, 2014, p. 5).

Research Question

The purpose of this research was to explore how residents in personal care homes experience privacy. Specifically the research explored how physical and social privacy was afforded to residents and also explored how residents feel their well-being and quality of life was affected by the privacy afforded to them in personal care homes.

Overview of the Thesis

The research explored the impact of a private, semi-private or shared accommodations on a resident's privacy. I am particularly interested in quality of life and issues surrounding dignity for Older Adults as a practicing Social Worker in a personal care home.

The introduction chapter reviewed trends in aging in Canada. Following an overview of aging trends in Canada the Provincial requirements for privacy in personal care homes was outlined. The chapter defined the research question. The chapter ends with a brief description of the researchers interests in aging.

Literature Review 2.

The literature review chapter provides the theoretical framework for the study and the ecosystems perspective based on the work of James Kelly and Urie Bronfenbrenner. Following a description of the theoretical framework, the literature search strategy is outlined. The major portion of the chapter provides a synthesis of the literature on privacy in personal care homes under the headings of: room design, roommates, shared accommodations, personal belongings, sexuality, provision of care, activities of daily living, palliative care, family visits, communication, policy and administration, and interactions with staff. The chapter ends with a brief observation of the literature and where further research is needed.

The literature defines privacy in a number of ways. Akpan (2006), Webster and Bryan (2009) referenced the Oxford English dictionary defines privacy as "a state in which one is not observed or disturbed by others". Solove (2002) describes privacy as being without other people. Privacy was described in four different areas: physical

privacy for the body and one's space; psychological privacy for maintaining one's sense of self, identity and feeling of control; and social privacy for visiting and privacy of information (Akpan, 2006; De Veer & Kerkstra, 2001; Hughes, 2004; Petronio & Kovach, 1997; Webster & Bryan, 2009; Le Low, Lee & Chan, 2006). Petronio and Kovach (1997) report that seniors' privacy diminishes as their health care needs increase.

When exploring privacy for residents in personal care homes a qualitative approach was used to conduct the research. The study used a case study approach with an emphasis on the ecosystems perspective. The aim of the qualitative research was to explore privacy in personal care homes in Winnipeg, Manitoba based on the ecosystems perspective. Through case study research the effects of the physical environment on the residents' well-being was explored.

Ecosystems Perspective

The ecosystems perspective guides clinical assessment and intervention in social work practice. The ecosystems perspective stemmed from clinical psychology. The ecosystems perspective was grounded in two frameworks: the ecological analogy and the ecological systems model. The ecosystems perspective guided analysis of the research however it was important to understand the history of how the perspective came to be.

The ecological analogy framework was originally developed by a community psychologist, James Kelly, and then elaborated upon by a developmental psychologist, Urie Bronfenbrenner (Rudkin, 2003). As a result, the ecological systems model evolved and was an accepted framework in Social Work due to its adaptive view of how human beings interact with their physical and social environment.

In clinical settings there was a belief that the issues residents face are attributed to social construction and the social environment (Payne, 1997). Germain and Gittermaine (1995) use ecological concepts from the ecological systems model to develop the ecosystems perspective for use in community Social Work (Novak & Campbell, 2001). The ecological systems perspective provides a useful framework for assessment at the micro and macro levels.

James Kelly examines four main ecological principles including interdependence, adaptation, cycling resources and succession. Kelly viewed interdependence as a concept in which all actions in an ecological system impact and affect each other (Rudkin, 2003). The premise for the principle of adaptation was that in order for organisms to survive they must be able to change and respond to evolving demands in their environment including norms, values, priorities and goals (Rudkin, 2003). The principle of the ecological analogy was the cycling of resources. The model addresses the flow of resources including human talents, skills, values, care, concern, support and economic resources that play a role in shaping community life. James Kelly reviewed the principle of succession; the view that communities were in a state of constant flux (Rudkin, 2003). The ecological analogy framework encourages critical thinking about the interactions of people and systems over time and at different levels of functioning (Rudkin, 2003).

In 1977 Urie Bronfenbrenner elaborated on James Kelly's ecological analogy framework (Rudkin, 2003). Bronfenbrenner viewed human development in the context of a person's fit, adaptation and exchanges within their social system taking into account their immediate family, community and country (Rudkin, 2003). Bronfenbrenner's

primary focus was on four main levels of social settings which affect the behavior and fit of a person within their community, which were labeled as the micro, meso, exo and macro systems levels (Rudkin 2003).

According to Bronfenbrenner, microsystems include the resident, their family and workplace. When evaluating microsystems, Bronfenbrenner promoted the examination of the reciprocal and bidirectional transactions of resources between the resident and their family, workplace and neighborhood (Rudkin, 2003). The mesosystems level takes into account the interaction and connections the resident has with people in their environment. A typical example would be an elderly person's connection and interactions shared with their nurse, physician, pastor, and so forth. The exosystems level examines larger social systems, with which the resident may not directly function. Exosystems may include community-based resources, which may have either a negative or positive impact on the resident. In a health care setting an exosystem are the daily routine of a resident in a personal care home. Community-based resources in a health care setting may include but were not limited to supports by practitioners, allied health, and recreation programs. The macrosystem examines the larger community culture and subcultures. The macrosystems level includes community structures: political systems, cultural values, laws, economic structure, and various social systems that influence the resident at the micro, meso, macro and exo systems levels. Bronfenbrenner examines an additional level of environment structure the chronosystem that encompasses the dimension of time that the resident uses when relating to their environment (Rudkin, 2003). Elements within the chronosystem included the timing of a loved one's death or diagnosis of an illness. Bronfenbrenner felt

that as people age the way they experience chronosystem changes and how the resident was influenced by major events in time would also change.

Bronfenbrenner's ecological systems model encourages the evaluation of the resident and their relationship and interactions with the community at the micro, meso, exo and macro systems level. All levels of the ecological system model interrelate and should be examined separately and cumulatively. The ecological systems model created a breadth of understanding of how communities function.

Bronfenbrenner's ecological systems model revolutionized many disciplines including Social Work and resident assessments. Carel Germain revolutionized the ecological systems model and operationalized the ecological structure of considering a person and environment fit concept in Social Work practice; she referred to the model as the ecosystems perspective (Germain, 1981).

The ecosystems perspective was a generalist model founded in evolutionary thinking about human development (Miley, 2007). In the field of Social Work the ecosystems perspective has been used to determine potential problems the resident may have with their physical and social environment at the micro, meso, exo or macro systems levels. The ecosystems perspective evaluates how residents interact, change, and evolve in accordance with the internal and external exchange of resources with other human, structural, social and environmental systems (Miley, 2007). The social environment considers the exchanges of resources between friends, families, neighborhoods, communities, formal organizations including health care, education, recreation, religious, economic and political systems across social space and time (Germain & Bloom, 1999).

The ecosystems perspective was particularly useful for social work assessments as the model examines the broader community functions, interactions and resources which were used to support the resident in improving their fit within the physical and social environment. Residents experience problems when there was a poor fit with their environment.

The ecosystems perspective examines the following areas when assessing the person's functioning in their physical and social environment: open systems, transactions, habitat, niche, person and environment fit, stress and coping mechanisms (Germain, 1981).

An open system was one in which the resident grows and develops by receiving support and input from outside sources (Germain, 1981). The resident participates in exchanges of resources and support when they are in an open system. Open systems are functional due to the exchange of resources. Closed system on the other hand is dysfunctional due to a lack of support, which inhibits positive growth and development (Heinonen & Spearman, 2009).

The ecosystem perspective views transactions of resources as reciprocal (Heinonen & Spearman, 2009). Systems receive and send resources in an ongoing exchange which promotes the well-being and growth of the system (Heinonen & Spearman, 2009).

The ecosystems perspective takes into account the person's habitat or the place the resident lives. In a positive ecosystem the resident has both actual and perceived security; this environment encourages personal growth. Habitats deficient in resources

either social or economic create personal problems and deficiencies for the resident (Heinonen & Spearman, 2009).

The ecosystems perspective examines the resident's niche and the position they occupy in the environment (Heinonen & Spearman, 2009). The resident's niche when positive fosters self-esteem, belonging, growth and prosperity. Conversely if the person does not have a positive niche the resident may become adversely affected by social, personal or economic problems (Germain, 1981).

The ecosystems perspective focuses on the person and environment fit; the fit between the resident and their social environment taking into account the resident's needs, rights, capacities and aspirations (Heinonen & Spearman, 2009). A positive person and environment fit are characterized by mutual social exchanges, positive growth and well-being. A poor person and environment fit are primarily caused by negative social exchanges, which impact the residents' potential for development and growth. (Germain & Bloom, 1999)

Stress is an important part of the ecosystems perspective. Stress may be emotional, personal, or an inner response to an internal or environmental stimulus, which can cause a dysfunctional response (Heinonen & Spearman, 2000). The ecosystems perspective evaluates coping measures which are a combination of personal and environmental resources the resident can use to overcome life's stressors such as death, illness and financial changes (Heinonen & Spearman, 2009). Residents who experience a life stressor must first assess the issue based on their knowledge and experience and then make a decision to act. If a person is unable to think clearly about how to react to a life stressor it may result in a crisis situation. An resident may choose to use various coping

measures depending on how severe they view the life stressor. For example a person responding to a life stressor may seek information, take no action, journal, deny the problem or make changes in their environment to address the stressor (Heinonen & Spearman, 2001).

The ecosystems perspective addresses social and environmental factors in assessment; empowers the resident; is strengths based; employs a broad-based view; examines cultural issues; and focuses on the resident. The overall focus shifts from blaming the resident's pathology to taking the perspective that the malfunction is in the community system. The ecosystem perspective looks for resources, supports and areas in which the resident is adapting well to their environment. Social Workers must build on the already available strengths and competencies of residents. Social Workers take a strength orientation in the ecosystems perspective when they acknowledge the complexity of the residents' environment and avoid reductionism in assessment and intervention whole assessing for ways to increase support and resources (Healey, 2005). A strengths approach to enabling older adults to cope with stressful events is particularly beneficial as they may be in a vulnerable position in which they have suffered losses and illness, and may benefit from being in a position of control.

The ecosystems perspectives are applicable to geriatrics as it considers the ecological process of aging over time. Social structure, government policy and social programs directly impact older adults particularly when issues related to income and health care (Novak & Campbell, 2001).

Ecosystems perspective is useful for broad-based practitioners in the assessment process when analyzing human behavior at the micro, meso, exo and macro systems level

(Rudkin, 2003). The ecosystems perspective looks at physical and social environmental factors which affect the well-being of aging populations specifically in regards to structural systems such as housing, health care system, income benefits and cultural perceptions towards the elderly (Rudkin, 2003). The ecosystems perspective views the resident as the central focus of the system and promotes looking at the broader functioning of the overall person and environment fit (Rudkin, 2003).

Novak & Campbell (2001) found that one of the primary strengths of the ecosystems perspective focuses on residents and their interactions. The ecosystems theory evaluates larger social structures and systems as they impact the resident's day-to-day experiences and actions.

There are a number of limitations to the ecosystems perspective: it is not considered a theory; it may encompass too large a range of factors in assessment; there may be a lack of intervention strategies; the perspective may not be appropriate for use with residents affected by depression or dementia; older adults may be too vulnerable and marginalized to mobilize as a group to affect structural injustices.

The literature provides debates as to whether or not the ecosystems perspective is a theory. The ecosystems perspective uses a combination of ideas from various general systems theory and ecology that are a useful framework for clinical assessment however, they do not have outright explanatory power which limit its use in research. It can be argued that ecosystems perspective may not be the most common or appropriate base for Social Work practice especially in problem-solving as it offers direction for assessment and intervention but does not outline clear intervention methods (Healey, 2005).

There is concern that the ecosystems perspective tries to address too large a range of practice for assessment. The ecosystems perspective could be challenged in that the assessment of the resident's life would be difficult for a practitioner to adequately evaluate if employing the broad-based spectrum of the micro, meso, exo, and macro levels of the resident's physical and social systems in detail.

An additional limitation of the ecosystems perspective arises when the resident is ineligible for services and resources and lacks the social supports and personal means to address a stressor. The ecosystems perspective discounts the reality that many elderly people are frail, vulnerable, or affected by illness, and thus may be unable to group together and mobilize to address social systems that are dysfunctional and negatively affecting their goodness of fit with their environment at the systems level.

Method

Literature was identified using a systematic search of available articles in government reports and peer-reviewed scholarly journals. A plan to search for information was shaped using primary concepts including privacy, personal care homes and accommodations. Synonyms for the primary concepts of privacy, personal care home and accommodations were identified. Words used for personal care home in the search included nursing homes and personal care homes. Terms for rooms were used in the database search such as shared rooms, shared accommodations, accommodations, wardrooms, multi-bed rooms, and private rooms. Synonyms were utilized to maximize potential results as concepts may be described using alternative terminology.

The first stage of the literature review involved a broad search of available literature. The Outreach Librarian for the Winnipeg Regional Health Authority

(WRHA), Personal care homes program at the Deer Lodge Craine Library was contacted to assist in a manual search of government reports and documents from the WRHA and Manitoba Health on shared accommodations and privacy in person care home; however no such documents were available. An additional search was completed using scholarly journal databases: Scopus and EBSCOhost.

The first searches in the on-line journal databases using key concepts of "person care home" and "privacy" did not retrieve any results. A Boolean search was completed pairing terms with operators "AND" and "OR" with the synonyms of the primary identified concepts to identify a broader selection of pertinent results. Parentheses were utilized around synonyms to distinguish that the terms are interchangeable; for example "(nursing homes OR personal care homes OR long term care) AND privacy AND (shared rooms OR accommodations OR private rooms OR shared accommodations OR ward rooms OR multi bed rooms)". The database search specifically looked for terms in the journal articles' title and abstract. In addition database searches were limited to peer reviewed scholarly journals between the years of January 1990 and May 2014; as scholarly articles use cumulative knowledge from the field and their literature builds on existing historical information. Using EBSCOhost 26 articles were retrieved of which only eight appeared relevant based on reviewing the title, abstract and subject words. Using Scopus, 199 articles were retrieved of which 42 articles were deemed relevant based on a review of the name of the article, abstract and subject words. As the Scopus database was broad and utilizes many on-line social science databases including EBSCOhost the eight articles found on EBSCOhost were included in the 42 articles retrieved on Scopus.

Subsequent searches were completed by looking at the references sections of pertinent journal articles for additional resources. Authors frequently found in applicable articles reference sections were searched in the database as experts in the scholarly field: L. J. Cutler, R. A. Kane, S. Skovach, and J. Robertson.

The second stage of the literature review was to assess the 42 identified papers objectively to determine if the literature was relevant. Articles which used rigorous qualitative and or quantitative research methods were included in the literature review. Papers were considered further if the researchers focused on aging populations in health care facilities with a focus on privacy. There was limited scholarly research on privacy in person care home especially from the perspective of the resident. Since there was a lack of available research the search was expanded to include non-English resources in addition to English based articles. The limited amount of scholarly research on privacy and person care home suggests there was a need for further research especially from the perspective from the resident. It also became apparent there was limited research regarding the resident's preferences of a personal care home environment that promotes their well-being and psychosocial adjustment (Le Low, Lee & Chan, 2006 and Howard, M. B., et al, 2014).

The narrative literature review provided a framework for understanding the issues impacting adjustment for seniors in personal care homes as influenced by their physical environment and level of privacy available in personal care homes. The literature identifies seven common themes that impacted privacy which directly influence adjustment and quality of life: opportunities to display personal items; roommate dynamics; privacy for elimination and personal care; privacy to communicate with

visitors and professionals; administration approaches and facility policy on privacy; opportunities to participate in sexual relationships; interactions with staff; and palliative care. (Le Low, Lee & Chan, 2006, Rigby, Payne & Froggatt, 2010; Sheppard, 2009 and Howard, M. B., et al, 2014)

Research Method

When exploring privacy for residents in personal care homes a qualitative approach was used to conduct the research. Case study approach was used with an emphasis on the ecosystems perspective (Yin, R. K., 2013).

The aim of the qualitative research was to explore privacy in personal care homes in Winnipeg, Manitoba, Canada based on the ecosystems perspective in order to identify ways the physical environment effect the well-being of the sample group. Residents from personal care homes in the Winnipeg Regional Health Authority were interviewed to explore their experience within the physical environment of the personal care home in which they reside; particularly resident's personal space and room accommodation were explored to determine how privacy affects their quality of life. A more thorough understanding on the effects of privacy and room accommodations from the perspective of residents in personal care homes will assist facilities and regional policy makers to consider systems changes, which will promote privacy and overall well-being.

Room Design

The literature addresses various physical room designs in personal care homes and how room layout impacts privacy for residents. A variety of room designs were cited in the literature including private, semi-private with curtain dividers, semi-private rooms with half wall dividers, private rooms with shared bathrooms and multi-bed wardrooms.

Room layouts differ among personal care homes as did the amount of privacy. Overall Barnes (2002) found that the provision of privacy for sound, sight and smell was the most important feature of a personal care home. Hughes (2004) and Le Low, Lee and Chang (2006) found that respondents in their study were aware that curtains provided visual privacy but did not provide opportunities for private verbal communication. Rigby, Payne and Froggatt (2010) and Sheppard (2009) found that no matter what type of room the residents were assigned older adults developed a strong attachment to the room and found moving difficult.

Roommates and Shared Accommodations

Advantages and disadvantages of having a roommate were identified in the literature. The respondents in Andersson, Pettersson & Sidenvall (2007) and Petronio and Kovach (1997) and Wang and Kuo (2006) studies attributed a greater feeling of loneliness and isolation with being in a private room due to a lack of social interaction. Kovach and Robinson (1996) found that having a roommate increased potential for conversation and social interaction; however residents with visual, hearing or cognitive deficits were faced with barriers to communication with their roommates. In Petronio & Kovach's (1997) study respondents verbalized an increased sense of security knowing that a roommate was in the room and they were not alone.

Conflicts may arise over privacy and personal belongings in shared accommodations (Petronio & Kovach, 1997). Calkins and Cassella (2007) found that residents were apprehensive about sharing a room with another resident, as they would feel uncomfortable having their daily activities observed and generally reported having a poor emotional connection with their roommate. From a clinical health perspective the

spread of infection was higher for residents who shared rooms (Calkins & Cassella, 2007). Choi, Ransom and Wyllie (2008) found that conflicts arose between roommates around television volume, disruptive sleep patterns and daily routine differences.

Cognitive functioning and behavioral issues of roommates directly impacted privacy and quality of life in personal care homes. One study found that having a roommate with dementia directly impacted the decline of the alert residents' cognitive abilities (Kovach & Robinson, 1996). Sheppard (2009), Choi, Ransom and Wyllie (2008), and De Veer and Kerkstra (2001) discussed the degree to which wandering residents entering rooms was a disturbance which directly impacted privacy, security and feeling at home.

Personal Belongings

The literature showed that older adults living in personal care homes as well as their families appreciate personal care homes that offer a home-like environment (De Veer & Kerkstra, 2001; Morgan & Stewart, 1999; and Sheppard, 2009). Rigby, Payne and Froggatt (2010) found that the transition to personal care homes can be very challenging for residents who move to personal care homes that do not offer a home-like atmosphere. Home-like atmospheres were characterized as personal care homes which encourage residents to personalize their rooms with their belongings, radios, telephones, televisions and collectables, and have access to outdoor spaces, windows, facility pets and indoor plants (Barnes, 2002; Cutler *et al*, 2006; Le Low, Lee & Chan, 2006; Sheppard, 2009; Rigby, Payne & Froggatt, 2010; and Wang & Kuo, 2006). According to Andersson, Pettersson and Sidenvall (2007) residents felt more at home in personal care

homes when they had access to privacy when visiting and an opportunity to offer loved ones coffee during visits.

According to Pertronio and Kovach (1997) as seniors age, they generally have less physical space and fewer personal possessions to look after; this was clearly the situation when older adults require more physical care and move to personal care homes which offer less physical space. In personal care homes, the resident's room was a significant space which the older adult identifies and exercises control over (Andersson, Pettersson & Sidenvall, 2007; Barnes, 2002; Calkins & Cassella, 2007; Cutler *et al*, 2006; and Le Low, Lee & Chan, 2006). The importance of personal belongings was amplified, as the residents only have enough space for a limited number of personal possessions (Petronio and Kovach, 1997). According to Hughes (2004) the resident's room was seen as a private space which provides a bed and a place to display important possessions. The room marks the older adult's individuality and fosters self-esteem and well-being. Calkins and Cassella (2007) report that residents who share rooms feel a loss of privacy and personal space and as a result they did not decorate their rooms to the same degree as residents in private rooms.

Personal belongings create a sense of security for the resident and reinforce self-identity; however the security can quickly be eroded when the residenst lose control over their environment and items go missing (Train *et al*, 2004; and Wang & Kuo, 2006). In personal care homes resident rooms are seen as personal and public space. Petronio and Kovach (1997) found that resident belongings are actually jointly cared for by staff and the resident. Personal belongings frequently go missing in personal care homes as they are misplaced, moved by roommates or taken by cognitively impaired residents who

wander (De Veer & Kerkstra, 2001). Petronio and Kovach (1997) found that items typically go missing at a higher rate when residents occupy shared accommodations resulting in conflict between roommates. According to Le Low, Lee & Chan (2006) having access to a lockable cupboard to store private belongings and important items were valuable to residents.

Sexuality

According to Dunn and Cutler (2002) 57% of men and 30% of women in their seventies, as well as 25% of men and 20% of women in their eighties were engaging in sexual activities at least once a month including vaginal intercourse, oral sex, anal intercourse and masturbation. Many older adults maintain their sexual interests into old age although their sexual activity decreases (Jagus & Benbow, 2002). Society holds an ageist belief that when elderly people engage in sexual activity it was considered disgusting, amusing, evokes feelings of disbelief or becomes the brunt of many jokes; this ageist belief was often held by staff and was evident in their approach to providing care (DeLamater & Sill, 2005). It was important to address societal ageist beliefs and encourage staff to utilize a resident-focused approach such as the strengths perspective when addressing sexual behavior in personal care homes.

According to DeLamater & Sill (2005) sexual desire was an innate motivational force that can be described as a natural, desire, need, urge, appetite, wish or want. It was important to understand aging and sexuality as it relates to older adults residing in personal care home settings. Psychological changes in later life affect sexual activity. The sexual expectations of women in later life often change and are influenced by early life sexual experiences, generational attitudes, knowledge about aging and sexual

functioning and societal beliefs (Benbow & Jagus, 2002). According to Benbow & Jagus (2002) women are often regarded as sexless and expected to lose all interest in sexual activity as they age. Myths persist because society promotes beliefs that elderly women are not sexually desirable, do not desire sex and are not physically capable of sexual activity (Benbow & Jagus, 2002). An elderly man, who may be interested in sex, may be stereotyped negatively. Stereotypes are further compounded by social factors.

Outside social factors affect the level of sexual activity and functioning of elderly men and women in personal care homes. Elderly people stop participating in sexual relationships and activity because of general infirmity, fear that it would expose them to ridicule, decreased privacy and a lack of an available partner (Benbow & Jagus, 2002). Societal attitudes and environmental factors significantly impact the level of sexual activity in personal care homes. According to Benbow & Jagus (2002) institutional settings are generally not conducive to developing sexual relationships and engaging in sexual activity. The environment in personal care homes was usually not designed to recognize the intimacy or sexual needs of residents. Many barriers impact sexual expression in personal care homes: lack or privacy, shared accommodations, institutional atmosphere, small single beds and disruptions from care providers (Lemieux, 2004 and Hughes, 2004). There was a definite need for person care home to provide elderly residents who wish to engage in appropriate sexual activities with space and privacy.

Intimacy was a vital part of human existence. Intimacy provides a sense of being in a rewarding and emotionally fulfilling relationship (Miles & Parker, 1999). Intimacy provides people of all ages with the opportunity to feel confident and safe. It was closely related to love, which encompasses emotional security, respect, helping, play,

communication and loyalty. For many elderly people love and intimacy was highly important but does not necessarily involve sex (Lemieux *et al*, 2004). Residents in person care home struggle with loneliness and fear of dying or dying alone (Miles & Parker, 1999). Intimacy, passionate love, companion love, and satisfying sexual intimacy are correlated with life satisfaction and psychological well-being of elderly people particularly in end stages of life (Lemieux *et al*, 2004). Personal care homes create many social and environmental barriers for elderly people, inhibiting intimacy and sexual relationships (Miles & Parker, 1999). In Lemieux *et al* (2004) article residents express that sexuality was an important aspect of palliative care and a lack of privacy in shared rooms and staff disruptions created barriers to intimacy and sexual activity. Respondents found single beds in health care are a barrier to expressing sexual activity (Lemieux *et al*, 2004).

The importance of touch and emotional connection to loved ones as a means of expressing understanding and comfort was an important part of providing quality health care (Lemieux *et al*, 2004). Expressive, comforting and non-necessary touch was an important part of maintaining resident identity and self-esteem (Mattiasson & Hemberg, 2005). Residents in personal care homes should be encouraged and permitted to participate in intimacy to express caring, comfort and love to one another.

Palliative Care

A number of concepts related to privacy were identified in the literature: homelike environment, sexuality, spirituality and communication with loved ones (Rigby, Payne & Froggatt, 2010). During end of life care for residents, family members and staff generally prefer a private room with limited access as there was additional privacy, fewer

disruptions by staff and co-residents, and opportunity to pursue one's own interests without worrying about roommates' disruptions (Rigby, Payne & Froggatt, 2010). During end of life care residents and families prefer not to share a room witth the dying resident to avoid seeing the end of life stages of care (Choi, Ransom & Wyllie, 2008; and Rigby, Payne & Froggatt, 2010). Residents express a need for privacy for prayer and spiritual worship during end of life care (Choi, Ransom & Wyllie, 2008; and Rigby, Payne & Froggatt, 2010).

Alternatively some palliative residents prefer sharing accommodations as it provides a sense of security to have another person in the room (Rigby, Payne & Froggatt, 2010). In many cases, residents benefit from sharing accommodations at the end of life stage when they have developed bonds and received emotional support from their roommate (Rigby, Payne & Froggatt, 2010).

Provision of Care and Activities of Daily Living

Residents in personal care homes were affected by health limitations and require care in varying capacities to meet their daily physical needs. The literature found that lack of privacy during activities of daily living, particularly elimination was a problem. Physically dependent residents had to be accompanied by staff during elimination and personal care which reduces privacy (Choi, Ransom & Wyllie, 2008; and Petronio & Kovach, 1997). Residents who are incontinent of bowel or bladder require assistance with toileting and receive either partial or limited privacy as staff need to provide direct care or observe toileting as a fall prevention strategy (Akpan, 2006: and Choi, Ransom & Wyllie, 2008). Residents with highly impaired mobility who use briefs, bedpans or commodes have the least physical privacy (Akpan, 2006).

Residents who maintain privacy during personal care are physically well enough to go to the washroom independently or complete their activities of daily living without assistance (Akpan, 2006). In addition residents with their own rooms and private washrooms enjoy the highest level or privacy (Train *et al*, 2004). When residents have to share common bathrooms with a roommate their privacy was reduced as there may be a perceived or actual interruption during elimination (Train *et al*, 2004). Webster and Bryan (2009) identified that residents found curtains in bathrooms provided limited privacy and prefered doors. Flexibility in daily routines was valued by residents and provided even the most dependent residents with a sense of control (De Veer & Kerkstra, 2001).

Family Visits and Communication

Privacy for visiting with loved ones was frequently discussed in the literature. Residents valued having access to lounges and private spaces for communication in private (De Veer & Kerkstra, 2001; Hughes, 2004; Le Low, Lee & Chan, 2006; and Wright, 2000). Douglas and Douglas (2005) reported that limited space directly impacted privacy particularly when visiting with friends and family.

Private rooms were optimal for providing privacy and a home-like atmosphere for secure, undisrupted and confidential conversation with loved ones (Andersson, Pettersson & Sidenvall, 2007; De Veer & Kerkstra, 2001; and Lemieux *et al*, 2004). Residents expressed concerns that although private rooms offer quiet space there is always the risk that staff may come in and disturb the conversation (Lemieux *et al*, 2004; and Wright, 2000). In semi-private and shared accommodations residents appreciated having curtains or partial walls for privacy however, it was felt that the barriers did not afford privacy for

communicating as roommates could hear what was being said (Hughes, 2004). Sheppard (2009) found that residents appreciated access to a private room to meet with health care professionals such as physicians.

Policy and Administration

Facility policy and administrative approach to privacy was highlighted as important influences concerning privacy for residents and their families. Privacy of health and personal information has been monitored through government legislation yet personal privacy in personal care homes was not (Anderson, Petterson & Sidenvall, 2007 and Sheppard, 2009).

Health care facilities especially personal care homes; have a culture to protect the health and safety of older adults, which was fostered through provincial mandates, public opinion and the media. Personal care homes have expectations that staff report resident behavior that may be considered inappropriate, harmful or abusive (Tabak & Shemesh-Kigli, 2006). Conflict arises when professional duty to protect the resident's dignity and health conflicts with the older adult's right to autonomy, self-expression and privacy (Tabak & Shemesh-Kigli, 2006).

The literature recommends personal care homes develop a resident's bill of rights which sets care standards for privacy, dignity and confidentiality for residents (De Veer & Kerkstra, 2001; Hughes, 2004). Facility administration must implement policies and management principles supporting day-to-day privacy for residents (Hughes, 2004). Simple privacy policies include the practice of knocking on doors before entering resident rooms (Hughes, 2004).

It may be necessary for personal care homes to develop an ethics committee to assist in resolving conflicts between staff and residents, facility promotion of safety from harm and the resident's right to privacy and self-determination (Tabak & Shemesh-Kigli, 2006).

Interactions with Staff

Staff approach to communication with residents was emphasized as an important area impacting privacy. When older adults move to a personal care home there was a transition in adjustment to determine care needs and privacy boundaries between residents and staff (De Veer & Kerkstra, 2001; Petronio & Kovach, 1997). The staff approach to resident care directly impacts the resident's quality of life.

Older adults in personal care homes are generally physically or cognitively dependent on staff to meet their daily needs, which reduce the resident's level of privacy (De Veer & Kerkstra, 2001; Petronio & Kovach, 1997). Encouraging residents to maintain a sense of control and choice over daily decisions help to improve their sense of dignity when privacy cannot be maintained (De Veer & Kerkstra, 2001; Petronio & Kovach, 1997; Webster & Bryan, 2009). It was recommended that staff communicate with residents in a respectful manner, which fosters respect and dignity particularly where privacy was compromised (De Veer & Kerkstra, 2001; Petronio & Kovach, 1997; Webster & Bryan, 2009). Hughes (2004) recommends that staff strive through formal and informal practices to tailor their interactions with residents to increase privacy; for example knocking on resident doors before entering. *Summary*

The literature showned the physical environment and layout of personal care homes directly impacts quality of life and adjustment for seniors. It would be beneficial

if residents could have input in the development of future personal care homes so buildings may be adapted and designed to meet their changing needs and preferences (Rigby, Payne & Froggatt, 2010).

The literature reinforces that residents have the right to privacy to maintain their physical, social and psychological needs (De Veer & Kerkstra, 2001; Petronio & Kovach, 1997). The literature review has shown that the physical and social environments in personal care homes directly impact adjustment, self-esteem, identity, well-being and the person and environment fit for residents (De Veer & Kerkstra, 2001; Rigby, Payne & Froggatt, 2010). It was recommended that policy makers, administrators and staff involve residents in establishing what their needs were for privacy during care and in their environment with an aim to improve quality of life (Barnes, 2002; and Rigby, Payne & Froggatt, 2010). If residents have continual input in the evaluation of the facility functionality regarding privacy the personal care home design could conceivably better meet the needs of the residents (Barnes, 2002; and Rigby, Payne & Froggatt, 2010).

Although the strengths perspective was useful and positive when working with older adults it does have limitations. The strengths perspective relies on the older adult identifying his or her own strengths and working towards a self-determined solution or objective, which would be difficult for severely cognitively impaired seniors with poor judgment and insight. In personal care homes it may be necessary for professional staff to place limitations or restrictions on privacy. The physical layout of the facility and resident rooms may present a barrier for implementation of the strengths perspective to increase privacy and quality of life.

The privacy of seniors living in personal care homes was an important issue, which needs more public attention. Privacy was a vital and important basic right of all human beings regardless of age. In order to improve the well-being of older adults' living in personal care homes it will be necessary to humanize personal care homes and empower residents to meet their needs by using a strengths perspective. Before personal care homes can be humanized the staff, families and society need to accept and learn more about the needs of seniors who reside in personal care homes (De Veer & Kerkstra, 2001; Miles & Parker, 1999).

Personal care homes are homes, and as such should take a holistic approach to providing care. Staff and management need to respect the residents' autonomy and right to self-determination and remember that the first priority was the resident not the medical or personal care intervention (NACA, 2005). Personal care homes should function as homes, which maintain individuality and quality of life for older adults with disabilities. Personal care homes are not simply buildings that function to maintain life. Relationships should be encouraged and the facility should provide residents with privacy for intimacy so innate and deep human needs and connections can be met.

Personal care homes should take the strengths perspective stance when developing and implementing policies to reduce barriers for intimacy and enable residents to bond and form fulfilling relationships. Health professionals strive to provide resident-centered care for older adults. In doing so staff must acknowledge the normalcy and essential nature of the human need for privacy and intimacy.

The literature review provided a theoretical framework for the study and identified the ecosystems perspective based on the work of James Kelly and Urie

Bronfenbrenner. Following a description of the theoretical framework, the literature search strategy was outlined. The chapter primarily provided a synthesis of the literature on privacy in personal care homes under the headings of: room design, roommates, shared accommodations, personal belongings, sexuality, provision of care, activities of daily living, palliative care, family visits, communication, policy and administration, and interactions with staff. The chapter ended with a brief observation of the literature and where further research is needed.

Methodology 3.

The methodology chapter reviews why case study research was selected. The chapter discusses the research question in detail. Information was provided regarding the role of the faculty advisor. The chapter provides an overview of sampling procedures, data collection, and the format for resident interviews. Following the discussion regarding the procedures of the case study confidentiality and privacy for participants and participating facilities is discussed. The chapter ends with an overview of the data analysis procedures.

Case Study Design

Privacy in personal care homes in the Winnipeg Region was explored using case study research. The study explored how physical and social privacy was afforded to residents; and to learn how privacy for residents impacts their well-being and quality of life. A multiple case studies approach was used with an emphasis on the ecosystems perspective. The study focused on ecosystems perspective within the context of the Personal Care Home, and more specifically the social and physical environment of the resident room (Yin, 2013).

The aim of the qualitative research was to explore privacy in personal care homes in Winnipeg, Manitoba based on the ecosystems perspective in order to identify ways the physical and social environment affect the well-being of a sample of residents (Germain & Bloom, 1999). Residents residing in private, semi-private or shared room in personal care homes in the Winnipeg Regional Health Authority were interviewed to explore their experiences within the environment of the facility. Of particular interest are the factors of personal space and type of room either private or shared accommodation. This study explored the impact that privacy or lack of privacy has on perceptions of well-being. A more thorough understanding of the effects of privacy and room accommodations from the perspective of residents in personal care homes will assist personal care homes and regional policy makers to consider systems changes to promote privacy and overall well-being for residents.

Case study research provides a rich, deep description of the residents' experiences in context. The research aims to fully describe the resident's experience as expressed by them. It was the aim of the study to honor the residents' reality, personal stories and viewpoint to develop a rich thorough description of issues of privacy within a personal care home. The case study approach to research respects the unique stories and experiences of the residents (Yin, 2013). Case study research was empirical in that the approach emphasizes observation and was naturalistic in the description of the experience (Stake, 1995).

The purpose of the study was to use maximum variation of cases to examine privacy from the perspective of several residents in personal care home through in-depth data collection during a semi-structured interview process (Stake, 1995). Maximum

variation will enable the researcher to explore differences between cases and draw comparisons and predict similar results (Yin, 2013). The case study approach will provide a richer supplementary information from multiple resident's experiences, social location and viewpoints (Yin, 2013).

Role of the Faculty Advisor

The faculty advisor provided insight and direction into the qualitative case study research method. Specifically the faculty advisor provided direction regarding the University of Manitoba Ethics Board application protocol. The faculty advisor clarified how best to apply convenience and purposeful sampling and audiotaped interviews. The faculty advisor assisted the researcher in developing appropriate open-ended interview questions. During the analysis phase the faculty advisor was a sounding board for coding.

Sampling

A multiple-case study on privacy in personal care homes from the resident's perspective will use a purposeful sample of five to eight residents in a personal care homes facility in Winnipeg, Manitoba. A purposeful sample will be used to ensure interested residents are competent and reside in various types of accommodations representing various social locations: private, semi-private and shared rooms.

There are 38 personal care homes in the Winnipeg Regional Health Authority, which provide nursing services, personal care, nutrition, recreation and housekeeping to residents with physical and cognitive disabilities. In the Winnipeg Regional Health Authority there are 5700 resident care beds (WRHA, 2011). As the emphasis of the research was on privacy and personal care homes sites were selected which offered a

variety of resident accommodations including wardrooms, semi-private rooms and private rooms. There are 15 personal care homes which offer varied accommodations. Due to a potential conflict of interest because the researcher has been employed as a Social Worker for one of the personal care homes which was affiliated with two other personal care homes; there were only 12 potential sites that may be considered to host the study. The 12 sites represent proprietary and not for profit personal care homes.

The researcher contacted all 12 personal care homes by letter requesting permission to conduct research at their site. Interested homes were selected to recruit a combined total of five to eight residents representing a range of room accommodations. Purposeful sampling of the personal care homes was used to select personal care homes which offer a variety of room style accommodations: private, semi-private and shared accommodations. Maximum variation sampling of residents will allowed for a representation of viewpoints from residents residing in varied accommodations.

For the purpose of the research five to eight residents who are available and willing to participate in the study were recruited for participation from consenting personal care homes. Residents scored a zero or one on the MDS RAI 2.0 Cognitive Performance Screening Score demonstrating that they are cognitively aware to participate. Residents could have been of either sex and of any cultural background. All residents recruited to participate in the study were fluent in English. Potential issues were identified that would affect the outcome of the research study and might include but are not limited to a resident's death, lack of interest from the personal care homes or residents and a lack of competent residents interested in participating. Due to the vulnerable nature of the resident's medical and social circumstances they might have

chosen to involve a family member, substitute decision maker and Power of Attorney in the consent process.

The research study did not involve any more risk or potential for harm than the older adults would experience in their everyday life. There was the potential that an adjustment issue to the personal care home environment or reflection on recent losses might be reflected upon by the resident. If a resident requires additional support a referral would have been made to the social worker on site or staff member of their choice. All the potential risks were identified and explained to the resident prior to signing participation consent forms.

Data Collection

Privacy in personal care homes was an important social and environmental issue. Manitoba Health and the Winnipeg Regional Health Authority identify privacy as a standard under the Resident Bill of Rights (MB Health, 2014, pg. 3).

Following University of Manitoba Research Ethics Board and the Winnipeg Regional Health Authority Ethics approval, personal care homes in the Winnipeg Regional Health Authority with personal care homes offering placement in wardroom, semi-private rooms and private accommodations were contacted. An announcement regarding the research project was made at the Manitoba Association of Personal Care Home Social Workers group meeting to provide information regarding the study and its purpose.

A follow-up a letter was sent to each of the 12 personal care homes, which offer shared accommodations to request permission to access the site to recruit potential residents. In the attached letter requesting personal care homes to participate in the

research study the researcher identified that she had dual roles as a Graduate Student and as a Social Worker employed at a personal care home.

With the permission of the Chief Executive Officer or equivalent at the facility a poster was placed in the personal care home outlining the study, research aim and time commitment to participate in the research. The recruitment poster was placed in a common area requesting that interested residents contact the researcher to determine if they meet the criteria for the study and to set up a time convenient to them to gain more information and complete a resident consent form. The researcher also presented the purpose of the study at the interested personal care homes' Resident Council meeting, which was a public forum to provide direct information regarding the project in order to recruit potential residents.

Interested residents were contacted to discuss their interest in the research project, the aim of the study, potential risks and benefits to the resident and voluntary withdrawal. Potential residents were required to complete consent forms to participate in the research project. The resident consent form were printed in size 14 Arial font which is the standard print in personal care homes when sharing information with residents. A time was scheduled that was convenient to the resident to complete the qualitative interview which lasted approximately one hour. Residents could have included a family member or legal representative during the consent process of the study if they wished.

To ensure that the interested residents meet the target sample criteria the facility Social Worker or primary Nurse was asked to provide a recent MDS RAI 2.0 Cognitive Performance Screening Score to ensure that the resident was cognitively alert. MDS RAI 2.0 Cognitive Performance Screening Scores are part of regularly ongoing assessments

completed by nursing at personal care homes in the Winnipeg Regional Health Authority (Morris, J. N., Hawes, C., Mor, V., Phillips, C., Fries, B. E., Nonemaker, S. & Murphy, K. 2012, Pg. 79).

Resident Interviews

The resident interviews were held in a private room provided by the facility. The interview lasted approximately one hour and was audio taped for accuracy and future transcription (Stake, 1995). As the residents participating in the interview process may reside in different personal care homes the researcher will record notes in the journaling process to describe the overall environment of the facility and resident room context. Recorded notes on the personal care homes will be used during analysis to contrast the residents' experiences and provide supplementary information on the home in the final report.

Prior to conducting the interviews the drafted semi-structured interview questions were reviewed with the research supervisor to ensure the meaning of the questions were clear, appropriate and easy to understand. Part of the University of Manitoba and Winnipeg Regional Health Authority Research Ethics Board application included a research proposal outlining the interview questions.

Audiotapes of the interviews were used to ensure exact word phrases, meanings and innuendos were captured when making the transcription notes following the interview (Stake, 1995).

The interview process may raise concerns regarding care or environmental issues within the personal care home; following the interview process the researcher will check in with the resident to determine if they were in need of support as an outcome of

participation in the research study. If the resident requireed further support or counseling a referral was made to the facility Social Worker or alternate staff member of the resident's choice. If a resident reported any maltreatment or abuse the Protections for Persons in Care Office was informed (Province of Manitoba, 2014). The Protections for Persons in Care Office is a department of Manitoba Health which investigates allegations of abuse in health facilities including personal care homes.

All consent forms, notes, logs, journals and audiotapes were stored in a locked filing cabinet within the researcher's home office to ensure confidentiality for residents. Audiotapes and written documentation will be destroyed one year after the completion of the final research paper. Any information that may directly identify a resident will be removed from the transcript.

During the data collection phase member checking was used with the residents using probing and summarizing statements to ensure that the resident's story were correctly understood. It was important to develop a positive rapport with the residents to ensure positive atmosphere, which places the resident at ease to provide open and honest responses to the semi-structured interview questions.

Confidentiality and Privacy

The privacy of residents and participating personal care homes was of the utmost importance to the research study. The information gathered at the facility and during the interview was kept confidential. Only the researcher and research supervisor will have access to the audio recording from the interview and notes taken during the interview.

The confidentiality of the participating facility was of upmost importance. All identifying information was removed so the facility cannot be identified (Yin, 2013).

The participating facility was granting access to the facility in a relationship of trust. It was the researchers professional obligation to maintain the confidentiality of the participating facility as the outcome of the research may or may not portray the facility in a positively.

Data Analysis

Prior to coding the data, if any information from the transcripts was unclear the researcher used member checking by contacting the resident at a later date to clarify statements and ensure the intended meaning of the resident (Stake, 1995). Member checking increases credibility of the research study as the authenticity of the research is confirmed (Stake, 1995).

The ecosystems perspective guided the fundamental process of analysis by providing a lens to evaluate how residents view their fit within the personal care home. The ecosystems perspective identified themes of level of security, sense of community, self-esteem and stressors. All interviews were transcribed. The transcripts from the interviews were read over five times prior to initial analysis to uncover themes, meanings and underlying innuendo (Stake, 1995). Themes may be identified directly from the problem statement or discovered through analysis. Through immersion in the data consistent themes and patterns will become evident; however a significant instance that vividly illustrates a resident's experience of privacy in a personal care home setting may have merit for inclusion in the final report. The data was sorted into themes to assist in developing a rich understanding of the case studies (Stake, R. E., 1995). The aim of categorical analysis was to dissect the resident stories into themes to organize a new meaning for the overall cases through description of the issues and related outcomes.

The themes within the information will be identified and categorized into similarities and differences based on both professional knowledge, the principles of the ecosystems perspective and understanding developed during the literature review. Through the search for patterns in the data it was expected that new issues and linkages between activities and outcomes were identified. Case study research provides a detailed rich viewpoint on issues. Themes may become evident in the data that will disconfirm findings.

A copy of the final report will be mailed to the residents in the case studies on request as well as the facility. Residents or the facility may contact the researcher by phone or email to request a copy of the report.

The methodology chapter reviewed why case study research was selected. The chapter went on to discuss the research question in detail. Information was provided regarding the role of the faculty advisor. The chapter provided an overview of sampling procedures, data collection, and format for resident interviews. Following the procedures of the case study methodology confidentiality and privacy for participants and participating facilities was discussed. The chapter ended with an overview of the data analysis procedures.

Analysis 4.

The analysis chapter discusses the instrumentation process for the case study research: resident interviews. Following instrumentation the chapter goes into detail regarding the subject selection. The chapter ends with a means of analysis of how the participant interviews were transcribed and analyses into codes and broken down into themes and sub-themes.

Instrumentation

The study utilized resident interviews to gain an in-depth understanding of how older adults residing in personal care homes perceive privacy in personal care homes residential settings. The interviews were structured using a series of open-ended questions. Questions were constructed using simple language and avoid using leading questions to reduce researcher bias.

The interviews began with classification questions, requesting that residents identify their age, cultural background, health status, room accommodation style and length of stay at the personal care home. The classification questions were used to the responses were sorted into themes based on the room accommodation style. Residents were requested to describe how they perceived privacy in personal care homes regarding four different themes: the facility environment, general questions related to privacy, social interactions and personal care. Additional sub-questions regarding the facility environment were asked regarding the residents past living accommodations, experiences in the resident's current room, shared accommodations, decorating and access to the room. The next series of sub-questions relate to privacy: wish to be alone, exposure and freedom to practice spirituality or religion. The social interaction sub-questions specifically address communication: visits with friends and family, interactions with roommates, intimacy with partners, ability to watch television and use the telephone. The final series of sub-questions relate to personal care including feedback on bathing, personal care during activities of daily living, physician visits and interactions with staff. Please see Appendix A: Resident Interview Semi-Structured Research Questions for a detailed example of the open-ended interview questions.

The research study used member checking to increase credibility and dependability. The researcher informed the resident at the time of completing the consent form that a copy of the finale research findings may be shared with respondents upon request which allowed residents to critically analyze the findings.

Subject Selection

For the purposes of the research study the subject selection process relied on purposeful sampling convenience. Personal care homes offering varied room accommodations were sent an introductory letter outlining the research study excluding homes in which the researcher had a past or present relationship. The subject selection was based on inclusion criteria that the residents are fluent in English and currently residing in a personal care homes. In order for residents to knowingly consent to participate in the study they must score a zero or one score on the MDS-RAI 2.0 Cognitive Performance Scale computerized screening tool demonstrating that the residents are cognitively well (Morris, J. N., Hawes, C., Mor, V., Phillips, C., Fries, B. E., Nonemaker, S. & Murphy, K. 2012, Pg. 79).

The three participating personal care homes had their Social Worker advertise the research study among residents via the Resident Council and used posters. Residents who meet the inclusion criteria had the opportunity to participate in the study. Participation was voluntary. All potential residents read or had the resident consent form read to them and signed the consent form prior to participating.

Means of Analysis

The audiotaped interviews were transcribed into the computer. Pseudonyms names were given to each of the residents. The researcher proceeded data analyzed

utilizing interpretive coding, and reflections to analysis the residents' interview responses. The researcher immersed herself in the transcriptions of the nine resident interviews by listening to the audiotaped interviews four times and then reading the transcribed notes to gain a deep and thorough understanding of the complexity of how privacy was perceived by older adults residing in personal care homes.

The first phase of data analysis: open coding. Open coding was an interpretive technique that both organizes the data and provides a means to introduce interpretations. The researcher read the resident interview transcripts in detail to gain a deep understanding of the expressed messages and viewpoints of the residents. The researchers then proceeded with open coding using themes verbatim from the resident interview responses. The researcher also looked for additional themes that reflect the ecosystems perspective including the residents perceived or actual security, self-esteem and connection with the community within the personal care home.

The interview responses were highly structured qualitative open-end responses, which naturally provide clear first round themes without greatly segmenting the resident responses. The preliminary themes include room style preference; safety and security; interactions with friends and family; control over belongings; general loss; staff interactions; spirituality; and roommate interactions. The researcher examined the interview transcripts responses a second time. Using a matrix the researcher categorizes segments within the resident interview transcripts under appropriate themes.

The researcher then looked at the larger categorical responses and identifies subthemes, which were themed into subthemes. Under safety and security, subthemes of theft, wandering residents, noise disturbances, interruptions and locking doors were

identified. Under the category of interactions with friends and family the following subthemes were identified: communicating with family, intimacy and friendship. Under the category control over belongings, subthemes are identified such as decorating personal space, television, and telephone. Under the category general loss, attitude in personal care are identified as a subcategory. Under the category staff interactions, the following areas were identified as subthemes: wish to be alone, privacy during care, housekeeping, doctor visits, night rounds, staff speaking other languages and spirituality. Under the category of roommate interactions concerns for roommates and conflict with roommates were identified as subthemes. The themes were predetermined based on the literature review. In the second level of analysis, coding subthemes emerged using constant comparative method.

Table 1: List of Themes and Subthemes

Theme	Subtheme
Safety and Security	Theft Wandering Interruptions Locking doors.
Communication	Intimacy Friendship
Decorating	Television Telephone use
Attitude Towards Personal care home Placement	
Staff Interactions	Wish to be alone Privacy during personal care Housekeeping Physician visits Staff night rounds Staff speaking other languages
Interaction with Roommates	Concern for roommates Conflict with roommates

The researcher identifies linkages and casual relationships between the themes, which later shape the overall focus of the findings and discussion of the study. In researcher then examined the themes. The themes were sorted, interpreted, compared and contrasted until the researcher through saturation was unable to determine any additional themes. Determining linkages and structure within the data and established themes then formed an overall impression. The researcher then summarized the prevalence of the themes, discuss similarities and differences among the themes including preference for a private or semi-private room, safety and security, communication with friends and family, staff interaction, and roommate interactions. Accountability was accomplished through maintaining matrixes of the initial coding procedures.

The analysis chapter discussed the instrumentation process for the case study research: resident interviews. Following this the chapter went into detail regarding how residents were selected to participate in the study. The chapter ended with a means of analysis of how the participant interviews were transcribed and codes into themes and sub-themes.

Evaluation and Discussion 5.

The evaluation and discussion chapter discusses in detail the primary themes and subthemes of the study: safety and security; communication; decorating; staff interactions; practicing religion and spirituality; and interactions with roommates. Following discussion of the themes and sub-themes the chapter explores limitations in the findings in the study as compared to the literature. The chapter ends by providing a discussion of how the ecosystems perspective provides a lens for analysis of the resident responses.

The literature review, ecosystems perspective and resident interviews brought to light a number of primary issues concerned residents residing in personal care homes. The residents expressed a preference for a private room and additional concerns regarding: safety and security; communication; decorating; staff interactions; practicing religion and spirituality; and interactions with roommates.

Several subthemes became apparent under safety and security: theft, wandering, interruptions and locking doors. Under the theme of communication two subthemes emerged: intimacy and friendship. Under the primary theme decorating sub-themes arose including television and telephone use. Under the primary theme of staff interactions several subthemes emerged: wish to be alone, privacy during personal care, housekeeping, physician visits, staff night rounds and staff speaking other languages. A number of subthemes emerged from the primary theme of interaction with roommates: concern for roommates and conflict with roommates.

Participating Personal Care Homes

Three personal care homes participated in the study. All of the personal care home that participated in the study are located in the Winnipeg Regional Health Authority. All personal care homes are required to meet Manitoba Health Provincial Standards and regional policies set out by the Winnipeg Regional Health Authority.

Of the three personal care homes, two are proprietary homes owned and operated by national corporations. The third facility was a non-profit facility owned and operated by a faith-based organization. The personal care homes ranged in bed size: one facility was under 100 beds and two facilities had over 150 beds as illustrated in Figure 1.

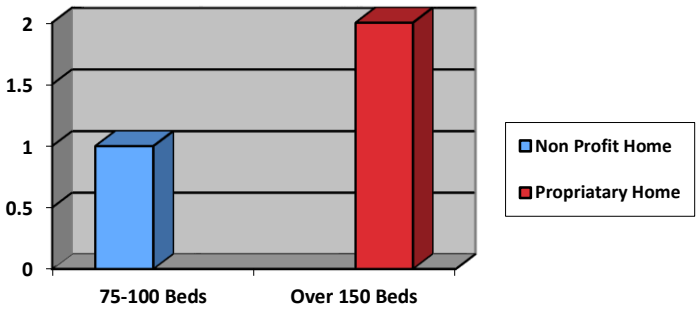

Figure: 1 Size and ownership of personal care home residents

Resident Background and Demographic Characteristics

age and sex.

Within the three participating personal care homes there were nine consenting older adults who meet participation criteria. Of the nine residents there were five men and four females as illustrated in Figure 2 below. Although the study was initially intended for five to eight residents an allowance for an additional resident was provided. The ages of the residents ranged from 58 to 88 years of age. Interestingly, three of the residents were under the age of 65. It was apparent that personal care homes are serving younger populations; for that reason residents under the age of 65 who resided in the personal care homes who meet criteria were included in the study.

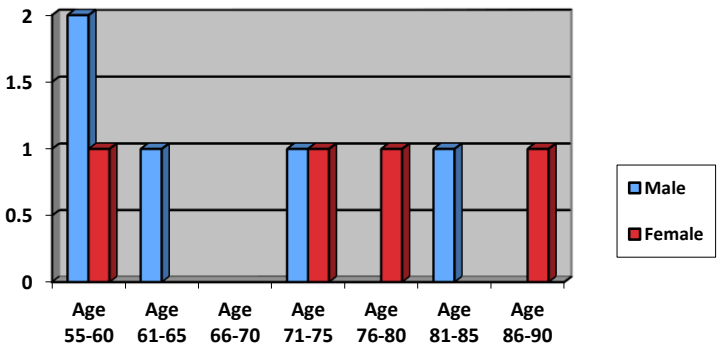

Figure 2: Resident age and sex

language.

The first language of a number of residents was a dialect other than English. One male resident's first language was Cree and another male resident spoke Ojibwa (Rick, Line 28) and (Andy, Line 25 & 37). A female resident first language was Slovenian (Anne, Line 18). However all the residents expressed that they were fluent in English.

room accommodation.

The residents lived in a variety of room style accommodations: one in a private room, four residents in a private room with a shared bathroom, one resident in four person quad room with a shared bath, and three residents in a semi-private room with a shared bath. Two of the residents shared that they had previously lived in semi-private accommodation with a shared bathroom before entering their private room within the same facility (Nancy, Line 41) and (Betty, Line 28-32).

Andy shared that he had previously been incarcerated at the Remand Centre where he shared a room with another inmate (Andy, Line 191). Harold had lived in a rooming house "just the McLaren Hotel"(Harold, Line 4). Nancy and Betty had transferred to their current personal care home from another personal care homes with

semi-private room accommodation (Nancy Line 41), & (Betty, Line 28-32). According to Anne a 77-year-old female resident currently residing in a four-person room.

> I moved to another personal care home from the hospital. I lived at that home with another lady. It was a two-person room. You share with a lady. Men share together. I had no choice I had to share a room. I was happy they took me it didn't bother me to share a room. I needed help to get dressed and go to the bathroom. (Anne, Line 58-61)

heritage.

Of the nine residents, eight were born in Canada and Anne was born in the former Yugoslavia (Anne, Line 6 & 18). Six of the residents were born in Winnipeg, Manitoba. One of the residents was born in rural Manitoba. Seven of the residents shared that their cultural heritage was Canadian of European decent. Andy and Rick shared that they were of First Nations ethnicity (Andy, Line 25), & (Rick, Line 28).

Five of the residents came from families where both parents worked outside of the home in professional positions, family or the military (Rick, Line 24), (Nancy, Line 24), (Anne, Line 20-30), (Harold, Line 16-17), and (Betty, Line 17-18). Rick, Betty and Donna's Mothers stayed at home to care for the children (Rick, Line 25), (Betty, Line 17-18), and (Donna, Line 17-18).

Anne who is currently residing in a four-person room shared that a belief in a Christian God was highly important to her; "I have had a very hard life but I have a very strong faith. I know God takes care of me and my family" (Anne, Line 37-38).

Eight of the residents were single or widowed at the time of the interview. One resident was currently married. Eight of the residents shared that they had children. Anne shared that she had been subjected to physical and verbal abuse in the family home and in their marriage.

> If I didn't listen or broke something, if something happened my Mother would say you are stupid. She would give me lots of likens sometimes if I do something wrong. I got married and my husband was a binge alcoholic. When he started drinking he wouldn't stop. I was lucky he was not a violent person. He never touched or hit me. He abused me with his words. (Anne, Line 32-35)

health.

All of the residents shared that they required personal care home placement due to illnesses. All nine residents cited multiple health concerns. Decline in mobility was cited as the most common reason for placement in personal care homes. The following health concerns were noted to affect residents: arthritis, cancer, back injury, nerve pain, asthma, high blood pressure, incontinence, diabetes, renal failure, visual impairment, and stroke. Multiple Sclerosis affected two female residents, which is why the residents were placed in a personal care home at a young age. Four residents sighted impairment due to decreased mobility and two residents were affected by diabetes.

length of personal care home stay.

The residents' length of stay in the personal care homes varied greatly from short to long-term placements as illustrated below in Figure 4. Four residents had resided in the personal care home for less than three months (Andy, Line 43), & (Nancy, Line 34), & (Anne, Line 43), & (Harold, Line 36). Three resident had resided in the facility for six to twelve months (Don, Line 29), & (Richard, Line 29), & (Donna Line 24). One older adult had resided in the personal care home between two to five years (Betty, Line 24). One resident had resided in the personal care home for 20 years (Rick, Line 34).

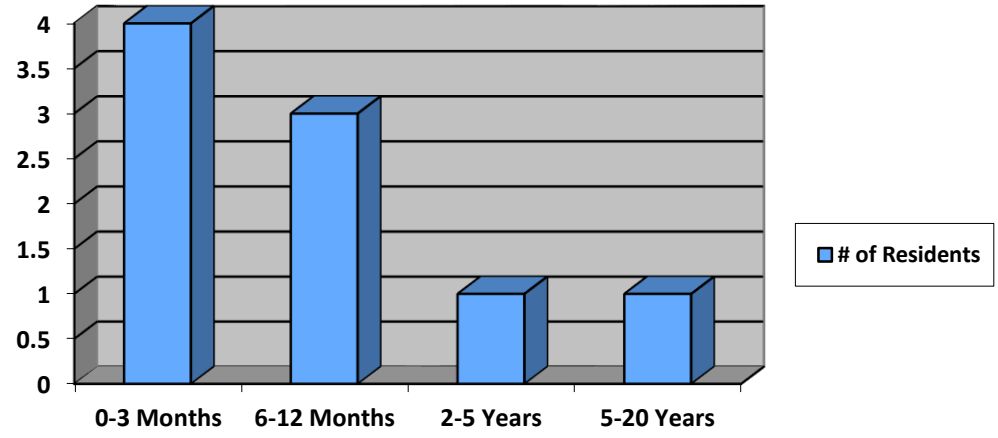

Figure 3: Length of Resident stay in PCH

Preference for a Private Room or Semi-private Room

Interestingly all nine residents expressed that they would prefer to be placed in a private room accommodation. Various rationale is provided for the preference towards a private room including desire to have increased space for personal belongings, concerns about not knowing who their roommate was going to be in a shared room setting, wanting to have increased privacy to practice spirituality, reduced disturbances from a roommate, perceived reduced conflict between roommates and the opportunity to lock the door to a private room. Placement in a private room was viewed positively as residents would have a increased sense of control over their space thus giving them a better person and environment fit which was consistent with the ecosystems perspective.

Nancy age 58-year-old shared that she prefers having a private room so she would have more personal space for her belongings "I can have my stuff out and have a bigger closet. I think that's it. More space." (Nancy, Line 58). Betty age 73 commented on the

opportunity to decorate more in a private room "In the semi-private room I didn't decorate as much but nobody said I couldn't decorate" (Betty, Line 57). Betty who is currently sharing a semi-private room shared that she would prefer a private room so she would have the freedom to watch television in privacy.

> I would prefer to be in a private room because I can watch my TV and the programs I like. I love having a single room. I have a nice view of the outside. I always know when the staff members go out for a smoke because they can't smoke on the property. I can see who's on their break. (Betty, Line 42-45)

All the residents shared a preference for having a private room as they do not have control over who their roommate will be in a semi-private room or what their roommate will be like. Nancy a 58-year-old female resident who had at one time resided in a semi-private room recalled a fear of being in a semi-private room due to the roommate's aggressive behavior "With one other lady. Don't go there. I'm sorry it was swearing and violence." (Nancy, Line 42)

Rick age of 58 currently residing in a private room with a shared bath discussed a preference for a private room so he was able to read the Bible without judgment from a roommate "a private room is better. I don't know what another person likes. I like reading the Bible and talking about Jesus. I like to be like that." (Rick, Line 67-68).

Don a 73-year-old male resident residing in a private room shared that he preferred a private room as past roommates have frequently disturbed him when using the bathroom. The male resident was distressed by past roommate's frequent falls.

> A private room is much better. My roommate was on the other side by the window and every twenty minutes he would get up to go to the bathroom. And he always was falling, falling in the bathroom. I could hear him hit the floor and I would push the button and call somebody for help. Yeah I worried about him. I knew something would happen if he didn't take his walker. I worried. It started getting to me. I see it happen with other people out there and I keep waiting. Don't fall. (Don, Line 41-46)

Richard age 64-year-old resident shared that disturbances from his roommate are concerning however overall they did get along. In this case the roommate often shut the room lights off or television off.

> I was by myself for a week. Then they brought in a roommate and he is quiet as a mouse. You never hear him. Sometimes he scares me because you can never hear him (laughs). Sometimes he comes over and shuts my TV or lights off. We finally got him used to having the light on at night. And other than that I have no problems we get along great. (Richard, Line 36-39)

Two female residents cited a preference for a private room as they would have the freedom to lock their room for additional privacy.

> I would like a private room because you can lock your door. I like time to myself. This shared room is like a private room when my roommate isn't here. I would want my own space if I was going to stay permanently in a home. (Donna, Line 40-42)

In this case the Donna appreciated that her current roommate did not spend a great deal of time in the room but there remained a preference for a private room. Betty a second female resident age 73 shared an increased sense of safety for being able to lock their private room door.

> It's pretty good to have a private room because we can have a lock on our door. Because were only one person in here. We have wanderers that will come into your room….It is scary when the people come into your room because you don't know what they're going to do or anything. We do have some violent people here. (Betty, Line 35-40)

Advantages and disadvantages are identified in the literature review in regards to having roommates. The respondents in Andersson, Pettersson & Sidenvall (2007) and Petronio and Kovach (1997) and Wang and Kuo (2006) studies attributed a greater feeling of loneliness and isolation with being in a private room due to a lack of social

interaction, which was not an expressed concern of the residents in the current project. The literature review cited that older adults have difficulty moving from their room due to strong attachments to the space as cited by Rigby, Payne and Froggatt (2010). While Sheppard (2009) found that no matter what type of room the residents are assigned the older adults develop a strong attachment to the room and found moving difficult. Compared to the previous research it does not appear that the residents have difficulty moving to a private room or more preferred personal care home facility. Receiving a private room was viewed very positively even for residents who have positive relationships with their roommates.

Safety and Security

A category of safety and security was established and further broken down into five subthemes based on the research question and the exploration of resident's experiences in personal care homes include theft, wandering residents, noise, interruptions and disturbances, and finally locking doors.

theft.

Theft of personal belongings was raised as secondary theme under safety and security by a male resident residing in a small non-profit facility. Andy a 59 year old male resident residing in a private room with a shared bath had a concern that money went missing from his room on more than one occasion. The male resident attributes the theft to housekeeping staff which negatively affect his feelings of security and fit with his fit within his room habitat.

> Well, the thing that I have to watch out for is if I get money I don't hide it anywhere in my room because it will go missing. So I am out of words for where I can keep it if I had money. That's the one thing that I have to let people clean

> up my room. Those are the only people that can check through my stuff and take money if they find it then they take it. (Andy, Line 181-185)

Betty a 73-year-old female resident residing in a semi-private room voiced similar concerns about theft from co-residents. In this case the person accused of stealing was a cognitively impaired roommate.

> I had another roommate she used to follow the nurses around when they gave the pills and she would take things. She would take things off my dresser. I asked her about it and she said she didn't take anything. But when she left the room I would wheel over and sure enough the missing things were there on her side of the room. It made me feel very annoyed. (Betty, Line 127-131)

Both experiences left the residents feeling very frustrated and violated. The residents felt vulnerable and a sense of poor control over their room and belongings. Theft caused significant emotional and personal stress to the residents, which negatively impacted their fit with environment.

The experiences of the residents were consistent with previous research. Personal belongings create a sense of security for the resident and reinforce self-identity; however the security can quickly be eroded when the resident loses control over their environment and items go missing (Train *et al*, 2004; and Wang & Kuo, 2006). Personal belongings frequently go missing in personal care homes as they are misplaced, moved by roommates or taken by wandering co-residents (De Veer & Kerkstra, 2001).

wandering residents.

Issues related to wandering residents affects residents residing in all three personal care homes. Four residents raised issues regarding residents who have behavioral issues of wandering within the personal care home. A number of residents voiced a lack of control over who came into their room as a real concern and stressor to

their person and environment fit. Although the resident's room was considered personal space, there are significant limitations preventing cognitively impaired residents from wrongfully entering rooms. Donna a 64-year-old female resident in a private room with a shared bath expresses a concern and sense of anger regarding wandering residents.

> Hmm, percentage wise it's probably ninety percent because staff and mainly other residents walk in and out of the room. It's not controlled. It is their home too they can go where they wish. But I don't think other peoples rooms are a place to go but these people do. I feel very angry. The first time it happened to me I thought I have people in my room that don't belong here. It's not very nice. (Donna, Line 51-55)

Nancy a female resident age 58 residing in a private room with a shared bath echo the concern regarding wandering residents; in this case her neighbor who shares her bathroom.

> I worry about my neighbor next door. She walks in the door. She wanders. A lot of the time. She looks in my room because she thinks her kids are little and comes in here to look for them. She is the way she is. I just ignore it. (Nancy, Line 92-94)

A third female resident Betty age 73 expresses an organizational issue related to the layout of the facility she resides in. In this case all the private rooms are located in a concentrated area. According to the resident many residents with behavioral issues related to dementia are placed in private rooms for safety in one specific area of the building.

> For me on the wing that I am on there are a lot of people who have dementia. So they don't know where they are going or why they have gone there. So they come into my room because I don't have my door closed at all times. I have to move forward with my wheelchair to stop them from coming in. If they are being aggressive I have to call for help. It's the most upsetting thing. (Betty, Line 168-172)

As part of safety and security noise, was identified as a significant environmental stressor. Betty went on to discuss that noise during the night can be very concerning.

> It would be really nice to have people who do not yell and bellow. They wake me up at 5 in the morning. On the wing I'm on they take people in if they are a problem with their roommate they get shipped to a private room in my wing. There are six wings total and two of them have private rooms. People come up to your room and they think it's their room. I tell them it's my room. There's this one lady who comes up and says this is my room you have all my clothes in there. She yells and screams and I have to call for help it makes me upset. (Betty, Line 66-71)

Overall residents who view wandering residents as a significant safety and security concern felt that having a private room with a locking door and the ability to call for help reduces their fear of unwanted people entering their room and increase their control over their environment. Having a lock on one's door made the residents more empowered to make decisions about their personal space. The findings of the research project were consistent with the literature review and ecosystems perspective around cognitively impaired residents and the impact of wandering behavior on privacy, security and safety.

Cognitive functioning and behavioral issues of co-residents directly impacts privacy and quality of life in personal care homes. According to existing literature by Sheppard (2009), Choi, Ransom and Wyllie (2008), and De Veer and Kerkstra (2001) wandering residents entering rooms was a disturbance that directly impacts privacy, security and feeling at home.

room interruptions.

A number of residents' cite roommate interruptions while using the washroom as a significant privacy concern, however the residents develop a level of acceptance and adapt to the communal environment. Two of the residents, one 59-year-old male and

one 58-year-old female shared that their roommate had walked in on them while using the washroom which was very unsettling. The female resident shared that "If the door is not locked she will come in. I have gotten used to it. She is the way she is. Wait if the bathroom is busy" (Nancy, Line 121). The male resident went on to discuss how he handled waiting for his shared a bathroom when occupied.

> Yeah, a few times. There's another bathroom just down the hallway here. I go there if I really need to go to the bathroom and can't wait. I have been in the remand center and I have shared a room with two mates there and that's ok. When I was in high school I had to share my room with three others. I lived like that for four years; that was ok and is now. (Andy, Line 159-160, & 191-193)

The male resident had a number of life experiences of sharing a bathroom in various settings including schooling and while being incarcerated. Both residents had adapted to communal living and accept the washroom disturbances as part of their social living situation.

Harold a 82-year-old male resident residing in a semi-private room found that his roommate was respectful of his privacy while using the bathroom, "No he is pretty good. He doesn't come in" (Harold, Line 57). In this case the roommates developed their own social rules to adapt to their shared living experience.

Andy a 58-year-old male resident in a private room with a shared bath used a strategy of putting a chain lock on the bathroom door when it was in use to prevent interruptions. "No. It's ok if people walk in. I put the chain up inside" (Andy, Line 166). The chain improved his level of privacy. Having a chain in the bathroom increases the residents control over interruptions, however does pose safety concerns that in an emergency staff may not be able to quickly get into the washroom to assist residents.

A secondary concern was raised regarding noise as an interruption and disturbance. Harold expressed that he prefers a private room so he can close his bedroom door at night to reduce noise.

> I would prefer a room by myself. Then you can have a TV. I would like to be able to close the door especially at night. At night you can hear lots of noise, people screaming (Harold, Line 51-53).

Further to the concerns regarding noise interruptions a 73-year-old female resident Betty residing in a semi-private room discussed how unsettling her roommate's hallucinations can be.

> Well, I had a lady roommate who would have hallucinations and she would think her kids were stuck somewhere or thought people had taken them somewhere and she would yell about it all the time. One day she was gone. I don't know if she died or got moved. (Betty, Line 123-125)

Both residents found noise at night disruptive and negatively impacting their fit with their environment. Residents were limited in how to manage noise and disruptions when coming from a roommate in the same space or the general building.

locking door.

Residents regularly identified the importance of being able to lock ones door. Overall it was felt that having locks on doors for resident use would provide increased privacy, safety, sense of control and security. A 73-year-old female resident Betty shared a vivid example of why locks are important to personal care home residents.

> It's pretty good to have a private room because we can have a lock on our door. Because were only one person in here. We have wanderers that will come into your room. After I got the single room one night I woke up at 3:00 in the morning and there was a naked man in my room. So the very next day they put a lock on my door. I close my door during the day but at night I lock it. It's scary when the people come into your room because you don't know what they're

> going to do or anything. We do have some violent people here. (Betty, Line 33-40)

The experiences of the residents were consistent with previous research. The majority of the residents place a significant emphasis on being able to lock their door or secure belongings. According to the literature review Petronio and Kovach (1997) found that items typically go missing at a higher rate when residents occupy shared accommodations leading to conflict between roommates. According to Le Low, Lee & Chan (2006) having access to a lockable cupboard to store private belongings and valuables is important to residents. An improved sense of security, control and safety empower residents to have a positive relationship with their physical and social environment.

Communication with Friends and Family

Communication with friends and family was further broken down into three subthemes based on the research question and the exploration of resident's experiences in personal care homes including communicating with family, intimacy with partners and friendship.

communicating with family.

Of the nine residents seven regularly receive visits from friends and family. Two of the residents have family who live out of town and are unable to visit regularly. All of the respondents both male and female receive visits from families in their rooms or in a common lounge reserved for resident and family use in the facility.

Harold an 82-year-old male resident residing in a semi-private room shared his experience visiting with family members.

> We visit in my room. In the hospital they had a room at the end of the hall for visitations. Here the friendship room if it's not busy. But it was busy this morning. I don't know of any other places to visit. On Friday my sister came to visit with her husband. (Harold, Line 83-85)

Donna a 64-year-old female resident shared a concern that although her family was able to visit in her room the space was limited especially for those with larger families.

> The room is small. If one of my sons comes with his family he has four children. It is very small there is no seating area. But there is privacy. My roommate leaves and allows me the privacy just as I do when her family comes. I don't mind leaving. (Donna, Line 66-68)

Based on the information the respondents shared it appears there was a lack of private areas or lounges for resident use which was especially problematic for people residing in shared rooms.

One of the 59-year-old male residents Andy residing in the non-profit facility shared that his family was anxious about visiting in his resident room and particularly felt uncomfortable sitting on his bed during visits. In this case the family are concerned about hygiene and being exposed to bedbugs. Although there was no indication from the resident or facility that bed bugs had ever been an issue.

> Well, when my son comes to visit me he usually stays only a short time. He sat on my bed here and he was afraid bed bugs would crawl up on him. He didn't want to sit on my bed because of that. He was afraid that bed bugs would get into his clothing. That is the complaint he had about being in my room. (Andy, Line 101-104)

The clinical setting and communal living environment placed additional perceived obstacles for the resident to visit with his family.

Two male residents age 73 and 64 both residing in a larger proprietary home share that they frequently visit with family members and friends over meals in the lounge or

dining room. The 64-year-old male resident Richard has a strong sense of community that developed from having visits with his family in a common area where they are able to interact with other residents and family members.

> My wife and I usually go downstairs. She joins us for lunch or supper then we sit in the lounge sometimes. She has made some friends her too. I have a friend on the second and fifth floor. We know quite a few people here. You get to know people. It's a community here. (Richard, Line 64-66)

Betty a female resident age 73 shared that at times it can be uncomfortable staying in a semi-private room when roommates receive visitors because there was no auditory privacy. The resident shares that it can be especially bothersome when a roommate and their family are speaking other languages.

> In the semi-private room I didn't get many visitors because my children live out of town. Sometimes my roommate who have visitors and they would speak another language and that was annoying. But they have the right to do that. You can hear pretty much whatever your roommate is doing. (Betty, Line 87-90)

Room layouts differ among personal care homes in the literature, as did the amount of privacy, which would be supported by the research within the three participating facilities. Overall Barnes (2002) reports that the provision of privacy for sound, sight and smell was the most important feature of a personal care home. Resident cited privacy for sound and sight as important however smell was not discussed. Hughes (2004) and Le Low, Lee and Chang (2006) find respondents in their studies are aware that curtains provide visual physical privacy but do not provide social privacy and opportunities for private verbal communication, which was supported by the experiences of the residents in the current research project.

Privacy for visiting with loved ones was frequently discussed in the literature review. In the existing literature residents value having access to lounges and private spaces for communicating in private which was consistent with the experiences of the residents in the current study (De Veer & Kerkstra, 2001; Hughes, 2004; Le Low, Lee & Chan, 2006; and Wright, 2000). Similar to the previous research by Andersson, Pettersson and Sidenvall (2007); De Veer and Kerkstra (2001); and Lemieux *et al* (2004) the residents express that private rooms are optimal for providing privacy and a home-like atmosphere for secure, undisrupted and confidential conversation with loved ones.

The residents in semi-private or shared multi-bed rooms in the study share the same experience as the respondents in Hughes (2004) study that curtains for privacy was appreciated but does not afford privacy for communicating as roommates could hear what was being discussed. The residents' value having a roommate that does not spend much time in the room as they have additional privacy for family visits. It was important for residents in shared accommodation to have access to private lounges for visiting. Contrary to the previous research the residents in the current study found that staff were not disruptive to family visits.

intimacy.

Of the nine residents, seven shared that they thought about intimacy. Of the four men and three female residents all felt that intimacy with a partner was a possibility if residents reside in a private room especially if the door has a lock. Richard a 64-year-old male resident residing in a private room with a shared bath expressed.

> Oh yeah, we can shut the door and lock it. Some of the goofy's come in and steal my clothes and go through my cupboards so you have to lock the door. Anyway you yell at them the wanderers to get out but they don't always listen. I can be with my wife we just lock the door. (Richard, Line 74-76)

Age does not seem to be a factor in which residents feel that privacy for intimacy was important. A 59-year-old and an 82-year-old male respondents feel they have enough privacy in a single room for intimacy but are not interested as their significant other died and they currently do not have a partner.

In one of the larger proprietary homes Betty a 73-year-old resident shared that staff were supportive of resident's choices and respected their need for intimacy.

> In a single room you could be intimate with a boyfriend. The Social Worker told me one time that this is your home and this is your room and you can do anything you want in your room. I thought I can have sex! Sure you could have sex. (Betty, Line 137-139)

Three of the residents felt that semi-private room accommodation do not offer enough privacy to be intimate with a partner. Don a 73-year-old male resident recalled his experience in a semi-private room.

> I guess I would in the private room if I wanted to. I would shut the door and it would be fine. In the shared room it wouldn't have been very good because I had a roommate and the door is always open. But I don't have anybody like that right now (laugh). (Don, Line 80-82)

Harold another male resident age 82 shared a similar story.

> I don't think so. Well I mean how could you be - there is someone else in the room. Not that I want to. But right now I am not in the mood either. My hopes are that I can get out of here and live somewhere on my own. But for the moment I have nowhere to go and this is my home. (Harold, Line 89-92)

Donna a 64-year-old female resident residing in a semi-private room had a similar message "No I don't have enough privacy to be intimate with a partner" (Donna, Line 78). The consensus among the residents was that a private room with a lock was necessary for intimate contact with a partner. Preference to lock one's room was

consistent with previous research by Hughes (2004) and Le Low, Lee and Chang (2006) that curtains do not provide sufficient privacy. Being able to take ownership over ones space by locking the door increases control and increases the resident's perception of privacy and security, which was consistent with the ecosystems perspective.

The residents in the study residing in shared accommodation feel that they do not have enough privacy to participate in an intimate relationship or lacked access to a partner. The findings of the study are consistent with Benbow and Jagus (2002) research. Elderly people stop participating in sexual relationships and activity because of general infirmity, fear that it would expose them to ridicule, decreased privacy and a lack of an available partner (Benbow & Jagus, 2002). The primary concern for the residents in the research project is potential interruptions by a roommate or lack of privacy provided by dividing curtain in a shared room. The residents who reside in private rooms felt that if they have a partner they will have enough privacy to participate in an intimate relationship.

friendship.

Five of the residents, two males and three females report that they have developed friendships with co-residents in the personal care home. Friendships in the personal care homes develop with neighbors and roommates and build a real sense of community, positive exchange of resources and supports, and improved the resident's self-esteem, which was consistent with the ecosystems perspective.

Rick a 58-year-old male resident residing in a private room with a shared bath discussed that he occasionally watched television with co-residents in his room; "It's ok, I am all by my lonesome. Once and awhile he comes in and we watch" (Rick, Line 104).

Donna a 64-year-old female resident frequently watches television in her room with her roommate; "she watched on my TV. It works well" (Donna, Line 130).

Four of the residents share that they have developed friendship with their roommates and their families. Anne a female resident 88 years of age residing in a four person shared room talked about her relationship with her roommates.

> I have privacy. Nobody bothers me. My roommates are very nice and quiet people. They are in their 90's. They have very nice families. Their families come to visit and always ask me how I am and how I'm feeling. They always talk to me. (Anne, Line 77-79)

Similarly Betty a 73-year old-female resident residing in a semi-private room went into detail about her strong relationship with her roommate and her family.

> When I first came here my roommate was just wonderful a really nice lady. Her daughter and three grandsons came almost every day and I got very friendly with them. It was kind of amusing because the one young man would come in at seven p.m. and I would wheel into the hallway and he knew I would want to go outside and have a cigarette so he would take me outside first then come back to visit. He was just wonderful. After she was in a different room she passed away. She had a little fridge and the one grandson came and said do you want it. I said that I wanted the fridge but there was no room here. So the two health care aides kicked me out of the room and moved everything around to find a spot for the fridge. It was pretty great. We got along very well. She was a lot older than me but we would go every morning after breakfast to the exercise class. We went in separately but she had to sit beside me or I would sit beside her. We were good friends. When she passed away it was awful. (Betty, Line 103-113)

The meaningful relationship the female resident has with her roommate was touching and the tremendous sense of loss she experienced when her friend died spoke highly of their close relationship.

Two of resident's one female 64 years old and one male 73 year old expressed that they "get along well with their roommates primarily because they leave each other alone or their roommate does not spend much time in the shared room" (Donna, Line 71-

74). A 73 year old male residing in a semi-private room shares "I got along with my roommate. I left him alone to do his thing" (Don, Line 76). Having strong relationships with roommates, co-residents and families provides additional resources and security for residents.

decorating.

Overall the residents felt that they were able to decorate their room or niche to suit their taste with furniture and personal items. All personal care homes provide a bed, bedside table, dresser and chair for the resident room. If residents choose they are able to bring in furniture space permitting.

In private rooms the overall feeling was that residents can bring in more personal items developing a stronger ownership over their niche room. Nancy a 58-year-old female resident shares that "it's been good. I can have my stuff out and have a bigger closet. I think that's it. More space" (Nancy, Line 59). A 64-year-old male resident Richard in a semi-private room shares what he can bring in to decorate his room.

> I have pictures and my little cars and a picture of my son and his little boy. I have a plant over there that moves up and down with the sunlight. I have a couple of Christmas things on the outside of the door. I brought my TV in from home. (Richard, Line 47-49)

Although the general consensus was the private room accommodations allow residents to bring in more belongings one 73-year-old female resident Betty shared that she has observed a co-resident being agitated when she was unable to bring in a favorite piece of furniture into a private room.

> This one lady was upset. They offered her a single room but she's got this huge recliner chair that wouldn't fit in the single room. But she thought if they rearranged the room it would fit. She prefers to sleep in her chair over the bed. I'm not sure what's going to happen with that. (Betty, Line 53-55)

Decorating ones room had two outcomes: improved self-esteem or created stressors for residents. The more personal items residents have the more ownership they have over their space, which aligns with the ecosystems perspective.

The majority of residents in the semi-private or multi-bed accommodations expressed that they are able to decorate their room but choose to bring in minimal items until they move into a private room. As summarized by Betty a 73-year-old female resident "in the semi-private room I didn't decorate as much but nobody said I couldn't decorate" (Betty, Line 57). Another female resident Anne age 88 shared that she is able to freely decorate "If you like to decorate you can. The furniture is from the personal care home you don't need your own furniture. I brought in my cross and my pictures of my family" (Anne, Line 72-73). Conversely a male resident Harold did not view his room as his own space or home and for that reason choose not to decorate "I don't decorate. Well (laughs) I don't have a house. My wife did the decorating and she passed away. I'm not interested" (Harold, Line 65-66).

Although the residents felt that they could decorate their semi-private room one female resident's age 73 shared that she had to give up many of her belongings as the room will not accommodate all of her possessions.

> I could have a TV in the semi-private room too. Because the rooms aren't huge I put most things in storage and told them to sell some things. I had boxes and boxes of books I donated here, which they sold in a sale. I also gave them fancy cups and saucers which they put in the cabinet to show off. I kept personal items like pictures and photo albums. I didn't have to bring in any furniture because they have two dressers. But you can bring in some things. (Betty, Line 47-51)

Even though the resident had to give up many of her personal belongings she showed

pride in the facility displaying her fancy cup collection for all to see. Betty adapted to her new environment and did not see losing her possessions as a stressor to her goodness of fit.

The setup of the resident rooms were consistently described by the residents as a space with the provision of a bed, dresser and bedside table with room for personal decorations, telephone and television which was consistent with the literature review. For most of the residents being able to have one's own television was the most important personal belonging to have access to; however all the residents have personal belongings decorating their room.

Calkins and Cassella (2007) found that residents who share rooms feel a loss of privacy and personal space; as a result they do not decorate their rooms to the same degree as residents in private rooms. The residents who share a room did not decorate to the same degree as residents in a private room as they are waiting to move into a private room eventually. However, residents do not report feeling a loss of personal space when sharing a room with a roommate they were compatible with.

television.

Having access to a television was seen as an important choice for older adults in personal care homes. All of the residents have a television in their room. Although all the personal care homes permit residents to have a personal television in their room there are expectations from the personal care homes regarding volume control. Five of the residents both male and female reported being concerned about television volume and tried to watch at a moderate or lower level so as to not disturb other residents. Anne a

77-year-old female resident in a shared multi-bed room discusses watching television in a multi-person room.

> I don't want to put the TV too loud. They told me that my roommate doesn't hear very good but the other two roommates I don't know. I don't watch the TV louder than 17 I don't want to make it louder and bother them. (Anne, Line 89-91)

Don a 73-year-old male resident residing in a private room shares a similar courtesy for other residents and not wanting to disturb others with their television. "I am a TV man, I like TV. So I am always watching it. I keep it down so I can hear it but so nobody else outside can hear it. Some people keep it on too loud" (Don, Line 85). In one of the larger proprietary homes the facility encourages resident to purchase earphones for their television if they require the television volume to be at a higher level.

> I have a radio right now that I play low and I was told if I want a TV I should have earphones. I can have a TV in my room if I have earphones. You can't have TV's blaring everywhere. Some of these people are deaf. I think it's a good rule. (Harold, Line 61-63)

It was evident that the residents feel a sense of community and respect for co-residents by keeping television volumes at an appropriate level.

Three of the female residents discuss watching television in a shared accommodation either a semi-private or multi-bed room. Two of the residents frequently watched television with their roommate. Nancy a 58-year-old female resident shares that "I only watched movies and she didn't complain. She could watch them or not" (Nancy, Line 132). Donna another female resident aged 64 shares her experience watching television with her roommate.

> It's nice it's my television I can sit and watch it. It is a little irritating when my roommate walks back and forth in front of the television. I don't like it. I respect her. My roommate likes the television loud so she sits closer to the television to hear well. I turn the television down when she is on the phone with her relatives. She watched on my television. It works well. (Donna, Line 80-83)

Although for the most part the roommates watch television collaboratively conflict still arose around disturbances of roommates walking in front of the television.

In the literature review it was reported by Choi, Ransom and Wyllie (2008) that conflicts arose between roommates around television volume, disruptive sleep patterns and daily routine differences. The residents in the research project however did not view watching television as problematic. There was a consistent agreement by the residents as to what volume level is appropriate as to not be considered disruptive. Several residents reported being supportive of facility recommendations to use earphones if wanting to watch television at a higher volume or during irregular hours. However, having a roommate walk in front of the television was considered a disruption which was uncontrollable.

telephone.

Of the nine residents three have a telephone in their room. Of those with telephones, two residents reside in a private room. One 64-year-old male resident who resides in a semi-private room uses a cell phone that he carries with him; "I use a cell phone. It works good" (Richard, Line 87). Four of the residents in both multi-bed, semi-private and private room accommodation do not have a phone in their room. Anne a 77 year old female resident choose not to have a telephone due to her health condition compounded by her belief that she will not have enough privacy to speak on the phone to her family. The resident went on to report a concern that she would disturb her roommates in a shared multi-person room if she used a telephone in the room.

> Here I don't have a telephone. I have a hard time to reach the telephone. If I want a telephone my family has to set that up to connect the phone. I told my

> family if I go to a single room I will get a telephone but not before. In a single room you can talk more loud on the phone and you won't bother anyone if the telephone is ringing. I don't want to bother other people. (Anne, Line 108-112)

Three male residents do not have a phone in their room but use the telephone at the nursing station or reception when needed. Andy a 59-year-old male resident shares his experience using the phone at reception.

> It's ok. There's a telephone at the front desk and I have used it. It's not far from here. You have to press 1 and 204 but it's easy to remember that. There's always someone in there that listens to you talk. I don't know if they record your conversations. I don't feel good about that; being heard by people. I would like to have more privacy. I don't know. I see people with cell phones they have in their room. But I don't have money to get a cell phone. (Andy, Line 129-139)

Residents appreciated being able to use the facility phone however having to use the phone in a public place or in a shared room presents greatly limited the amount of privacy for calls and increased potential for disturbance to others which was a stressor.

attitude toward personal care home placement.

Donna age 64 shares her experiencing with adjusting to a personal care home from her community residence.

> It has been scary. A loss of independence. A loss of freedom. Just scary for me it was scary in the beginning. Now it is getting better. I still have a loss of independence. I still am not able to do as I want without someone else coming along with me. They call them an escort or a family member. I can go outside the home I am not restricted to that. Other than how far I go. I might be restricted with that I don't know… The room is not scary the whole situation is scary. I came from a home setting to hospital to a care home setting. It is a very big adjustment. It still is. (Donna, Line 31-38)

Many of the residents share their viewpoint of living in a personal care home and the importance of choosing to have a positive attitude as being a key part of their successful adaptation to their new habitat. Richard a 64-year-old male resident residing

in a private room compares himself to other residents who have a negative viewpoint of personal care homes.

> You have people complaining all the time about this place saying it's worse than being in jail. They put me in here to die. You can hear them all complaining. But I like this place. I just shrug my shoulders and don't even worry about it. It's the way you look at things. There's no reason to complain here. You get fed three times a day. You have a place to sleep your clothes are being done. They take care of you so good. The nurses and staff are great. They give you your pills. But the shower business could be better – twice a week would be better. I'm used to showering twice a day before and after work. It's a big change. You have to have a good attitude. You can't feel sorry for yourself or you will go nuts. I said to myself I would accept what's coming. (Richard, Line 142-150)

Betty a 73-year-old female resident discusses accepting the circumstances of personal care.

> The best thing about privacy is that I can do whatever I want. The only thing I would change is that I would be out of here if I could. I am pretty happy overall if you call being happy being in a nursing home. I am making the best of it. You have no choice so what are you going to do. (Betty, Line 174-177)

Further to that Harold a male resident age 82 shared his experience with needing assistance and requiring personal care home placement.

> For me there is enough privacy here. People have to understand that they ended up here because they can't manage on their own. They are dependent on somebody for help and that's the way it goes. Here it's good. (Harold, Line 125-127)

The literature shows that older adults living in personal care homes and their families appreciate facilities that offer a home-like environment (De Veer & Kerkstra, 2001; Morgan & Stewart, 1999; and Sheppard, 2009). Rigby, Payne and Froggatt (2010) report that the transition to personal care homes can be very challenging for residents who move to personal care homes that do not offer a home-like atmosphere or express a

desire to return home. Two of the younger residents verbalized that they had adjusted to institutional living but had a strong wish to return to the community. For the younger residents the personal care home adjustment was very stressful and they were closed off from resources and were under stress which affected their goodness of fit with the home.

Staff Interactions

wish to be alone.

The wish to have privacy and be alone came up on more than one occasion during the resident interviews. The wish to be alone was discussed by six of the residents: three male ages 59, 64 and 73 and three female residents age 64, 73 and 77 (Andy, Line 87), (Nancy, Line 90-94), (Anne, Line 10), (Don, Line 61-66), (Richard, Line 41-44), & (Donna, Line 10). Three of the residents felt that they had adequate privacy and time to be alone as they live in a private room or have absent roommates. Rick a male resident age 58 in a private room reports that he is able to be alone because he can close the door to his room; "No, I just shut my door and I am ok. I can hear someone knock on my door" (Rick, Line 87). Donna a female resident age 64 residing in a semi-private room shares a similar viewpoint, "I'm never concerned people can hear or see me when I want to be by myself. My roommate is hardly in the room" (Donna, Line 58-59). Having a roommate that does not spend much time in the room or has a private room attributes to increased privacy and the ability to be alone.

Residents in semi-private or shared accommodation who have roommates that frequently spend time in the room find that there was less privacy and time to be alone. Don a 73-year-old male resident reflects on a past experience in a semi-private room.

> In the shared room my roommate always had visitors coming in and talking on his side. But there is nothing you can do about that. My roommate has to have

> visitors. I didn't have many visitors myself. I felt like they can see me. They had a curtain you could pull around but you can always hear them you can't help but hear them. You know, sometimes I was uncomfortable. (Don, Line 61-66)

Although the shared rooms offer privacy curtains they do not create a barrier for audio privacy. For the male resident, his roommate's conversations with visitors was a disruptive stressor. Betty age 73 in a semi-private room shares concerns about being able to hear her roommate; "I don't think so. My problem is that I can hear other people" (Betty, Line 79). Further to that Nancy a female 77-year-old resident in a semi-private room reports that she feels exposed and has limited privacy in the double room during visits and care; "Ah Yeah. I felt terrible. I felt exposed" (Nancy, Line 73). The desire to have uninterrupted private time was equally important to both sexes and younger and older adults. Sharing a room was a consistent stressor and impacted the residents' well-being and fit with their environment.

privacy during care.

All the residents discussed privacy during care. Areas that were discussed by the residents include dressing, toileting and bathing. Residents who were able to independently meet their activities of daily living report having increased privacy. While residents who required more staff intervention for activities of daily living reported feeling more exposed. Harold an 82-year-old male resident shared "The staff don't help me. I can do it by myself. I get up myself here. I get up at six am and go to the washroom and wash myself. The staff don't tell me when to get up" (Harold, Line 101-102). The residents report having greater freedom and privacy in the personal care home because he was independent.

For residents requiring staff assistance with dressing in shared accommodation the

privacy curtains became very important for maintaining dignity and personal privacy. Anne a 77-year-old female resident residing in a four-person wardroom discussed the importance of privacy curtains during care.

> When the staff come and help me dress up they usually wrap a curtain around me. They have to help me put the stockings on and they have to put them on when I am still in the bed. Then they help me with my panties and slacks. Then they take me to the washroom and wash me good everywhere. Then they put a pad in my panties. (Anne, Line 129-132)

Residents who are dependent on staff for care and reside in shared accommodation have a common concern regarding exposure. One female resident Nancy age 58 in a private room with a shared bath simply feels exposed when using the washroom; "Ah Yeah. I felt terrible" (Nancy, Line 73). Having the ability to physically go to the washroom was highly valued. Anne a 77-year-old resident residing in a four-person wardroom shared how much more comfortable and dignifying it was for her to be upgraded from using a bedside commode to using the washroom during the night with staff assistance.

> I have to go to the bathroom a couple of times in the night because I have a very weak bladder. When I have to go I have to go. Before they gave me a commode beside the bed. The staff asked me one day to walk to the bathroom with the walker. I liked that a lot better. I didn't feel comfortable on the commode. The commode is so big and sometimes the pail didn't stay very good and things spill and then you need to wash the floor. It is much better this way. I feel happy here. (Anne, Line 121-126)

Residents in personal care homes are affected by health limitations and require care in varying capacities to meet their daily physical needs. The literature reports that privacy during activities of daily living particularly elimination was a problem. Physically dependent residents have to be accompanied by staff during elimination and personal care reducing privacy (Choi, Ransom & Wyllie, 2008; and Petronio & Kovach, 1997).

Residents with highly limited mobility who use incontinent products or bedpans on their bed or commodes to eliminate their bowel or bladder have the lowest level of privacy (Akpan, 2006). Residents cited going to the bathroom as a privacy concern related to using a commode in a four person shared room. Privacy issues related to using a commode were directly related to the commode spilling on the floor of the shared room. When the resident was upgraded to using the bathroom in her room instead of the commode her quality of life improved.

Betty age 73 residing in a semiprivate room shares that the sex of the staff person impacts privacy and feelings of exposure for many residents.

> The staff are all very good. I have never had one that I have objected to. Some of the women do not want a man to help them or take them to the bathroom. I don't particularly want a man to bath me; but I have always had women. Otherwise I don't care if a male or a female take me to the bathroom or change my clothes; they know how to do their job and they do it well. It doesn't bother me at all. (Betty, Line 144-148)

Although the sex of the caregiver was not a concern for this resident it was an important factor for many co-residents.

All the residents felt that baths were provided by the personal care homes in a respectful manner, which preserves their dignity and honors personal privacy. In all cases a staff member assists the resident to a private tub room to receive a shower or bath. The residents were brought to the tub room in either street clothing or in nightwear and a housecoat. One staff person assists the resident with the bath and only one resident receives a bath in the room at one time. Harold an 82-year-old male resident residing in a semi-private room shares his experience with bathing.

> A person takes me to a room for the bath. I like that bath – a bubble bath. It's only me and the care person. I soak for at least 15 minutes. It doesn't matter if it's a

> lady or a man. It don't matter. I don't mind their help. No, I go down to the bath in my clothes. They wrap me up in a robe and take me down to the bath. I bath Tuesday evenings. (Harold, Line 105-111)

Another male resident Don age 73 shares a similar experience.

> One of the girls comes in and tells me I am ready for my bath. It's on a Tuesday morning. I am the only one in the room and one of the girls is with me. I prefer the bath. It doesn't bother me that the girls are there because I had homecare before. I got used to them being there because I needed the extra help. I am used to it now. (Don, Line 100-103)

Two younger male residents report that they could receive a bath more than once a week. Andy a 59-year-old male resident in a proprietary home shares; "my bath. They give me a bath once a week and I don't dare miss. It's only once a week and if I miss I will stink for the next week. It's valuable to come out of there clean" (Andy, Line 143-144). Another male resident Richard age 64 discusses his wish for more frequent baths; "I have my shower on Fridays it's only once a week it's too bad it couldn't be more often. But that's the way it is" (Richard, Line 94-98). The younger male residents prefer more than one bath per week. Only having a weekly bath negatively impacted the younger residents self-esteem.

In the literature review Calkins and Cassella (2007) found that residents were apprehensive about sharing a room with another resident, as they feel uncomfortable having their daily activities observed by a roommate. Both residents in private and shared accommodation feel that shutting the door or closing the privacy curtain maintains their privacy. The residents feel staff were respectful during the provision of care especially during bath time. It should be noted that the use of a commode in a semiprivate room was viewed as less desirable then going to the bathroom.

Residents who maintain the highest level of privacy were independent with personal care however overall the residents all express that staff members were respectful and they were accepting of the facility care routine especially bathing. According to the research residents who maintain privacy during personal care were physically well enough to go to the washroom independently or complete activities of daily living without assistance which was supported by the experiences of the residents in the current study (Akpan, 2006). Residents with their own rooms and private washrooms enjoy the highest level or privacy (Train *et al*, 2004). When residents have to share common bathrooms with a roommate their privacy was reduced, as there may be a perceived or actual interruption during elimination (Train *et al*, 2004). Residents who share a bathroom in the current study appreciate having a lock on the door to ensure privacy, which reduced concerns about interruptions during elimination.

housekeeping.

Six of nine of the residents reported enjoying expected daily interactions with housekeeping staff. Relationships with staff were seen as a resource and built a sense of community. All of six residents feel that the housekeeping staff would return if they were busy. The residents report feeling comfortable having housekeeping come in to clean their room while they were there. Nancy a 58-year-old female resident shares "it's great here. It's very clean. They let me know when they're here. They came back if I am busy" (Nancy, Line 159-160). Another 77-year-old female resident Anne residing in a four-person room touches on her relationship with the housekeeper; "the housekeeper is very nice. She cleans when I watch TV. She cleans around me. She is very nice" (Anne, Line 144-145). While Don a 73-year-old male in a private room reported that the

housekeeping staff were very respectful by knocking before entering his room; "I let the housekeeper come in and mop the floor. I let them have the time and get out of their way. The staff knock before coming in" (Don, Line 113-115).

Two of the resident's one male and one female felt more comfortable leaving their room while housekeeping was there to clean. Betty a 73-year-old female resident in a semi-private room shares her experience.

> The housekeepers come down every day to wash the floors and clean the room. I ask her if she wants me to get out to clean the floors. She tells me that I don't' have to leave that she can go around me. Or else they say sure and I leave and sit in the hallway. If I was busy with something they would just come in and wouldn't come back another time. But it wouldn't bother me. (Betty, Line 162-166)

The female respondent lived in the personal care home for a number of years and seems accustomed to the facility routine. While Harold an 82-year-old male resident in a semi-private room prefers to leave his room while housekeeping cleans which stems from a lifelong tradition; "I leave when housekeeping come in to clean the room. I get out. I did the same thing with my wife (Laughs)" (Harold, Line 120-121).

Nancy one of the female residents reflected on her experience with housekeeping staff at the alternate facility, "it didn't matter they just came in. I just ignored them. They could talk to you more. About anything and use their manners. Please and thank you is not something they use" (Nancy, Line 161-165). The relationship staff members have with the residents really impact whether housekeeping duties are considered an intrusion.

physician visits.

According to seven of the residents four male and three female the Physician visits infrequently but was available on request. When the Physician visits a resident it

usually occurs in their room. All of the residents including those in shared accommodation feel that their privacy was respected. Anne a 77-year-old female resident residing in a four-person wardroom shared her experience with the Physician.

> The Doctor has come to see me once in my room. I had to go on the bed and take my top down. She checked me and everything. The other day the man Doctor came to check my heart. I also had to take my clothes off. It's private because my roommate doesn't hear much. They also pull the curtain all around my bed it's for privacy. I like the privacy when they come. (Anne, Line 136-139)

Betty another 73-year-old female resident in a semi-private room discusses the process for accessing the Physician.

> Well, they don't see me on a regular basis unless I have a complaint. My Doctor is a female. If I want to see her I let the staff know ahead of time and on the day she comes in she sees me. She comes down to my room and we discuss whatever it is. It's fine. (Betty, Line 157-159)

Similarly Richard a 64-year-old male resident in a semi-private room discusses his level of privacy when seeing the Physician; "The Doctor comes in the room. I don't pull the curtain because my roommate is never in the room. She checks my breathing and my heart" (Richard, Line 110-111). Harold one of the male residents age 82 expressed that other allied health professionals use the resident's room as a private venue to discuss health issues.

> I saw the doctor in the room. I also saw the Dietician who said I was underweight and then the Therapist, the Occupational Therapist in my room to check my leg. I want to do things myself or I will never get better. I don't care if he's (roommate) is in the room. I actually don't think he was there. (Harold, Line 110-111)

Nancy a 58-year-old female resident shares that on occasion the Physician meets with her at the nurses' station, which was a more open location, "in my room. At the office sometimes at the nurses station. I didn't see the Doctor much. It was open at the nurses'

station which was ok" (Nancy, Line 55-56). Although the residents did not find Physician visits problematic in a shared room there was limited auditory privacy and questions should be raised about protection for personal health information.

night rounds.

Only one male resident Andy age 59 discusses nightly rounds completed by nursing staff as an interruption.

> Privacy here is ok. I have nothing to complain about except that I can't lock my door at night because there is security that has to come and check up on me at certain times of the night. The door has to be unlocked at all times. (Andy, Line 82-84)

The resident viewed the staff nightly checks as a disturbance to his privacy.

speaking other languages.

Staff speaking other languages was not a primary concern by all the residents. It was interesting to note the experience of Nancy a 58-year-old female resident; "the care workers would talk in Filipino and I didn't like it. I couldn't understand them. I just couldn't understand them" (Nancy, Line 90-94). Staff speaking other languages in the resident room was viewed as an unwelcome annoyance.

practicing religion and spirituality.

The freedom to participate in religious services and meet with clergy was voiced as something important to four of the residents: three female and one male. Two residents in the non-profit faith based facility expressed that they appreciated being able to meet with the onsite clergy. A 58-year-old female resident Nancy shared "Yes, It's good. I have talked to the minister here and she was quite nice. I talk in her office" (Nancy, Line 97). Another female resident Anne age 77 discussed spiritual care.

> There is a pastor lady here. We have a memorial service for Remembrance Day. She sings and speaks. She offered to come and see me privately. On Sunday I watch mass on the television then go to the service here. The service is not much different. (Anne, Line 94-96)

It was interesting to note that both residents mentioned that they were able to meet privately with the chaplain in her office.

The two other residents in the larger proprietary personal care homes brought up that they were able to pray comfortably in their rooms. A male resident Richard age 64 in a private room with a shared bath communicated how he experienced spirituality in the home:

> Well, I was born Roman Catholic but I'm not a strong Roman Catholic. If I have to pray I just pray lying in bed when I'm lying around thinking about stuff. It's no problem. (Richard, Line 59-60)

Betty a female resident age 73 in another proprietary facility had a similar message about her freedom to practice her faith; "We have absolute freedom for that. I have a bible and we have a weekly service for different people Catholic or Protestant. I have no concerns" (Betty, Line 82-83). The literature review highlights that residents express a need for privacy for prayer and spiritual worship during end of life care (Choi, Ransom & Wyllie, 2008; and Rigby, Payne & Froggatt, 2010). The need to participate in spiritual worship was supported on an ongoing basis by all of the personal care homes through optional church services for residents and access to clergy. No concerns were expressed by any of the residents regarding their ability to freely and privately practice their religious or spiritual beliefs.

Roommate Interactions

Although the general consensus among the residents was positive in regards to having a roommate, occasional conflicts with roommates were identified.

The residents who reside or had resided in semi-private room accommodations or wardroom had many positive things to share about their experiences: benefits of having a quiet roommate, friendship and being able to advocate for one another. Although the general consensus among the residents was positive in regards to having a roommate occasional conflicts with roommates came up in regards to language barriers, disruptions, roommates walking in front of the television, fear of aggression and auditory interruptions due to a lack of physical dividers in rooms. Most of the concerns regarding co-residents derived from cognitively impaired residents wandering into the wrong room or demonstrations of disruptive behavior.

Two female residents discussed the benefits of having a quiet roommate. Nancy a 58-year-old female resident shared an experience she had while placed on an interim basis in a semi-private room.

> No, not really unless I pulled the curtain between me and my roommate. She was in bed all the time. She couldn't understand anything if she heard something. She was there a lot longer. And she didn't speak English. She spoke Argentina I think. (Nancy, Line 107-108)

While Anne a 77 year old female resident in a wardroom enjoyed her room placement and interactions with her roommates.

> I have privacy. Nobody bothers me. My roommates are very nice and quiet people. They are in there nineties. They have very nice families. Their families come to visit and always ask me how I am and how I'm feeling. They always talk to me. (Anne, Line 77-79)

Not only did the resident appreciate how quiet and "nice" her roommate was she also enjoyed the interactions she shared with their families. The resident had an improved self-esteem and sense of community because of the relationships she developed with her roommate and their family.

Betty another female residents age 73 shared a very strong connection and friendship with her roommate and her family which continued when the resident moved into a private accommodation.

> When I first came here my roommate was just wonderful; a really nice lady. Her daughter and three grandsons came almost every day and I got very friendly with them. It was kind of amusing because the one young man would come in at seven pm and I would wheel into the hallway and he knew I would want to go outside and have a cigarette so he would take me outside first then come back to visit. He was just wonderful. (Betty, Line 28-32)

The friendship fostered between the two residents was very strong and mutually beneficial. Residing in a shared accommodation for a number of residents meant increased social interactions between the resident and their roommate's family members. As sighted by Kovach and Robinson (1996) in the literature review having a roommate increases potential for conversation and social interaction. Residents with visual, hearing or cognitive deficits were faced with barriers to communicating with their roommates. Residents found language barriers to be a significant barrier for communication and bonding with roommates.

Two residents from different personal care homes shared a mutual concern for their roommate's wellbeing and safety. Nancy a 58-year-old female resident shared an experience she had while in a semi-private room where her roommate was injured during a mechanical lift transfer; "no, but she was dropped from a Hoyer and I couldn't trust

them after that. I figure if you drop someone out of a Hoyer lift you shouldn't be doing it" (Nancy, Line 65-66). The incident her roommate had with the staff during a Hoyer lift transfer created concern for her roommate and distrust towards the staff. Don a 73-year-old male resident shares a past experience in a semi-private room where he advocated for his then roommate.

> A private room is much better. My roommate was on the other side by the window and every 20 minutes he would get up to go to the bathroom. And he always was falling; falling in the bathroom. I could hear him hit the floor and I would push the button and call somebody for help. Yeah I worried about him. I knew something would happen if he didn't take his walker. I worried. It started getting to me. I see it happen with other people out there and I keep waiting. Don't fall. (Don, Line 41-46)

Petronio & Kovach (1997) found respondents verbalize an increase sense of security knowing that a roommate was in the room. However concerns for the roommates care created undo stress and eroded the relationship. For the male resident in the study the sense of responsibility for his roommate became a burden and he was moved into a private room.

Disruptive behavior of roommates was cited as an annoyance in shared accommodations. The primary concerns cited confusion, disruption and theft. A 73-year-old female respondent Betty reflected on past roommate's behavior, which was considered disruptive, "Well, I had a lady roommate who would have hallucinations and she would think her kids were stuck somewhere or thought people had taken them somewhere and she would yell about it all the time" (Betty, Line 123-125). The experience was unsettling for the resident. The same female resident had another negative experience with a different roommate who exhibited wandering behavior with hoarding tendencies.

> Then I had another roommate she used to follow the nurses around when they gave the pills and she would take things. She would take things off my dresser. I asked her about it and she said she didn't take anything. But when she left the room I would wheel over and sure enough the missing things were there on her side of the room. It made me feel very annoyed. (Betty, Line 127-131)

Based on the experiences of the residents a positive match or connection between roommates was extremely important.

Variations from the Literature Review

Studies in the literature review addressed a number of topics that were not referenced by the residents in the research project including concerns regarding the spread of infection, privacy during palliative care and the impact of policy and administration (Barnes 2002), (Calkins & Cassella, 2007) & (Rigby, Payne & Froggatt, 2010).

Calkins and Cassella (2007) found that from a clinical perspective the spread of infection was higher for residents who shared rooms. There was no mention of the spread of infection between roommates in shared accommodation as being a concern by the residents.

The literature review examined privacy during the provision of palliative care. Rigby, Payne and Froggatt (2010) report that during end of life care for residents family members and staff generally prefer a private room as there was increased privacy, fewer disruptions by staff and co-residents and opportunity to pursue one's own interests without worrying about disrupting roommates. The residents did not raise any concerns regarding the provision of privacy during end of life care for themselves or their roommates in semi-private or private accommodation; this may be due to the residents not personally experiencing a roommate's death.

Although the residents in the research study did not reference the impact of policy and administration on privacy the previous research did raise a number of valuable points to consider. The literature recommends that personal care homes develop a resident's bill of rights, which set care standards for privacy, dignity and confidentiality for residents which were identified as important quality of life issues for the residents in the current research project (De Veer & Kerkstra, 2001; Hughes, 2004).

Ecosystems Perspective

The ecosystems perspective was useful when evaluating the residents' experiences as it provided a framework that focused on residents and their interactions. The ecosystems perspective was useful as a lens to determine themes related to resident fit with their environment, adaptation, stressors and supports. The ecosystems perspective was used during the case study research to provide a framework in understanding the experiences reported by the residents' particularly in regards to their adjustment, control and functioning within their physical and social environment at the family and community personal care home level. It was evident during the research that the expectations and demands of the residents change due to their health care needs. The residents were very appreciative of the resources and services provided by the personal care homes to meet their physical care needs.

The residents who had open systems and flow of resources adapted and had a positive adjustment to the facility. The residents developed new routines and had a positive outlook on receiving care, welcomed staff support and opportunities for interaction with staff and co-residents. The expectations and norms changed for the younger senior residents as they adapted to the physical and social environment as their

length of stay at the facility progressed. Rudkin (2003) premise for the principle of adaptation for residents and their ability to respond to evolving demands in their environment and adapt to new norms, values, priorities and goals. Residents who fostered positive relationship with staff, co-residents and family members had increased supports and more positive fit with their social and physical environment.

The evaluation and discussion chapter discussed in detail the primary themes and subthemes of the study: safety and security; communication; decorating; staff interactions; practicing religion and spirituality; and interactions with roommates. Following discussion of the themes and sub-themes the chapter explored limitations in the findings in the study as compared to the literature. The chapter ended by providing a discussion of how the ecosystems perspective provided a lens for analysis of the resident responses.

Recommendations 6.

The recommendations chapter discusses important observations and suggestions for personal care home administration, government and facility designers: resident access to locks; specialized units for cognitively impaired residents; private health assessments rooms; phasing out multi-bed rooms; use of room barriers; privacy for intimacy; increased private lounges for visiting; and private rooms with common telephones.

The literature suggests privacy is essential for overall well-being of residents in PCH's. The findings of this study provided a more thorough understanding of privacy and well-being of residents of PCH's in Winnipeg. The findings may assist facilitators,

regional policy makers, planners, and institutional designers in their consideration of privacy as a factor in resident well-being.

The ecosystems perspective was helpful in interpreting the case studies on privacy in personal care homes. The ecosystems perspective considered the process of aging over time and took into account how residents and communities functioned within their environment. The approach was helpful in determining how older adults and residents may be supported to achieve their best fit, reduce stress, improved coping and adjustment to the physical and social environment in which they reside.

Several consistent themes emerged from the experiences of the residents in the research study. Personal care home administration and government regulating bodies should consider the following recommendations: resident access to locks; specialized units for cognitively impaired residents; private health assessment rooms; phasing out multi-bed room; use of room barriers and privacy for intimacy; increased private lounges for visiting; and private common telephone.

Resident Access to Locks

Residents' rooms were seen as personal and public space. The literature review clearly showed that personal belongings frequently went missing in personal care homes as they were misplaced, moved by roommates or taken by wandering co-residents (De Veer & Kerkstra, 2001). Petronio and Kovach (1997) report that items typically go missing at a higher rate when residents occupy shared accommodations creating conflict between roommates. According to Le Low, Lee & Chan (2006) having access to a lockable cupboard to store private belongings and valuables was important to residents. The resident's experiences support the findings in the literature review that having access

to a locked cabinet or being able to lock the resident room would be appreciated. Being able to protect personal belongings was considered valuable especially in a semi-private or shared room as it was a resource that provides security and control for residents over their environment. However, it is important to consider the safety of residents. If residents were provided with the ability to lock their door staff should have a master key or a way of entering the room in an emergency situation will be required.

Specialized Units for Cognitively Impaired Residents

A consistent theme during the research study was the disruption and concern over cognitively impaired residents wrongfully entering resident rooms. Depending on the number of cognitively impaired residents placed at a given facility with advanced wandering behavioral it may be beneficial to have a specialized care area to preserve the privacy of cognitively well residents. Alternatively personal care homes could offer specialized units for cognitively well residents to provide increased privacy and promote ownership over resident's personal space. Offering specialized areas would reduce disruptions, fear, anxiety and potential for accidental theft and foster personal relationships.

Private Health Assessment Rooms

Residents were able to meet with health care professionals, physician and allied health staff in their rooms with the curtains or the door closed. It would be beneficial for personal care homes to designate a special room for assessment purposes that would offer privacy in personal care homes that have semi-private or shared wardroom accommodations. The privacy curtains in shared or semi-private accommodations did not offer enough auditory privacy to ensure personal health information was private and

confidential. In any new facility construction a private assessment room should be considered.

Phasing out Multi-bed Rooms

Given the experiences of the residents' multi-person four bed rooms should be phased out in personal care home settings as they impact the amount of privacy for personal care, family communication and ownership over one's personal space. Many of the residents shared positive experiences about having a roommate in a semi-private room however a four person room greatly impacts the likelihood of a positive person and environment fit for older adults.

Use of Room Barriers

All of the personal care homes with semi-private or multi-beds offered privacy curtains as a means of increasing privacy for residents. The residents appreciated the curtain barriers as it provided increased visual privacy particularly during care. However the curtain barriers did not provide any auditory privacy, which was disruptive during family visits and the provision of care. It is recommended that personal care homes consider replacing privacy curtains with a more permanent physical barrier such as a partial wall or solid divider to increase privacy.

Intimacy

The environment in personal care homes was usually not designed to recognize the intimacy or sexual needs of residents. Many barriers impact sexual expression in personal care homes: lack of privacy, shared accommodations, institutional atmosphere, small single beds and disruptions from care providers (Lemieux, 2004) and (Hughes, 2004). The experience of the residents supports the previous literature. There was a

definite need for personal care homes to provide elderly residents who wish to engage in sexual activities with space and privacy. Additional space and privacy may be afforded to residents with the provision of private rooms, physical wall barriers in shared accommodations, increased access to private lounges for visiting and room locks.

Increased Private Lounges for Visiting

The residents residing in shared accommodations that had regular family visits expressed a concern they did not have enough space or auditory privacy for visiting. Although all of the participating personal care homes offer lounges for visiting with loved ones the rooms are frequently used or reserved by other families or the facility for meetings and programs. Facilities need to provide increased access to private family lounges for residents especially in personal care homes that have semi-private or multi-bed rooms.

Private Common Telephone

Although all of the participating personal care homes permit residents to have a personal telephone in their room not all residents choose to have one due to financial limitations, waiting for a private room or due to infrequent use. All of the personal care homes permit residents to use the telephone at the nursing station or front office as required. A number of the resident's stated the space was too public and that calls were monitored or overheard. It would be beneficial for personal care homes to offer a phone for resident access in a private area.

The recommendations chapter discussed important observations and suggestions for personal care home administration, government and facility designers. Areas for consideration included resident access to locks; specialized units for cognitively impaired

residents; private health assessments rooms; phasing out multi-bed rooms; use of room barriers; privacy for intimacy; increased private lounges for visiting; and private rooms with common telephones.

Conclusion 7.

The chapter discusses the importance of privacy as a topic for research. The chapter goes on to discuss the limitations and benefits of the research project followed by the unexpected findings for the researcher. The chapter ends by discussing the contributions the research makes to social workers, social work students and students in health disciplines.

The privacy of residents living in personal care homes was an important issue that requires more public attention. Privacy is a vital and important basic right of all human beings regardless of age. To improve the well-being of older adults' residing in personal care homes settings we need to promote increased privacy for residents. Personal care homes should function as homes that maintain individuality and promote quality of life for older adults with health issues. Relationships should be encouraged and the personal care homes should provide residents with privacy for intimacy so innate and deep human needs can be met.

The residents in this study expressed no concerns about the provision of privacy during personal care. Continued facility improvements need to be made in matching roommates with residents that are compatible to reduce conflict and increase the likelihood of positive social connections. Personal care homes must also increase the opportunities for access to private visiting rooms. It was evident that quality of life for residents was very important in the Winnipeg Region, personal care homes and the

government bodies need to maintain their success and continue to allocate additional resources to make further improvements to personal care homes. It was beneficial for the health region to implement a more effective strategy for placing cognitively impaired residents.

Limitations of Research

Given the vulnerability of the sample population it was possible that the resident's story may not reflect their true reality; the residents may feel unsafe sharing their true opinions due to a concern of upsetting staff or their families or fear of the facility withholding care.

The study was limited in applying the findings to larger populations, as only a small sample of residents has been included in the case sample. Results from the study were difficult to generalize to larger populations of personal care homes, as the sample group does not represent residents who are cognitively impaired or who are not fluent in English.

It is important to note that the sample was unique compared to typical personal care home facilities as three of the residents were under 65; five of the participants were males, two of the residents were of first nations cultural background and all of the residents were considered cognitively well based on the RAI-MDS 2.0 Cognitive Performance Scale. Although the research has value the sample population was representative of most personal care home resident populations in Winnipeg, Manitoba.

The variations of living arrangements of residents in the study were primarily made up of residents residing in shared accommodation or private rooms with shared bathrooms. Only one resident participant resided in a private room with a private

bathroom; for that reason the impact of room accommodation was not referenced more. Variations of how the room type impacts resident experiences of privacy would have been clearer if more resident participants had resided in a private room with a private bathroom.

Benefits of Research

There were many benefits to completing the research project on privacy in personal care homes. Privacy in personal care homes was an important social and environmental issue which Manitoba Health and the Winnipeg Regional Health Authority examine under the standards assessment tool when auditing personal care homes as seen in the Resident Bill of Rights section (Manitoba Health, 2014). Findings from the research may benefit personal care homes in tailoring their physical environment and programming. The information discovered from the case studies was of interest to social workers in personal care homes as it will potentially assist in preparing residents for adjustment to the personal care home following admission. Overall the research project will provide insight and valuable information on how older adults in personal care homes experience privacy.

Unexpected Findings for the Researcher

During the research and analysis of the resident interviews there were a number of unexpected findings: Residents did not report concerns about auditory privacy during physician medical assessments in shared accommodations. Given the emphasis on the protection of personal health information it was surprising that the residents did not express a concern that roommates and visitors could hear the discussion they have with the physician during medical visits. Residents did not report any concerns regarding the

level of privacy provided to them during personal care particularly bathing, dressing, grooming and toileting. It was surprising that the residents felt enough privacy was offered to them during personal care in semi-private and shared rooms by using a curtain barrier. Residents reported strong ties and relationship with roommates, co-residents and family members of other residents. It was an unexpected finding to learn their were such strong community relationships in the personal care homes.

Contribution to Social Work and Social Work Education

The research directly benefits the social work profession particularly students with an interest in health or professionals practicing in personal care homes settings. Long term care is an important area of employment for Social workers and a growing field as our population ages and places increase demand for service. Privacy is an important and dimensional concept-affecting resident in health settings. Manitoba Health values privacy and all health personal care homes should strive to accommodate residents' needs for physical and social privacy. If wocial workers are fully informed regarding privacy issues and residents preferences they may better advocate for policy and system change. Privacy should be given attention in health and aging curriculums; particularly the four dimensions of privacy: physical privacy for the body and one's space; psychological privacy for maintaining one's sense of self, identity and feeling of control; and social privacy for visiting and privacy of information (Akpan, 2006; De Veer & Kerkstra, 2001; Hughes, 2004; Petronio & Kovach, 1997; Webster & Bryan, 2009; Le Low, Lee & Chan, 2006).

A lack of privacy for residents in personal care homes settings creates emotional stressors and negatively effects well-being and adjustment within their home setting.

Many residents in personal care homes are affected by multiple illnesses and are generally considered to be frail and more vulnerable thus requiring increased social work intervention and advocacy. Social work plays a very active role in protecting the rights of residents in personal care setting to promote use of resources, goodness of fit and overall well-being.

Social workers need to become aware of the social and physical needs of seniors and how best to meet them. The research assists social workers in becoming more aware of potential breakdowns in the system in which older adults person and environment fit may become dysfunctional. Social workers are considered front line management and are in a position of influence to model positive and respectful interactions for staff; guide and impact facility policy to improve care and service delivery. The information reported from the case study research may be useful in assisting residents to prepare for adjustment to a personal care home following admission.

Social work students, other health disciplines and practitioners need to be aware of three important principles for applied practice. The benefit of residents decorating their room habitat to improve ownership over the space and attachment to the facility. Importance of residents having access to a lockable cupboard or being able to lock their room to protect important personal items and increase their control and security. Recognize the sense of community that develops amongst residents and family members through interactions among roommates, in facility lounges, over meals and recreation programs and the supports, resources, and accept norms that develop as a result of the community relationships. Overall the research project will provide insight and valuable information on how older adults in personal care homes experience privacy.

The chapter highlighted the importance of privacy as a topic for research. The chapter went on to review the limitations and benefits for the research project followed by the unexpected findings of the researcher. The chapter ended by exploring the contributions the research made to social workers, social work students and students in health disciplines.

"Where experience is the master, the scholar is made to know the value of years, and respects them accordingly." James Fenimore Cooper

Appendix A: Resident Interview Semi-Structured Research Questions

Capacity Information:

1. Do you know the name the building we are in?
2. How long have you resided at this home?
3. Do you know what this study is about?

Background Information:

1. Resident information:
2. Age
3. Gender
4. Health Issues
5. Cultural background
6. Length of stay
7. English first of second language
8. Type of room resident resides in private, semi-private or wardroom? Have you lived in any other style of room while at this facility? Contrast the differences?

Environmental:

1. Can you tell me about living at the personal care home compare to where you used to live in the past?
2. What has been your experience living in a (private, semi-private, ward room)?
3. Have you ever lived in a shared accommodation in your life time prior to living in this facility?
4. Would you prefer to be in a shared room or private room? Why?
5. Explain to me what kind of items you are allowed to bring into your room?
6. Can you tell me about how the climate (temperature, lights, door) is controlled in your room? How are decisions made about temperature, lighting, door closed/open made?

Privacy:

1. Can you tell me about privacy at the personal care home and what would you change?
2. Are you ever concerned that people can hear or see you when you wish to be alone?
3. Can you tell me about what it's like to practice your religion or spiritual needs?

Social Interactions:

1. Can you tell me about what it's like to visit with friends and family at the personal care home?
2. What is your relationship like with your roommate?
3. If you wanted to be intimate with a partner or spouse do you feel as though you have a place to be together?
4. Can you tell me about what it's like to watch television in your room?
5. Can you tell me about what it's like to use the telephone in your room?

Personal Care:

1. Can you tell me about what it's like to have your bath or shower?
2. Can you tell me about what its like during personal care (bath, washroom use, changing)?
3. Can you tell me about what it's like when you see the Physician?
4. What impact does the staff have on your privacy (nursing, housekeeping, etc)?

Probes (For above questions if required):

1. Can you tell me a bit more about the last time you experienced that or felt that way?
2. Can you give me a specific example of that?
3. Do you personally feel that way?
4. Is that something you have experienced?
5. Can you tell me more?
6. Can you expand on your answer?
7. Can you explain your answer?

Wrap up Questions:

1. Do you have anything to add?
2. Is there anything I should have asked?

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