

THE LIFE SATISFACTION
OF THE ELDERLY HOSPITALIZED PATIENT
WAITING TO MOVE TO A NURSING HOME

A PRACTICUM REPORT
SUBMITTED TO
THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS
FOR THE DEGREE
MASTER OF SOCIAL WORK

BY

JUDITH ELIZABETH AHRENS-TOWNSEND

JULY 23, 1990

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PATIENT WAITING TO MOVE TO A NURSING HOME

BY

JUDITH ELIZABETH AHRENS-TOWNSEND

A practicum submitted to the Faculty of Graduate Studies
of the University of Manitoba in partial fulfillment of the
requirements of the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

Elderly people who are waiting to move to a personal care home may wait for a considerable length of time on an Acute or a Geriatric ward in the hospital. An investigation was undertaken, using interviews with 36 hospitalized patients waiting for placement in a personal care home and with 6 key informants, to determine the patients' life satisfaction. The research question that was investigated was whether patients on the Geriatric wards would have higher overall life satisfaction scores than patients on the Acute wards as measured by the Andrews and Withey (1976) Quality of Life Terrible-Delightful scale. The hypothesis that was tested was that life satisfaction would be correlated with those items involving relationships and social interaction, namely, family relations, friendships, recreation and living partner. Findings indicate that people are equally satisfied on both types of wards and that their level of life satisfaction increased with length of time in the hospital. Findings also indicate that patients on the Geriatric Medicine service are more satisfied with their family relations and with the hospital environment than the patients on the Acute service. The data indicate that self-esteem was the most strongly correlated with life satisfaction followed by health, living environment, recreation and finances. Implications for policy, program and practice development for meeting this population's psycho-social needs is discussed. First, settling into an

acute medical setting and adopting a 'sick role' can likely be avoided by emphasizing and providing opportunities for socialization and interaction and by quicker movement out of this setting. As well, perhaps the focus needs to be on the internal adjustment and grieving process that the patient may experience related to health and social changes. Second, self-esteem can likely be improved by allowing increased decision-making and control when possible, and by assisting and encouraging patients to engage in the activities that are meaningful to them through increased individualization. Third, maintaining relationships (ie. family, friends, staff) can likely best be achieved by grouping panelled patients together and addressing this issue at a program level, especially on the Acute service.

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INTRODUCTION

The life satisfaction of elderly hospitalized people awaiting nursing home placement requires attention. Hospitalized chronically ill elderly people have unique psycho-social needs that must be addressed to maintain their life satisfaction. Life satisfaction is defined as the individual's well-being or happiness. While elderly hospitalized patients wait to move to a nursing home, their medical status within the health care system should not exclude them from receiving services and benefits from programs and policies that will maintain their level of life satisfaction. The importance of life satisfaction for this group should not be minimized nor should it be regarded as secondary or unrelated to their health care needs. Rather, their psycho-social well-being and happiness must be seriously considered and addressed since a lengthy period of time is spent on the hospital wards. The hospital becomes their home for this period of time and it is essential that attention be paid to these issues.

This study investigated the life satisfaction of "panelled patients" at the St. Boniface General Hospital, that is hospitalized patients awaiting nursing home placement. The study took a social needs assessment approach and focussed particularly on issues of life satisfaction for this group

(Neuber, 1980). The study results may be generalized to other St. Boniface General Hospital panelled patients who are not cognitively impaired.

The aim of this study was to provide useful information for program and policy development for the future of long term care of the hospitalized panelled elderly patient.

My own learning objectives were two-fold. The first was to gain experience in designing and implementing, from start to completion, a social needs assessment. The second was to expand my knowledge and understanding of the health care of the elderly, particularly as it relates to their life satisfaction.

This practicum report is divided into six chapters. Chapter I reviews the literature on life satisfaction. Chapter II describes the design of the practicum. The patient and key informant results are presented in Chapter III and Chapter IV respectively. Chapter V contains the implications of the findings and Chapter VI contains an evaluation of the practicum process and a conclusion.

CHAPTER I
LITERATURE REVIEW

LIFE SATISFACTION

In a society where the medical model of health care is based on medicine, cures, physicians and institutionalization (Harrington et al, 1985), there is a great need to place an emphasis on the psycho-social aspects of a person's life. The elderly may indeed have increased medical needs. However, for many elderly persons, such factors as social activity and interaction, as well as relationships, may be of equal importance as health status. Often health care settings focus on medical expertise and sophisticated equipment, but fail to incorporate the social and emotional aspects of living. It is for these reasons that greater attention to life satisfaction for elderly persons and the factors linked to its provision is required.

Life Satisfaction As A Subjective Concept

Life satisfaction refers to "the individual's appraisal of life past and present" (Chappell, Strain, Blandford, 1986, p.40). It is a subjective view of one's own life and happiness. It is considered among gerontologists as "a useful indicator of adjustments and successful aging" (James et al, 1986, p.648). Other terms associated with life satisfaction are "quality of life", "happiness", "positive view of life", "morale", and "well-being". Many studies on

the topic of life satisfaction have focused on "what leads people to evaluate their lives in positive terms" (Diener, 1984, p.543) and have concluded that life satisfaction "relies on the standards of the respondent to determine what is the good life" (Diener, 1984, p.543).

The Multiple Discrepancies Theory

The Multiple Discrepancies Theory of life satisfaction (Michalos, 1985) suggests that satisfaction is a function of perceived gaps between what one has and what:

- one wants;
- relevant others have;
- the best one has had in the past;
- one is expected to have had in the past;
- one expects to have in the future;
- one deserves;
- one needs.

This implies that life satisfaction is associated with the individual's perceptions of his/her needs, wants and expectations, as well as comparisons with oneself, norms, standards and other reference groups. This suggests that although people have their own differences and perceptions, there is also much similarity and uniformity amongst each other. As the gap closes between what one has and one needs, wants and expects, satisfaction increases for the individual.

LITERATURE ON THE LIFE SATISFACTION OF THE ELDERLY

Studies on life satisfaction have attempted to identify what factors can be linked to life satisfaction of the elderly. Associated with higher overall life satisfaction are satisfaction with social activity and interaction (Grant & Chappell, 1983; Graney, 1975; Markides & Martin, 1979; Tobin & Neugarten, 1961; Conner et al, 1979; Aging in Manitoba, 1973; Smith & Lipman, 1972), companionship and social supports (Chappell & Badger, 1989; Bowling et al, 1989), social integration (Liang et al, 1980), higher levels of role involvement (Elliott & Barris, 1984) family and friends (Aging in Manitoba, 1973), perceived health status (Grant & Chappell, 1983; Wolk & Telleen, 1976; Markides & Martin, 1979; Gfellner, 1989), higher functional status (Osberg et al, 1987), housing (Wolk & Telleen, 1976), environment (Lawton et al, 1978), person-environment congruence (Nehrke et al, 1984), lower levels of economical and social-psychological constraint and increased opportunities for self-determination (Vallerand, 1989; Smith & Lipman, 1972; Wolk & Telleen, 1976).

Activity, Interaction and Relationships

Some of the consistently most important elements involved in the life satisfaction of the aged are social interaction, activity level and relationships with family and friends. Some studies have focussed solely on activity levels (Graney, 1975; Markides & Martin, 1979; Tobin & Neugarten,

1961; Smith & Lipman; Grant & Chappell, 1983) and others on the quality of the interaction and degree of companionship with others (Bowling et al, 1989; Conner et al, 1979; Liang et al, 1980; Chappell & Badger, 1989) as important for higher life satisfaction levels. Health is considered of primary importance for maintaining one's level of activity and subsequently ones' quality of life.

The relationship between life satisfaction and social interaction in the aging was investigated by Tobin and Neugarten (1961). Their study tested the hypothesis implicit in the disengagement theory "that there is a positive relationship between disengagement and psychological well-being in the aged" (p. 344). The study sample consisted of people fifty years of age and over who were living in the community and who were relatively well. Their results found that for this group social interaction was positively related to life satisfaction in the elderly and that this association increased with age. This supports a theory of engagement with aging (p.346) and the need for increased opportunities for social interaction.

The relationship between happiness and social participation in aging was also investigated by Graney (1975) in a longitudinal study of women aged 62 to 89 years who were living in the community and who were in good health. Their levels of activity were reported in nine measures of social

participation. The results confirmed what was found in other previous studies that "happiness and social activity were directly related" (p. 703).

A study by Markides and Martin (1979) considered a causal model of life satisfaction among the elderly. It too used a community based sample of seniors aged sixty years and over. Life satisfaction was measured using the Life Satisfaction Index (LSI) (Neugarten et al, 1961). Self reports of health and measures of socioeconomic status and formal and informal activity levels were used. The results demonstrated that both activity levels and self-reported health were strong predictors of life satisfaction. Although health was found directly to influence life satisfaction it also had an indirect influence on it by "permitting or preventing individuals from engaging in essential life satisfying activities" (p.91). This points to health as the primary factor with activity as a secondary factor influencing life satisfaction in the elderly.

Some investigators have focussed on the quality of the interpersonal relationships (Conner et al, 1979; Liang et al, 1980) and the presence of a confidant or other meaningful significant other (Chappell & Badger, 1989; Bowling et al, 1989), rather than solely on the frequency of interaction and activity. None of the subjects were institutionalized in these studies. The results indicated

that the number of interactions were not always important for life satisfaction. Rather the quality and meaning of the relationship and the presence of someone who could be confided in were the most crucial factors for well being.

In the extensive ten volume study entitled Aging in Manitoba: Needs and Resources (1973), life satisfaction and its correlates for both community and institutional elders were investigated. The findings indicate that only 43.2% of the elderly in facilities (ie. hostels, nursing homes, mental and extended care hospitals) have good or excellent life satisfaction, as measured by the Life Satisfaction Inventory-A (LSI-A) (Neugarten et al, 1961). The findings conclude that increased happiness would be found for this group:

- "- by being closer to family or friends (30.5%);
- through more opportunity to do what they enjoy (24.2%);
- through more participation with others (21.5%);
- through opportunities for participation in their own language (10.6%);
- through opportunities for volunteer work or employment (5.0%)" (Thompson and Havens, 1974, p. 7).

These results emphasize the importance of both the relationship with family and friends, and the opportunity

for meaningful social activity and interaction for increased life satisfaction.

Effects of Institutionalization

Other studies have focused on the effects of institutionalization on the elderly, particularly in acute care hospital wards. Findings suggest that there are frequently iatrogenic effects for these people such as falls (McArdle et al, 1975; Gillick et al, 1982), infections (McArdle et al, 1975), eating problems, increased incontinence and confusion (Gillick et al, 1982), and drug complications and interactions (Steel et al, 1981). As well, health care professionals recognize that those waiting on acute care wards can become neglected and depressed (Globe and Mail, 1987). In general, the literature suggests that hospital life for extended periods contributes to social and physical deterioration in the elderly especially for those living on an acute care ward.

THE SICK ROLE

In order to further understand the psycho-social issues associated with the chronically ill elderly it is necessary to examine the 'sick role' concept.

The sick role was first conceptualized by Talcott Parsons (1951). Sickness was recognized in terms of its social role. The model included four role expectations for the sick

person relative to the sick role (Parsons, 1951, pp. 436-437). The first is "the exemptions from normal social role responsibilities" which is both a right and an obligation of a sick person. The second role expectation is the sick person is exempt from responsibility for the illness and therefore must "be taken care of" in order to recover. The third views illness as being undesirable with an obligation of the patient to get well as quickly as possible. The fourth expectation is for the person to accept help from and cooperate with medical persons in order to allow oneself to get better. The sick role defines the sick person as being helpless and in need of help by health care professionals in order to cure oneself of illnesses which are beyond one's control or ability to deal with (pp. 440-441). The dependency associated with the sick role, although viewed as undesirable, is also viewed as a necessary step for recovering and moving out of the illness.

Researchers have pointed out that Parson's model applies to those who are acutely ill rather than chronically ill and needs to be modified to reflect this. For the chronically ill there is no expectation of nor working towards getting better and moving out of the sick role. It is not a temporary state for this group but rather a new permanent role that requires adjustment to. Words like 'chronic' and 'illness' are often associated with hopelessness and helplessness. Those who have chronic illnesses are often

"allowed to play the sick role and be excused from social obligations" (Lipman & Sterne, 1969, p. 197).

For the aged, dependence has been socially legitimized and reinforced in various ways such as through mandatory retirement, Old Age Security and methods of responding to chronic conditions (Lipman & Sterne, 1969). For those who have been accustomed to independence in previous years this ascribed role can produce feelings of low morale, failure, degradation and frustration (Lipman & Sterne, 1969). A study by Petroni (1969) found that older people perceived more right to the sick role than younger people and that "respondents perceived more legitimacy to the sick role for chronic than for acute illnesses" (p. 180).

The emotional responses for patients entering into the role of chronic illness can be that of mourning and depression (Callahan et al, 1966). The sick role responses can manifest themselves in the following manner according to Callahan et al (1966). There may, at first, be a preoccupation with oneself and one's physical illnesses which may be accepted and reinforced by both the patient and the people around him/her. Second, there may be a reduction of interest towards outside everyday events, including that of friends and family. Third, the patient may react with a certain degree of emotional dependence related to "the physical dependence forced upon him by the illness itself" (p. 888).

This may be reinforced by the nurturing and caretaking roles played by the hospital staff. The fourth reaction may be a hypochondriacal behavior. These reactions depend largely on the kind of person the patient was prior to the illness and whether or not the patient is willing and able to make the necessary adjustments in using the non-sick parts in gaining control. Other sick role reactions may include denial and lack of cooperation with therapy and changes necessary for adjusting to the condition. On the other extreme is total dependence, inactivity and non-participation in physical or social roles.

The healthier reaction is that of mutual participation (Callahan et al, 1966). This model describes the patient as being less dependent and passive and as having more control, while acknowledging the need for assistance with certain items. This role requires the relinquishing of the staff's and family's need for authority and the need that causes them to maintain the patient in the sick role. It may also require interpersonal work with the patient to help deal with the difficulties, changes and feelings associated with the chronic illness. It promotes a gaining of control, by the patient, while letting go of the idea of a cure as is proposed in the original Parsonian model. The new relationship incorporates the patient's psycho-social needs into the health care plan and promotes a balance of meeting

the dependency needs, by family and staff, while stressing the patient's remaining abilities.

In summary, the literature indicates that the elderly have specific needs for maintaining their life satisfaction. Associated with higher life satisfaction are satisfaction with family life, social activity and interaction, companionship and social supports, perceived health status, housing, social integration, environment, less economic and social-psychological constraint, person-environment congruence, higher functional status, and increased role involvement. Most of the studies pertain to elderly people who are relatively well and living in the community. This study provides some new data on how these factors apply to the elderly living in an acute care institution.

The Aging in Manitoba Study (1973) provides a sound model for identifying the needs of the elderly. Although it deals, in part, with life satisfaction for the institutionalized elderly in various settings, it does not single out and deal specifically with the group investigated in this study, that is, panelled, hospitalized patients.

The literature on long term hospitalization of the elderly supports the notion of negative effects of hospitalization for this group but tends to focus on medical issues and physical aspects rather than on the psycho-social needs.

None of the investigations deal specifically with the group being studied in this project.

The notion of the 'sick role' is also an important concept to consider when exploring the psycho-social aspects associated with the chronic care elderly. Often emotional dependence and a removal from social role responsibility is reinforced by society at large and particularly by the health care system when people become ill. Although this may be appropriate for the recovery of the acutely ill it is not so for the chronically ill. A prolonged sick role without hope of recovery can result in depression and low morale because of the losses associated with a changed health status. A healthier response to chronic illness includes assuming greater control, when possible, and accepting a dependency role, when necessary. This adjustment is an essential one for the chronic care patient because it creates a balance between the need for care and assistance and the need for self-determination.

CHAPTER II
PRACTICUM DESIGN

THE CONTEXT

The St. Boniface General Hospital is an 878 bed acute care hospital in Winnipeg, Manitoba with a catchment area of the Province of Manitoba. When an elderly patient is admitted to the St. Boniface hospital, the intent is to provide treatment and the goal is for the patient to return home. Patients are generally admitted for surgical procedures, for investigations and treatment of medical/social problems, or for rehabilitation purposes. Some are admitted to the Medical/Surgical service and others to the Geriatric Medicine service. Admissions occur through the Emergency Department or by referral from a physician or geriatrician and there are specific criteria in place for admission to either service. The criteria will be discussed in detail below.

Manitoba's Continuing Care Program

Those patients who complete or respond well to their treatment are discharged home. Others are not able to return home because they are assessed as no longer being able to manage adequately and safely. These people then apply through the Manitoba Government Continuing Care Program and may be accepted for admission to a nursing home. As part of the application process an assessment determines if the

elderly person can be maintained at home or if nursing home placement is required. If nursing home placement is considered necessary then each case is reviewed by a panel consisting of a geriatrician, a social worker and a nurse. The panel confirms the need for nursing home placement, reviews the level of care required by the patient and explores the possibility of the patient returning to their home with home care services to await placement. This application and acceptance process is referred to as "panelling" and the hospitalized patients, once assessed as requiring a nursing home, are called "panelled patients". The panelling process is the same for people in the community and for people who are hospitalized. Following panelling all approved applications are placed on a central waiting list at the Office of Continuing Care where they wait for a nursing home bed to become available.

The hospitalized panelled patients are no longer in need of acute care in a hospital but are also unable to return home because their needs exceed those which can be met through home care services. Therefore they are 'in limbo' and must remain in hospital. For a variety of reasons the wait can be lengthy (in some cases a couple of years) and the setting in which the individual is waiting may be viewed as being less than desirable in terms of its effect on the elder's life satisfaction.

HOSPITAL WARDS

The waiting period can take place on either Medical/Surgical wards or on Geriatric wards, as both services have beds that are allocated to and funded for panelled patients. The two services are considerably different.

Medical/Surgical Service

The Medical/Surgical service is intended for patients who require specific medical treatment or investigation or who require surgery. The patient can be admitted from outside the hospital or from Emergency by a physician. All patients are admitted with the intent of receiving treatment and returning to their home. Patients sometimes transfer out of this service and into the Geriatric service if they are good rehabilitation candidates and are expected to require a longer stay. However once panelled, it is hospital policy that a patient is generally not transferred off this service and into Geriatric Medicine because they are no longer considered suitable for rehabilitation. As a result, it is here, rather than on a Geriatric ward, that the patient awaits nursing home placement even though their health status may be similar to that of the Geriatric service panelled patient.

The wards are traditional hospital wards and patient turnover tends to be more frequent than on the Geriatric wards. For example in the month of March 1990, 707 admissions

occurred on this service, which consists of approximately 348 beds. This is compared to 31 admissions on Geriatric Medicine which consists of 156 beds (St. Boniface Hospital Statistics Department). Medical/Surgical wards are geared towards the general population and are usually occupied by short stay patients. In 1989, the average length of stay on the Medical service was 16 days. This is compared to an average length of stay on the Geriatric Medicine wards of 142 days and a global average of 8.5 days (1989 Financial Report, Department of Finance, St. Boniface General Hospital). There are few or no lounge areas and patients have their meals in their rooms. There is often no common television and patients are expected to rent a television if they wish, which can become costly for long stay patients. There are no recreational activities available on these wards because it is not required nor is it appropriate for the general population on this service.

The Medical/Surgical service has a total of approximately 348 beds of which a maximum of 28 are funded for panelled patients. When the bed occupancy for the panelled patients on this service is at full or over capacity then these patients are given priority over the Geriatric service panelled patients for moving to a nursing home. Thus the transfer of this group can take place more quickly.

Geriatric Service

The Geriatric service is intended for rehabilitation and long stay elderly patients. Patients admitted to this service can come from outside the hospital, from Emergency, or from another ward. The patient must, however, have geriatric medical problems which are suitable for rehabilitation, and must be admitted by a geriatrician or specific physician, depending on the service area. Patients admitted to this service are expected to return to their home following treatment. However, if panelled for nursing home placement they may remain on the hospital ward until their transfer to the nursing home.

The Geriatric service is different than the Medical/Surgical service in terms of its philosophy, purpose, services and atmosphere. The patient turn-over is slower on this service compared to the Medical/Surgical service, and it is generally accepted that patients will require a longer period of time on the ward. There is awareness and attention paid to the elderly's psycho-social needs while they are residents of these wards. For example, lounge areas are available for patients and their families/visitors, and patients are given the choice of having their meals with the other patients in this area. Social activities geared specifically to the needs of this group are organized by a Recreation Therapist and take place in the lounge area. A television is set up for patient use in a communal area and

patients are permitted to bring their own television into their room. Often the lounges will contain a piano and/or a stereo and it will be decorated in a less sterile and more "comfortable" fashion. Patients are encouraged to dress in their street clothes and outings are organized for those who are able to participate. These programs and practices are considered important for the patient's quality of life.

The Geriatric service has a total of 158 beds. There is no restriction on the number of beds allocated for occupancy by panelled patients. This has implications for the length of stay on the different wards. Whereas the Medical/Surgical service panelled patients have priority for moving to a nursing home when the panelled patient bed occupancy reaches its limit (ie. over 28 panelled patients), the same is not so for the Geriatric service. There is no restriction placed on the number of beds occupied by panelled patients on the Geriatric Medicine service. Because there is no priority for these patients to move to a nursing home the length of hospital stay could be longer.

When considering panelled patients waiting for a transfer to a nursing home while residing on a hospital ward, several questions emerge:

1. Is there a difference in the level of life satisfaction of panelled patients on the Medical/Surgical as compared with Geriatric services?

2. What factors are associated with their life satisfaction?
3. Does the health care system address the perceived psycho-social needs of panelled patients?

These questions are critical and require attention for two primary reasons. First, the shift in Canada's age structure of the population points to a corresponding increase in the need for long term care (Heller et al, 1986).

Secondly, both elderly citizens and health care providers are aware of the elderly's care needs and the relevance and importance of life satisfaction during the final stages of their lives. Policy makers in the health care and aging fields will need to continue focusing their decision-making efforts on how chronic care elderly people will be cared for and what services and provisions are required for enhancing their quality of life. One might speculate that providing only the basic needs of food, clothing and shelter are not enough to sustain an adequate level of life satisfaction. Increasing pressure by seniors groups is being placed on policy makers to address these and other issues.

This study investigated the research question of whether panelled patients on the Geriatric service will show a higher level of overall life satisfaction than panelled

patients on the Medical/Surgical service as measured by higher scores on the Andrews and Withey (1976) Quality Of Life scale.

The following hypothesis was addressed in this study.

Panelled patients with higher levels of overall life satisfaction will show higher satisfaction with their social contacts and relationships as measured by correlations between life-as-a-whole and family relations, friendships, living partner and recreation activity.

DESIGN

Cross-Sectional Survey

The design that was used was a cross-sectional survey design. The cross-sectional design is a correlational design that involves a survey of the subjects at one point in time. This design obtains information about individuals' "properties and dispositions" (Nachmias, 1981, p.123) and then uses various data analysis techniques to compare different sub-groups. The comparisons between groups is statistical and based on correlational techniques (Nachmias, 1981).

Data Sources

Three data sources were used. This allowed for a comparison of information from different perspectives and the

identification of gaps and similarities between these sources. This study obtained information from the following data sources: St. Boniface Hospital patient file data base, key informants, and consumers (patients).

A comprehensive demographic/statistical profile was available for each hospital patient and access to this data was approved for the purposes of this study. The data was provided by the social workers on the wards for each panelled patient already in hospital and for each new panelled patient admitted up to and including September 21, 1989. Two data forms were used (Appendix III). Data forms were forwarded to the author who entered them into a file in the University of Manitoba mainframe computer. The data collected provided information regarding:

- Patient Name
- Birthdate
- Sex
- Marital Status
- Hospital Admission Date
- Location
- Panelled Date
- Information Regarding Cognitive Impairment
- Level Of Care

Key Informant Data

Key informant data was obtained from people other than the patients themselves. This information was important for a needs assessment because it provided a different perspective to the patient's situation. The various perspectives helped to determine the similarities and gaps between the viewpoints and can provide a more complete understanding of the problem. This information helped to clarify what services and programs were offered on each of the wards, staff attitudes regarding the needs of the patients, and the general philosophy of the staff.

Specific key people were selected for in-person interviews because of their perceptions of the environment and services provided, the well-being of the patients, and how the system attempts to address this issue (APPENDIX VI). The study's design planned for interviews with the following key informants:

- two Social Workers familiar with the wards and patients;
- two Nurses familiar with the wards and patients;
- one Director of Nursing for the Geriatric service;
- one Director of Nursing for the Medical/Surgical service;
- one Medical Director for the Geriatric service;
- one Medical Director for the Medical/Surgical service.

Directors from both services were interviewed because they were able to provide information at a policy and program level. The Director of Nursing and a clinical nurse from the Medical service were unavailable for an interview. The two Social Workers and the Geriatric Medicine Nurse were available to provide information on a more practical level through their direct experience with the patients. The Social Workers were selected randomly from a pool of twelve social workers. The Nurse was selected upon recommendation from the Director of Nursing for three reasons. First, permission was required to participate in the study. Second, those who were more willing to participate were also prepared to offer their own time. Third, because of staff shifts and days off it was more practical for the selection to be made by someone who was more familiar with the nurses' schedules.

Sample

The appropriate subjects for inclusion in the study were those who were:

- panelled
- living on a hospital ward
- cognitively intact

All appropriate subjects during a three and a half month period were approached for participation in the study. Those who were excluded were patients who were cognitively

impaired to the extent that they would be unable to appropriately respond to the questions. Their ability to participate was determined partly by information retrieved from the data base and by the professional recommendations of the nurses and social workers who were familiar with them.

Assessment Of Mental Competency

The process for determining a patient's level of cognitive impairment was through the available patient data from the Basic Data Forms and through consultation with staff members involved with the patient. On the Basic Data Forms the social workers provided information to the author regarding the patient's mental status by indicating which of the three categories a patient fell most suitably under, as follows:

1. not cognitively impaired;
2. cognitively impaired to some extent;
3. cognitively impaired.

The panelling process, which all participants had undergone, clearly shows mental incompetency when it exists. A patient who is considered cognitively impaired will not have signed the application for personal care home placement but rather will have been represented by a significant other such as a relative or friend who has private committeeship or by the Public Trustee, acting in the best interest of the patient.

The process of having a representative act on behalf of the patient is a legal process which deems the patient mentally incompetent.

A patient who was not cognitively impaired was one who continues to make his /her own decisions in a competent manner. All patients in this category were considered suitable for inclusion in the study.

A gray area existed in which an individual was not considered entirely mentally incompetent or entirely cognitively intact, but fell somewhere between. This was the group that was categorized under "cognitively impaired to some extent". All panelled patients were assessed by a physician, nurse and social worker prior to panelling. Often various tools were used to determine level of impairment, such as the Folstein Mini Mental Status Examination, especially when some cognitive impairment was evident. Generally the various disciplines would comment on the patient's mental status using the results of testing with such a tool or by offering their own impressions based on their involvement with the patient.

It was not possible to set rigid guidelines for determining the individual's ability to participate in the study when the patient fell into this category. The difficulties in setting guidelines for the social workers to use arose

because cognitive impairment takes many forms, affects different functionings in each individual and may vary from day to day. The professional judgements of the social workers and nurses were used in conjunction with the Basic Data information for deciding on the suitability of each patient for participation in the study. Since, prior to an interview, there was no sure way of knowing which patients in this category were capable of responding appropriately in the interview the social workers and/or nurses provided their professional opinions regarding unsuitable and suitable subjects. Examples of unsuitable subjects included patients who were easily agitated or who would have had difficulty comprehending and responding to the questions.

For those whom staff were uncertain as to their suitability, the author used a trial and error method to complete the interview. If, after the interview began, difficulties arose and it was evident that the subject was unsuitable, then the subject was excluded from the study. Every effort was made to adapt the questions and conduct the interview in such a way that it was understood and easily responded to by the individual. This resulted in more qualitative and richer responses by the patients.

More subjects were available from the Geriatric service than the Medical/Surgical service because of its higher numbers of elderly panelled patients. Twenty-three patients from the

Geriatric Medicine service were interviewed out of a possible seventy-five panelled patients on this service. This compared to thirteen patients from the Medical/Surgical service interviewed out of a possible twenty-eight panelled patients on this service. Proxies were not used because of the nature of life satisfaction as a personal and subjective measure.

Client interviews were conducted from the beginning of June, 1989 to the end of October, 1989. This was followed by key informant interviews.

The design discussed above was the most appropriate given the time and resource limitations as well as the nature of the study. The correlational and descriptive knowledge levels that were obtained were necessary for a social needs assessment. The cross-sectional survey design was appropriate for obtaining this level of knowledge and for defining the population and its characteristics (Tripodi, 1983). This data began to provide useful information about the present way in which the system of care operates and its contributions to the patients' life satisfaction. This type of design is useful for program and policy decisions which provided feedback relating to the original purposes of the study.

The results were generalizable to the St. Boniface Hospital and not to other hospitals. The level of generalizability was appropriate for the study.

OPERATIONALIZATION OF KEY CONCEPTS

Elderly

Elderly refers to those who are sixty-five years of age and older.

Panelled Patients

Panelled patients refers to hospitalized individuals whose applications have been approved by the Manitoba Government Continuing Care Panel for placement in a nursing home, but who are not yet admitted to the nursing home.

St. Boniface General Hospital

The St Boniface General Hospital is an acute care teaching hospital with a catchment area which includes the entire province of Manitoba.

Geriatric Service

The Geriatric service includes wards E2, E4, E5 and E6 at the St. Boniface General Hospital.

Medical/Surgical Service

The Medical/Surgical wards are those designated as such in the hospital. This report also refers to these services as the Acute service.

Life Satisfaction Measure

Life satisfaction was measured using the Andrews and Withey (1976) Quality Of Life scale (APPENDIX I). This scale measures life satisfaction in two ways. First, it asks the subject to rate their life-as-a-whole, referred to as "global" life satisfaction. Secondly, it asks the subject to rate their satisfaction with a number of life situations, referred to as "domains". The domains used were as follows: health, finances, family relations, friendships, housing, living partner, recreation activity, religion, self-esteem, and transportation. This Quality of Life measure was reported to have substantial levels of validity and reliability (Andrews and Withey, 1976, p.216). Andrews and Withey (1976, p. 216) estimated the D-T measure's validity to be at about .8. For reliability, 15-minute reliabilities averaged .66 and a 6-month reliability was .40. Permission was obtained from the authors for use of this measure (APPENDIX VII).

The 'health' variable referred only to ones' own perception of their physical health and functional capacity and excluded the respondent's assessment of psycho-social well-

being. The latter was represented in some of the other items. The client's actual diagnosis was not considered in this category but was represented in the demographic data.

The 'finances' variable referred to the patients' perceived financial status, including income and assets. Their actual financial status was not considered.

The variables 'family relations' and 'friendships' referred to various components of their relationships. These included the perceived quality and/or frequency of the contacts with family and friends in the form of personal contact, phone calls, letters, etc.

The 'housing' variable was specifically in reference to the patients' assessment of their hospital environment. Some items that could be considered in this category were the room, the entire ward, space, decor, noise levels, lounge areas, staffing, etc.

Recreation activity included many different types of activities engaged in for pleasure when the patient was not doing activities of daily living such as bathing, dressing, eating, etc. It referred to the perceived quality and quantity of the activity performed either in or out of one's room and included such items as reading, television,

outings, organized programs, informal get togethers, visiting, individual activities, etc.

The variable 'religion' referred to one's spiritual fulfillment while in hospital regardless of religious affiliation or attendance at religious services.

The items considered when evaluating 'self-esteem' were how patients felt about themselves, their sense of self respect and feelings of self worth.

Finally, 'transportation' was access to, availability and affordability of public and/or private transportation outside the hospital, where applicable.

Using partial correlation techniques, substantial levels of covariation exist in the predictors of satisfaction with life-as-a-whole from satisfaction with the specific domains (Michalos, 1980). Each item of the scale was rated on a seven point scale from "Delightful" to "Terrible", referred to as the D-T scale. The specification of the domains was intended for the identification of the factors that were the most important for this group of subject's overall life satisfaction.

In addition to the previously discussed measure, three open ended questions were asked of the subjects. These questions

further investigated the patients' life satisfaction and how they felt it could be improved. The intent was to provide a cross reference to the D-T scale and to provide additional qualitative and descriptive data. The questions were as follows:

1. What, in general, would make your life happier?
2. What could the hospital do to improve your stay here?
3. What do you like the best about this ward?

The Process: Preliminary Staff Meetings, Patient Identification and Patient Interviews

The success of the practicum required the cooperation and support of the social work staff. Prior to the client interviews and data collection memos were circulated to and meetings were held with staff (APPENDIX II). The first meeting with the social workers was held in the Spring, 1989. Its purpose was to inform workers of the study's purpose, to explain the writer's plans for carrying out the study, and to ask for the assistance of the social workers in data collection and in identifying and introducing appropriate interviewees. At this time support was obtained from the social work team. A second meeting was held in June, 1989 just prior to the client interviews to review and familiarize the social workers with the data forms that they would be completing, the interview process to be carried

out, and the interview schedule to be used. Further exchanges of information were carried out through brief updates given at team meetings from time to time and through one to one meetings with the social workers. The interviewer worked very closely with the social workers throughout this process. Obtaining the social workers' support and willingness to assist was critical for accessing both the patients and the patient data.

All panelled patients were reviewed by the author and the social worker involved with the patient to discuss their suitability for inclusion in the study. When a patient was selected for inclusion in the study and an interview was planned by the interviewer, the interviewer began by contacting the patient's social worker and arranging for a time to meet with the patient. The interviewer, accompanied by the social worker, approached the patient in person to provide introductions, to provide the patient with a verbal explanation of the purposes of the study and to obtain written consent for participation in the study (APPENDIX V). A written explanation of the study had also been prepared to distribute to interviewees (APPENDIX IV). However this was found to be confusing to the patients and was excluded from use. Once consent was granted the interviewer proceeded with the interview in a private area of the hospital. It was necessary to obtain consent in person rather than by mail so that patients could be provided with more complete

explanations and clarifications of their involvement in the study while their social worker was present. This resulted in increased comfort for the patient regarding their involvement in the study and a higher rate of consent for inclusion.

All interviews were conducted by the author on a one-to-one basis. Each interview was short and simple, and was completed in approximately 45-60 minutes. Lengthy surveys can become burdensome and tiring for the patient which, in turn, will have an effect on the accuracy of the responses by the patients. The brief and structured interview schedule was followed by some open ended questions. The open ended questions not only allowed for some rich qualitative data but also gave the respondent an opportunity to verbalize his/her own thoughts and feelings on the subject.

ANALYSIS

The data were analyzed using both quantitative and qualitative methods which served to compliment each other.

First, the demographic data provided a basic description of the population under study. Frequency tables were used to describe the patients on the Geriatric and Medical/Surgical services in terms of sex, age, level of care, length of time panelled/admitted, location, etc. Mean life satisfaction

scores and mean life-as-a-whole scores were also calculated for the demographic items.

Second, bivariate analysis was used. Cross tabulations examined the relationships between the independent (global life satisfaction) and dependent demographic (eg. location, sex, level of care, length of wait, etc.) variables by comparing the mean scores for different groupings of patients for the overall life satisfaction measure and for the life-as-a-whole measure. Correlation coefficients were also used to examine the relationship between the global life-as-a-whole measure and the various domains (health, finances, family etc.).

Multi-variate analysis was also used. Multiple regression and partial correlation coefficient analyses further examined the relationships between specific variables to provide more detail to the results.

The open ended questions asked of the patients added richness and detail to the quantitative study. This data was organized and compared to the other qualitative and quantitative data in order to make the results more meaningful.

The data obtained from the key informants was qualitative and was used primarily for descriptive and comparative

purposes. It was helpful in determining the way in which the hospital perceives and addresses the issue of life satisfaction for this group, and its related philosophies, policies, programs and practices.

Most of the data analysis results were not statistically significant. They did, however, indicate some trends and provided qualitative material important for discussion and consideration.

CHAPTER III

RESULTS OF THE PATIENT DATA AND INTERVIEWS

The information gathered from the data forms and from the interviews with the patients was compiled and analyzed. Both quantitative and qualitative results were obtained which are presented in this section.

DEMOGRAPHIC DATA

Description of the Acute And Geriatric Service Panelled Patient Population

The total number of hospital patients who had already been panelled prior to May 1, 1989 or who were panelled between May 1, 1989 and September 21, 1989 was 103 patients. Of these, 28 people (27.2% of the total) were on an Acute ward (Medical or Surgical) and 75 people (72.8% of the total) were on a Geriatric Medicine ward. Of the 28 people on the Acute wards 13 (46.4%) were interviewed and 15 (53.6%) were not. Of the 75 people on the Geriatric Medicine wards 23 (30.7%) were interviewed and 52 (69.3%) were not. In total 36 (35%) people were interviewed and 67 (65%) were not (TABLE 1).

Of those who were not interviewed the breakdown for the reason for non participation reported by the patients' social workers is presented in TABLE 2.

TABLE 1 - Panelled Patients at St. Boniface Hospital

103 PANELLED PATIENTS			
ACUTE		GERIATRIC	
28		75	
NOT INTERVIEWED	INTERVIEWED	NOT INTERVIEWED	INTERVIEWED
15	13	52	23

The majority of the patients who were unable to participate in the study were unable to do so because of cognitive impairment. They were considered unable to adequately understand and participate in an interview of this nature. Fifteen percent of the non-participants had either been discharged to a personal care home or had deceased prior to being able to interview them. Only a few (4.4%) were too ill or anxious to be interviewed and 3% refused. One patient was excluded because of age (mid twenties). The psycho-social issues would be different for this age group and therefore the interview would be irrelevant for this study.

Demographic Characteristics

The mean age of the respondents was 80.8 years (TABLE 3). There were a higher number of women than men with 61.1% of

TABLE 2 - Reason for Non Participation in the Study

REASON	ACUTE	GERIATRIC	TOTAL (%)
COGNITIVE IMPAIR.	12	39	51 (76.1)
DISCHARGED	1	5	6 (9.0)
DECEASED	1	3	4 (6.0)
ANXIOUS/ILL	0	3	3 (4.4)
REFUSED	0	2	2 (3.0)
NON GERIATRIC	1	0	1 (1.5)
TOTALS	15	52	67

the patients being women and 38.9% men. Of the women 59.1% were on the Geriatric service and 40.9% were on the Acute service. Of the men 71.4% were on the Geriatric service and 28.6% were on the Acute service. This distribution is similar to the male/female ratio for the elderly in the general population (Novak, 1988).

Only five percent of the patients were married. Most (61.1%) were widowed which is common for people in this age group. 13.9% were single (never married) and those who were separated or divorced comprised 8.3% of this group. This category was the lowest likely because separations and divorces were generally not socially acceptable for this generation.

TABLE 3 - Demographic Characteristics of the Panelled Patients

CHARACTERISTIC	FREQUENCY
SERVICE	
Acute	13 (36.1%)
Geriatric	23 (63.9%)
SEX	
Male	14 (38.9%)
Female	22 (61.1%)
CARE LEVEL	
1 & 2	27 (75.0%)
3 & 4	9 (25.0%)
MARITAL STATUS	
Single	5 (13.9%)
Married	5 (13.9%)
Separated/Divorced	3 (8.3%)
Widowed	22 (61.1%)
Not Known	
AGE	
64 - 75 Years	9 (25.0%)
76 - 85 Years	14 (38.9%)
86 - 96 Years	13 (36.1%)
POST PANEL TIME	
1 - 59 Days	12 (33.3%)
62 - 251 Days	12 (33.3%)
261 - 584 Days	12 (33.3%)
PRE HOSPITAL SITUATION	
Living Alone	27 (75.0%)
Living With Spouse/Family	9 (25.0%)
PRE HOSPITAL RESIDENCE	
Senior Citizen Housing	16 (44.4%)
Apartment	5 (13.9%)
House	13 (36.1%)
Hotel	2 (5.6%)

COGNITIVE IMPAIRMENT

None	23 (63.9%)
Some	11 (30.5%)
Very	2 (5.6%)

TOTAL HOSPITAL TIME

65 - 239 Days	13 (36.1%)
255 - 353 Days	11 (30.5%)
377 - 693 Days	12 (33.3%)

Most of the patients (75%) lived alone prior to hospitalization. The remainder lived either with their spouse or with another family member. Since only five percent were married this would indicate that twenty percent of the respondents had been previously living with another family member.

The majority lived in a senior citizen's housing complex (44.4%) prior to their hospitalization, followed closely by those living in a house (36.1%). Only 13.9% lived in a standard apartment and 5.6% lived in a hotel.

Seventy five percent of those interviewed were panelled at a level one or two. On a care level scale of one to four these would be the patients who were more independent and required the least amount of assistance in their activities of daily living. The remainder were levels three and four. This was not representative of all of the panelled patients at St.

Boniface General Hospital but only representative of those who were cognitively intact to the extent that they could understand and respond appropriately to the interview. Often levels three and four patients require increased assistance not only because of their physical functional level but because of their decreased cognitive status.

The total average length of hospital stay from admission to the time of this study's interview was 10.5 months. The mean length of hospital stay prior to panelling was 4.6 months and post panelling was 5.1 months to the interview. The important category to consider for this study was the post panelling time frame because this was when the patient was considered medically stable and no longer in need of hospitalization. During this time patients are ready to move to a personal care home when a bed becomes available. The pre-panelling time frame was considered to be when the patient was considered medically unstable and still in need of hospitalization.

The diagnoses of the patients were diverse. These were classified into broader categories of diseases using the International Classification of Diseases (1978) and a profile is presented in TABLE 4 for the entire sample and also separately for the patients on the Geriatric and Acute services.

TABLE 4 - Diagnoses of the Panelled Patients

DISEASE	GERIATRIC	ACUTE	TOTAL
ENDOCRINE, NUTRITION, METABOLIC, IMMUNITY	0	2	2
MENTAL	2	0	2
NERVOUS SYSTEM, SENSES	2	2	4
CIRCULATORY	9	3	12
DIGESTIVE	1	2	3
GENITOURINARY	0	1	1
SKIN	1	0	1
MUSCULOSKELETAL	1	0	1
SYMPTOMS, SIGNS, ILL-DEFINED	2	2	4
INJURY	2	1	3
MISSING	3	0	3
	23	13	36

The most clustered category was that of circulatory diseases. These often included patients who have had a cardio vascular attack (stroke) or congestive heart failure. The majority of these patients were found on the Geriatric

service. This would be due to the extensive rehabilitation efforts following the strokes.

PATIENT INTERVIEWS

Survey Results

A goal of the survey was to determine how patients perceived their level of life satisfaction at the present in the hospital. In the survey patients were asked to rate their satisfaction with the following items : 1 - health; 2 - finances; 3 - family relations; 4 - friendships; 5 - housing (hospital environment); 6 - living partner(s); 7 - recreation activity; 8 - religion (spiritual fulfillment); 9 - self esteem; 10 - transportation; 11 - life-as-a-whole. The scale utilized was a seven point Likert scale as follows: 7 = delightful; 6 = very satisfying; 5 = satisfying; 4 = mixed; 3 = dissatisfying; 2 = very dissatisfying; 1 = terrible.

Using the average of the patients' responses to the first ten items the mean life satisfaction was calculated for a number of different categories. This score was a cumulative score of the ten items. Also calculated were the mean life-as-a-whole scores which was an average of the eleventh item in the questionnaire. This item consisted of a pointed question asking the respondents to rate how satisfied they were with their life-as-a-whole at present. The mean life

satisfaction and the mean life-as-a-whole scores are presented for the basic demographic items in TABLE 5.

The overall mean life-as-a-whole for all of the panelled patients was 3.806 (dissatisfied - mixed) compared to the overall mean life satisfaction of 4.573 (mixed - satisfied). The average life-as-a-whole scores for all of the individual demographic variables were lower than the average life satisfaction scores for the same variables. The average life-as-a-whole scores for the demographic categories fell within the range of three to five (dissatisfied to satisfied) on the Terrible - Delightful scale whereas the mean life satisfaction scores fell between four and five (mixed and satisfied). This indicates that although people rated most of the ten individual items as being in the mid to satisfactory range, there were other factors that made them feel that their lives were not satisfactory and therefore rated the question about their life-as-a-whole more negatively.

Mean life-as-a-whole and life satisfaction scores were compared with elderly people in another study which focussed on "Living Arrangements and Primary Care" (Chappell & Powell, 1990). The study investigated the life satisfaction of people who were living in the community and who were married, living alone or living with others. It used a random sample of 1286 people, aged 60 years and over. The

**TABLE 5 - Mean Life Satisfaction and Life-As-A-Whole Scores
for the Demographic Items**

CATEGORY	LIFE SATISFACTION		LIFE-AS-A-WHOLE	
	mean	S.D.	mean	S.D.
SERVICE				
Acute	4.617	.760	3.923	1.013
Geriatric	4.548	.706	3.739	.953
SEX				
Male	4.671	.770	3.714	.997
Female	4.511	.690	3.864	.971
CARE LEVEL				
1	4.600	N/A	3.000	N/A
2	4.597	.720	3.846	.967
3	4.307	.894	3.500	.983
4	4.885	.577	4.333	1.155
MARITAL STATUS				
Single	4.876	.837	4.000	1.095
Married	4.522	.837	3.400	1.000
Separated/Divorced	4.126	.577	3.333	1.155
Widowed	4.571	.722	3.955	.958
Not Known				
AGE				
64 - 75 Years	4.228	.833	3.889	1.054
76 - 85 Years	4.732	.699	3.286	.975
86 - 96 Years	4.640	.641	4.308	.870
TOTAL HOSPITAL TIME				
65 - 239 Days	4.285	.725	3.385	1.038
255 - 353 Days	4.905	.647	4.636	.820
377 - 693 Days	4.581	.718	3.500	.888
POST PANEL TIME				
1 - 59 Days	4.307	.669	3.083	1.030
62 - 251 Days	4.474	.718	4.250	.900
261 - 584 Days	4.938	.669	4.083	.953
PRE HOSPITAL SITUATION				
Living Alone	4.568	.734	3.963	.974
With Spouse/Family	4.587	.667	3.333	.866
PRE HOSPITAL RESIDENCE				
Senior Cit Housing	4.496	.854	4.063	.931

Apartment	4.434	.447	3.000	1.095
House	4.779	.506	3.769	1.000
Hotel	4.914	.707	4.000	1.414
COGNITIVE IMPAIRMENT				
None	4.514	.706	3.522	.996
Some	4.618	.775	4.273	.820
Very	5.000	.707	4.500	1.414

Terrible-Delightful Quality of Life scale (Andrews & Withey, 1976) was used in this study to measure life satisfaction. The results indicated that the mean life satisfaction score was 5.40 (Satisfied - Very Satisfied) as compared to 4.573 (Mixed - Satisfied) for this study. The life-as-a-whole score for the subjects in the Chappell and Powell (1990) study was 5.15 (Satisfied - Very Satisfied) as compared to 3.806 (Dissatisfied - Mixed) in this study. The lower score for this study can likely be explained by differences in health status and living situation (ie. home vs. hospital).

The patients on the Acute wards and on the Geriatric Medicine wards scored very similarly, contrary to the hypothesis that Geriatric Medicine ward patients would score higher. When crosstabulations were done the results indicated that 61.5% of the Acute ward patients stated that they were satisfied when asked about their life-as-a-whole compared to only 43.5% of the Geriatric Medicine patients (TABLE 6).

TABLE 6 - Crosstabulation of Service by Satisfaction with Life-as-a-Whole

SERVICE	DISSATISFIED	MIXED	SATISFIED	TOTAL
	% (n)	% (n)	% (n)	% (n)
ACUTE	38.5	0	61.5	100.0 (13)
GERIATRIC	43.5	13.0	43.5	100.0 (23)
TOTAL	41.7 (15)	8.3 (3)	50.0 (18)	100.0 (36)

The hypothesis was made on the basis that panelled patients would respond more favorably to the attributes of the Geriatric wards. Some of these include less sterile surroundings, such as colored walls, pictures, plants, and lounge/family areas, recreation programs, patients bringing in their own belongings, matching of roommates, greater staff knowledge and awareness of the needs of this population, primary nursing, approaches to care, etc.

Patients' comments on the open-ended questions supported the results of the similar scores.

The following are some of the patient's comments and some speculations about the results. First, patients on the acute wards often stated that they did not expect anything different from a hospital setting such as those items offered on the Geriatric Medicine wards. They generally

expected to have their personal care and medical needs attended to which was being achieved on both services. This does not necessarily negate the need for such items as recreation programs and social interaction for elderly patients but indicates that those on the acute service do not feel as though they are missing out on anything because they do not expect anything different from a hospital.

The Multiple Discrepancies Theory of Life Satisfaction suggests that satisfaction is a function of what the client perceives as gaps between what he/she wants, deserves and needs, expects to have, has had in the past, and others have (Michalos, 1985). If the perceived needs, wants and expectations are primarily that of medical and personal care then these are congruent with what is being provided and the patients would be fairly satisfied regardless of the alternate programs offered. Once the Geriatric Medicine environment has been experienced then perhaps the perceived gaps between what one has, wants and deserves, and what others have, would change and then patients may become more dissatisfied as their expectations increase.

Secondly, a comment sometimes made by patients was that they were satisfied being left alone. They generally viewed themselves as being sick and did not want to be involved in socialization or any other activities. This 'sick role' would likely be reinforced in a hospital setting. The

environment can be very powerful in inducing helplessness and giving up (Langer & Avorn, 1987) and "incompetence may be inferred from very subtle environmental and interpersonal cues" (p. 465).

The desire to be left alone may also be a function of patients previously being accustomed to their independence, a greater emphasis on work, and a non familiarity of this generation with recreational activities, particularly with those provided on the Geriatric Medicine service.

Males and females scored similarly. Crosstabulations showed that both groups were equally satisfied and dissatisfied with their life-as-a-whole (TABLE 7) with each group having 50% of their people satisfied.

TABLE 7 - Crosstabulation of Sex by Satisfaction With Life-As-A-Whole

LEVEL	DISSATISFIED	MIXED	SATISFIED	TOTAL
	% (n)	% (n)	% (n)	% (n)
MALE	42.9	7.1	50.0	100.0 (14)
FEMALE	40.9	9.1	50.0	100.0 (22)
TOTAL	41.7 (15)	8.3 (3)	50.0 (18)	100.0 (36)

Although the combined scores of the level 1 and 2 patients was higher than the level 3 and 4 patients, when these were examined as four separate categories the distribution was different. Individually the level threes and fours scored slightly higher than the others (TABLE 8).

TABLE 8 - Crosstabulation of Care Level by Life Satisfaction

LEVEL	DISSATISFIED	MIXED	SATISFIED	TOTAL
	% (n)	% (n)	% (n)	% (n)
1	0	100.0	0	100.0 (1)
2	23.1	50.0	26.9	100.0 (26)
3	33.3	33.3	33.3	100.0 (6)
4	0	66.7	33.3	100.0 (3)
TOTAL	22.2 (8)	50.0 (18)	27.8 (10)	100.0 (36)

Speculations can be made about the level of care results. As the patients' care needs increase and they are having increasing difficulty caring for themselves, perhaps they find more security and comfort in being cared for by health care personnel in a safe setting. This group may have already adjusted to the realities of their decreased physical status whereas those classified at a lighter level of care are somewhat more independent and in a state of

transition. They know that they need assistance but still wonder if they could be managing in their own homes.

In the Marital Status category the single (never married) patients were the most satisfied while the separated/divorced were the least. When responding to the life-as-a-whole question 60% of the single people were satisfied while 66.7% of the separated or divorced were dissatisfied (TABLE 9).

TABLE 9 - Crosstabulation of Marital Status by Satisfaction with Life-as-a Whole

STATUS	DISSATISFIED	MIXED	SATISFIED	TOTAL
	% (n)	% (n)	% (n)	% (n)
SINGLE	40.0	0	60.0	100.0 (5)
MARRIED	40.0	20.0	40.0	100.0 (5)
SEP/DIV	66.7	0	33.3	100.0 (3)
WIDOWED	36.4	9.1	54.5	100.0 (22)
UNKNOWN	100.0	0	0	100.0 (1)
TOTAL	41.7 (15)	8.3 (3)	50.0 (18)	100.0 (36)

One might speculate that single people, who may have fewer expectations for reliance upon care by other family members, are satisfied with the level of care provided in the hospital. Although the small numbers of respondents in this category are not sufficient to substantiate this finding the literature suggests that loneliness, lack of social supports and companionship is related to lower levels of well-being (Bowling et al, 1989; Chappell & Badger, 1989; Conner et al, 1979). The quantity and the quality of their practical and social-emotional supports may increase with hospitalization because of the attention from the staff.

When the pre-hospital living situation was considered those who had been previously living alone were more satisfied than those who had been living with someone else. The crosstabulations indicated that when asked about their life-as-a-whole 59.3% of those who had lived alone considered themselves to be satisfied at present and 55.6% of those who had lived with someone were dissatisfied (TABLE 10).

While the literature does not support a link between living alone and decreased life satisfaction one might speculate that for the group of people who were previously living alone, there may be decreased opportunities for companionship and fewer supports, as compared to those living with a family member. This may contribute to

TABLE 10 - Crosstabulation of Pre Hospital Living Situation by Satisfaction with Life-as-a-Whole

LIVING	DISSATISFIED	MIXED	SATISFIED	TOTAL
	% (n)	% (n)	% (n)	% (n)
ALONE	37.0	3.7	59.3	100.0 (27)
SPOUSE/ FAMILY	55.6	22.2	22.2	100.0 (9)
TOTAL	41.7 (36)	8.3 (3)	50.0 (18)	100.0 (36)

increased satisfaction with the care and support provided in the hospital. The literature links the presence of meaningful relationships to higher levels of life satisfaction (Chappell & Badger, 1989; Conner et al, 1979; Bowling et al, 1989). For those who were previously alone the support of the hospital staff may be perceived as being more desirable and safer than being alone. Those who had lived with a spouse or family member may have preferred this level of interpersonal relationship rather than that which would be available in the hospital in spite of difficulties in managing at home. Or perhaps they just really miss the people themselves.

When the results were considered in terms of age the youngest (under 75 years) were the most dissatisfied in the mean life satisfaction category but the 76 - 85 year olds

were the least satisfied when asked about their life-as-a-whole. The 86 years and over group had 61.5% of the patients satisfied with their life-as-a-whole (TABLE 11).

TABLE 11 - Crosstabulation of Age by Satisfaction With Life-As-A-Whole

AGE	DISSATISFIED	MIXED	SATISFIED	TOTAL
Years	% (n)	% (n)	% (n)	% (n)
64-75	44.4	0	55.6	100.0 (9)
76-85	57.1	7.1	35.7	100.0 (14)
86-96	23.1	15.4	61.5	100.0 (13)
TOTAL	41.7 (15)	8.3 (3)	50.0 (18)	100.0 (36)

The following are speculations about the age difference results. Perhaps the older patients can consider their lives, more than the younger elders, to have been full and are more willing to accept their declining status. As well they have likely already had to adapt to many changes and so may have developed better adaptation mechanisms. Other explanations may be disengagement (Novak,1988) for the older group or a sense of resignation.

When considering the patients' total length of hospital stay from admission to the interview time those who had been

hospitalized less than 8 months tended to be the most dissatisfied. Following panelling for personal care home placement life satisfaction scores increased with longer length of hospital stay (TABLE 12).

The length of stay results indicate that the longer people stay in hospital the more settled and satisfied they become with their surroundings and the staff assisting them. This may also be due to becoming more compliant and resigned, and adopting a 'sick role' (Callahan, 1966; Segall, 1976). This lengthy wait can have a negative impact on patients when they move to a personal care home. The more settled and adjusted they become to the hospital the more difficult it would likely be to relocate and readjust. With increasing time the hospital becomes more comfortable and becomes their home regardless of the atmosphere.

TABLE 12 - Crosstabulation of Length of Time Following Panelling to Interview by Life Satisfaction

TIME	DISSATISFIED	MIXED	SATISFIED	TOTAL
DAYS	% (n)	% (n)	% (n)	% (n)
1-59	25.0	58.3	16.7	100.0 (12)
62-251	33.3	50.0	16.7	100.0 (12)
261-584	8.3	41.7	50.0	100.0 (12)
TOTAL	22.2 (8)	50.0 (18)	27.8 (10)	100.0 (36)

Life satisfaction increased with increased cognitive impairment. Of the non cognitively impaired 52.2% were dissatisfied with their life-as-a-whole whereas 63.6% and 50% of the partially impaired and the cognitively impaired respectively were satisfied (TABLE 13).

The mental status results can be explained in a similar way to the levels of care. Those who were cognitively intact might believe they could manage outside of an institution and may be ambivalent about their need for institutionalization.

TABLE 13 - Crosstabulation of Cognitive Impairment by Satisfaction with Life-as-a-Whole

IMPAIRED	DISSATISFIED	MIXED	SATISFIED	TOTAL
	% (n)	% (n)	% (n)	% (n)
NO	52.2	4.3	43.5	100.0 (23)
SOME	18.2	18.2	63.6	100.0 (11)
YES	50.0	0	50.0	100.0 (2)
TOTAL	41.7 (15)	8.3 (3)	50.0 (18)	100.0 (36)

In keeping with the Multiple Discrepancies Theory perhaps a gap exists between their perceived needs and wants and what is being offered in this type of environment. In contrast,

those who are more cognitively impaired may appreciate the security provided by the hospital which relieves them of the pressures of trying to manage with difficulty and confusion on their own. The gap would decrease between their perceived needs and what is actually being provided, thereby increasing the level of congruity between the patient and the hospital's role and thus their satisfaction.

Life Satisfaction As Reported By The Panelled Patients

The mean life satisfaction scores were calculated for the eleven variables (health, finances...life-as-a-whole) in the client questionnaire. The results include the mean scores for all of the respondents as well as the breakdown for the Geriatric and Acute services (TABLE 14).

All of the mean life satisfaction scores for the eleven variables fell between three and six (dissatisfied and very satisfied). The three items that the patients were most dissatisfied with were health, self-esteem and living partner. These results were similar for both services however for the Geriatric service the patients were the most dissatisfied with their health and for the Acute service the patients were the most dissatisfied with their self-esteem. The overall mean scores for all of the respondents indicate that the patients were the most satisfied with transportation, family and religion. This was not found when

TABLE 14 - Mean Scores for the Domains

VARIABLE	OVERALL		GERIATRIC	ACUTE
	MEAN	S.D	MEAN	MEAN
HEALTH	3.778	1.775	3.478	4.308
FINANCES	4.848	1.228	4.714	5.083
FAMILY RELATIONS	4.972	1.612	5.174	4.615
FRIENDSHIPS	4.485	1.564	4.450	4.538
ENVIRONMENT	4.889	1.304	5.043	4.615
LIVING PARTNER	4.343	1.211	4.273	4.462
RECREATION ACTIVITY	4.444	1.520	4.391	4.538
RELIGION	4.968	1.224	4.905	5.100
SELF ESTEEM	4.114	1.549	4.174	4.000
TRANSPORTATION	5.143	1.145	5.105	5.222
LIFE-AS-A-WHOLE	3.806	1.600	3.739	3.923

each service was examined separately. For the Geriatric service, patients were the most satisfied with their family relations followed by transportation and hospital environment. The Acute service patients were the most satisfied with transportation followed by religion and finances.

The item that the patients were overall most dissatisfied with was their health, particularly those on the Geriatric service. In the open ended questions when patients were asked 'what would make their life happier' many of the responses related to better health (APPENDIX VIII). Fifty-six percent of the patients (20 patients) made comments to this effect of which 16 were from the Geriatric Medicine service and 4 were from the Acute service. This was

consistently perceived as the greatest problem which impacted negatively on other aspects of their life such as independence and ability to do the things that they wanted to do. Patients often commented that their health meant everything to them but also recognized that nothing more could be done for them in this area. The importance of perceived good health for life satisfaction is consistent with the literature (Markides & Martin, 1979; McConatha & McConatha, 1989; Wolk & Telleen, 1976). There is no clear explanation for the higher satisfaction with health for the Acute service patients but perhaps the increased medical focus on this service contributes to this finding. Also maybe the Geriatric service patients had higher expectations of rehabilitation and were more disappointed at not being able to return home.

The second lowest scoring item in the first ten domains was self-esteem. During the open ended interview patients often commented on how useless they felt and how they were now a burden on others with no useful role contrary to what they were accustomed to in the past. Both number of roles and the meaningfulness of these roles have been found to be positively related to life satisfaction (Elliott & Barris, 1987). However for hospital patients there was little opportunity to pursue what was meaningful, thereby contributing to lower satisfaction with self esteem.

There were other items that patients commented on in the open ended questions relating to their self-esteem. Many commented on their lack of control, freedom, choice and independence (APPENDIX VIII). Forty-two percent of the patients (16 patients) referred to these items. There is evidence that for institutionalized elders increased self determination and control in every day activities is important for increased life satisfaction (Vallerand et al, 1989).

Some of the patients felt that they wanted to be able to make more decisions for themselves such as bed time and other such routines. As well, many felt that their self respect and dignity were negatively affected by such practices as being handled carelessly, being left on the toilet too long, and not getting to the toilet on time. These comments arose for patients on both services. One gentleman that participated in the study felt good about being able to discuss his opinions about himself and about the hospital. Some time following the interview with him the writer received feedback from the social worker on his ward that whenever this gentleman was dissatisfied with the ward he would ask to see the writer so that he could relate the incident. He likely felt more in control and that his opinions and comments were meaningful and valued when he was listened to in this manner. He may have also felt that he

had an important role by being able to assist with this project.

The third lowest scoring item was living partner with a mean score of 4.343. People on both services commented negatively on the number of roommate changes they had experienced during their hospital stay although rarely did they speak negatively about the people themselves who were their roommates. Another comment that was made by patients was regarding the noise levels on the ward, particularly with respect to the noise made by other more confused patients. Sometimes the cognitively impaired people would wander into other patients' rooms which would make patients feel that they had little privacy and control. This relates to the patients' expressed need for more privacy and to be left alone. People generally wanted to have a space, however small in size, to consider their own.

The patients on the Acute service were slightly more satisfied with their living partners than those on the Geriatric service. This is contrary to what would be expected as the Geriatric Medicine wards have a slower patient turnover and often staff will attempt to address the compatibility issue for long stay patients by placing compatible people together and by attempting to encourage relationships. The Acute service is less likely to be able to do this as their panelled patients are scattered

throughout the service and roommates are often short stay patients. Perhaps this difference is due to lower expectations the Acute service patients had of the hospital environment and patients. Few relationships between roommates would have the opportunity to develop on the Acute service. In the Geriatric service the patients would have more of an opportunity to establish a relationship with their roommate and then their roommate would leave through a transfer to a personal care home or through death. This could be discouraging, disappointing and frightening to patients.

The item that the patients found to be most satisfactory was the transportation. This item was found amongst the three most satisfactory items for patients on both services. Those who went out for appointments and social outings found the availability of and accessibility to transportation (private and public) to be no problem. This item did not pertain to many of the patients as most tended to remain within the hospital setting and did not expect to be going out while they were hospitalized. This level of satisfaction was representative only of those who were able to obtain transportation to go out and transportation was not highly impacted on by the hospital.

The second most positively rated item was family relations with a mean life satisfaction score of 4.972. For patients

on the Geriatric Medicine wards this was the item that they were the most satisfied with. The Acute ward patients were less satisfied with family relations and the mean score for this item did not fall within the top three satisfactory items for this group of patients. This category did not reflect the frequency of family visits as an objective measure but rather it represented patients' subjective evaluations of their relationships which included both quantity and quality. Although this item rated higher than many of the others, one of the most frequently made comments by patients on both services, other than their wish for better health, was the wish for more family contact (APPENDIX VIII). Thirty-nine percent of the patients (14 patients) made comments to this effect. Patients often wished that family and friends would visit more often and that they could have easier and more frequent access to telephones for contacting their significant others.

The difference in satisfaction with family relations for the two services may not necessarily be related to differences in the frequencies of family visits. It may be related to the differences in visiting conditions on the two services. The Geriatric wards offer more privacy for patients and their visitors because they have areas designated for visiting that are furnished with comfortable seating and resemble a home-like environment. This would contribute to quality visits which would help to foster or maintain family

relations. Patients often commented positively about these areas. The Acute wards do not offer this environment and so patients, especially those in semi-private rooms, would have little opportunity for quality visits with their relatives. They would have to visit in their room with their roommate present and/or their visits would occur in the midst of a multitude of medically-related activities or in the noisy hallways. This could contribute to the deterioration of and dissatisfaction with family relations.

The item scoring the third highest life satisfaction score was satisfaction with religion, ie. spiritual fulfillment. This item was not amongst the most satisfactory for the patients on the Geriatric Medicine wards but was for the Acute patients. Patients generally felt that their spiritual needs were satisfied through private visits from relevant outside sources or through in-hospital pastoral care services available to all patients, through attendance at hospital religious services and through private religious activities. Opportunities for religious involvement exist equally for patients on both services. Aside from the spiritual fulfillment experienced by the Acute service patients perhaps the visits from pastoral care workers assume greater importance as an "activity" and opportunity for meaningful social interaction within the hospital setting particularly for this group of patients. There are

few other opportunities provided within the hospital for these people.

The Geriatric service patients indicated that the hospital environment was amongst the three most satisfactory items for them. They scored higher than the Acute service patients in this area. This suggests that the efforts to create a less sterile and more appropriate environment has likely had a positive impact on the patients. This may also be part of the "sick role" psyche where patients perceive themselves as being sick and requiring hospitalization and this level of medical attention.

The Acute service patients indicated that their finances were amongst the most satisfactory of the questionnaire items. Since the panelled patients throughout the hospital are paying equal per diem rates and because this rate is subsidized and in keeping with the Old Age Pension and Guaranteed Income Supplement rates, this item would not likely be a significant issue for patients on either service and would not be impacted on by the hospital.

Patients' responses to their life-as-a-whole resulted in a low mean life satisfaction score of 3.806 (dissatisfied). This score was lower than all but one of the other individual scores, the lowest being health, and was found to be low scoring for patients on both services. Although the

first ten variables were chosen for the interview schedule because they were expected to be the most relevant variables for this population they are not likely entirely representative of all aspects of the patients' lives and areas of importance for them. This is evident because the patients scored higher on the individual items than on their perceptions of their life-as-a-whole. Factors such as meals, personal care, privacy, control and decision making were mentioned and discussed during the open ended section of the interview and were raised as primary daily issues for the patients. These become increasingly important when one's world shrinks.

The Relationship Between Life-As-A-Whole And The Domains

The strength and direction of the relationship between life-as-a-whole and the other ten domains was examined using a correlation coefficient analysis, a multiple regression analysis and a partial correlation coefficient analysis.

In the correlation analysis (APPENDIX XI) the item most highly correlated with life-as-a-whole was self-esteem followed by health, environment, recreation and finances. The results do not indicate a causal relationship between the variables. They suggest that the domains and life-as-a-whole co-vary.

The family relations, friendships and living partner did not correlate significantly with life-as-a-whole as earlier suggested in the hypothesis. However the respondents often commented that, although they were satisfied with family, they wished that they could be closer to family and be with them more frequently. There was little contact with friends, however this was usually accepted and understood by patients as their friends were often elderly and were unable to visit. They felt that easier access to a telephone would help to maintain their family and friend relationships.

There has already been discussion about self-esteem, health, environment and finances so the following discussion will focus on recreation as one of the items that correlated with life-as-a-whole. The second hypothesis included recreation as a factor related to life satisfaction. When this topic was discussed in more depth with patients, those on the Acute wards stated that they were satisfied with their activity level in the hospital and were not necessarily in favor of organized in-hospital programs for them. Some wanted to be left alone. Patients sometime stated "I'm sick and can not do anything" or "I like to be left alone". As discussed earlier this could be due to a number of factors including expectations and sick role. Those on the Geriatric Medicine service had mixed comments about the programs offered. Some attended regularly and enjoyed them. Others found that they were not meaningful for them.

The comments that arose frequently on both services pertained to continuity and control (APPENDIX VIII). Twenty-five percent of the patients expressed the desire to be able to do the things they used to do and enjoy, and to do what they wanted to do. Some of these included going outside, driving a car, going for a drive, going on a trip, getting together with family and friends, doing house and yard work, going to church. Their needs and desires did not match what was actually being offered which, consistent with the Multiple Discrepancies Theory, would contribute to lower life satisfaction. Activities in and of themselves did not necessarily improve peoples' life satisfaction. The more important factor seemed to be the meaningfulness of the activity. The expressed wishes for certain activities often related less to leisure activities and more to the activities of daily living, the practical tasks and the social activities that the elders were more accustomed to.

A multiple regression analysis (APPENDIX X) was done to further investigate the relationship between self-esteem, health and life-as-a-whole. The data showed that life-as-a-whole could be explained more by self-esteem than by perceived health. As earlier mentioned, in the correlation coefficients self-esteem was more highly correlated with life-as-a-whole ($r=.766$) than was health correlated with life-as-a-whole ($r=.497$). Although the correlations between the variables showed a significant relationship between

life-as-a-whole and health, the regression analysis indicated that this relationship was not significant when controlling for the other independent variables. The relationship between life-as-a-whole and self-esteem was statistically significant ($p=.0053$) while the relationship between life-as-a-whole and health was not significant ($p=.3000$). The beta scores for self-esteem was also higher (.597155) than the beta for health (.222155) indicating a stronger relationship between self-esteem and life-as-a-whole. As well, in the correlation analysis there was a moderate positive relationship between self-esteem and health ($r=.411$). Therefore, these data suggest that the relationship between health and life-as-a-whole can be explained by variables such as self-esteem. One speculation may be that a person's health effects his/her self-esteem which, in turn, influences satisfaction with life-as-a-whole. The small numbers in this sample makes this analysis tenuous but this hypothesis could be tested using a larger sample.

A partial correlation coefficient analysis was done with the three variables of life-as-a-whole, self-esteem and health (APPENDIX XII). The results continued to show that self-esteem was the most powerful variable for life satisfaction. The results indicated that approximately 50% of the variation in life-as-a-whole could be explained by self-esteem ($r=.7101$) when the relationship between life-as-a-

whole and self-esteem were examined, including health and controlling for its effects. Approximately 5% of the variation in life-as-a-whole could be explained by health ($r=.2302$) when the relationship between life-as-a-whole and health was examined, including self-esteem and controlling for its effects. This further supports the importance of self-esteem.

Additional Comments By Patients

There were a number of additional important items discussed during the interview which have not been discussed in this report. The most significant was that respondents consistently spoke positively about the staff. They found all levels of staff to be competent, caring and providing of good service (APPENDIX VIII). On the Geriatric Medicine service 83% of the patients remarked in this way compared to 31% of the patients on the Acute service. This may not reflect a difference in competency, caring and service provision by the different services but rather their policies, programs and approaches. The Geriatric services use a primary nursing approach where patients are assigned the same nurse for extended periods of time. Although the patients did not make direct reference to this particular approach one might speculate that this policy contributes to their positive comments about the staff. Primary nursing allows a relationship to develop which could benefit the patient. The patient feels that he/she has someone to talk

to and confide in who cares. The literature supports the need for a confidant, qualitative relationships and companionship for increased life satisfaction (Bowling et al, 1989; Conner et al, 1979; Chappell & Badger, 1989). The Acute service does not use this nursing approach so that the patients have a constant turnover of staff.

Besides the primary nursing approach, the staff on the Geriatric Medicine service are more accustomed to dealing with this particular population and with long term care issues. Panelled patients are the norm on this service and practices are built in and supported at a program and policy level. On the Acute service, patients with higher medical requirements, such as those recovering from surgery, may be given priority in terms of hospital staff attention than are panelled patients. These psycho-social benefits of the Geriatric services to the patients were evident from the interview comments.

A number of other positive comments were made by patients (APPENDIX VIII). These included the feeling of safety and security offered by the hospital (2 patients), good meals (4 patients), the feeling of inclusion in decision making by some (1 patient), recreation programs (2 patients), and being allowed to bring in their own TV on the Geriatric service (1 patient). These comments were made by patients on both services.

In addition to the previously mentioned comments that patients felt would contribute to greater happiness, a number of patients wished that they could get out of the hospital and go home or go to a nursing home (9 patients). This was likely related to feelings of being 'in limbo' and the desire to become more settled at their destination.

SUMMARY

The data suggest those who had lower life satisfaction scores were level 1 and 2 patients, those who were not cognitively impaired, those who had been in hospital for shorter lengths of time, those who had previously lived with someone else, and those who were separated or divorced. Those who required less care may have had greater ambivalence about their need for the type of care being provided which may have contributed to their lower levels of satisfaction. They may still be in a state of transition regarding the acceptance of their present status. The same explanation could apply to those who had been in hospital for a shorter period of time and who had not yet come to terms with their changed situation. The patients who had previously lived with a family member or spouse were also less satisfied. This may be explained in terms of the change in the nature of their relationships and closeness to family once they were hospitalized. They would likely feel more isolated and lonely having moved away from their family and home and into the hospital.

Those who were most satisfied were those who had greater care needs, were more cognitively impaired, those who had been hospitalized for a longer period of time, those who were younger, those who were single and those who had been living alone prior to hospitalization. Those who required more medical care and assistance with activities of daily living found security and comfort having their needs tended to. The patients who were hospitalized for longer lengths of time were also more settled and satisfied. This may be explained because they have adjusted to the surroundings and routine, have assumed a sick role in a medical setting and/or become more compliant with less choice and freedom. Helplessness can be reinforced and fostered in this type of setting. Becoming more settled with time can have a negative impact on a move to a personal care home as people are uprooted and relocated. For the patients who were previously alone or single there was increased satisfaction as well. This was likely because the level of support and companionship increased with hospitalization as compared to being at home alone.

Contrary to the original research assumption, the satisfaction of patients on the Acute and Geriatric services were similar. In fact, the Acute service patients indicated a slightly higher level of satisfaction than the patients on the Geriatric service. This could be explained using the Multiple Discrepancies Theory. The patients on the Acute

service did not expect the hospital to provide much more than personal and medical care of which medical care was the main focus on this service. This role congruity would have a tendency to reinforce a sick role and helplessness. The Geriatric service, in its attempts to pay attention to the psycho-social needs of the patients would raise their expectations of the role of the hospital and create a gap between what is expected and what can be provided.

The results from the life satisfaction variables pointed to three items that patients found to be unsatisfactory: health, self-esteem and living partner (TABLE 14). Patients felt that their poor health impacted negatively on their independence and their ability to do the things they wanted to do. This was at the root of their dissatisfaction with other psycho-social issues. Their perceptions of their self-esteem was poor and they described themselves and their situations using words like useless, burden and undignified. Their wish was for greater freedom, choice, independence and decision making. Patients were dissatisfied with the number of roommate changes that occurred. These likely had an impact on the forming of good relationships and contributed to feelings of loss, fear and disappointment with the discharge or death of roommates. The Acute service patients seemed to have lower expectations regarding this and were more accustomed to changing roommates. Living partners, which included patients in other rooms, were often

disruptive and this was viewed as being intrusive to ones' privacy.

The Geriatric patients indicated higher satisfaction with family relations, environment and transportation (TABLE 14). The satisfaction with the first two items were likely attributable to the improvements made on the Geriatric service geared toward these particular issues. These were factors which were related to fostering relationships and improving self-esteem. Regardless of the level of satisfaction with family, patients almost always wished for more closeness and contact with their families. Transportation was not impacted on by the hospital.

The patients on the Acute service were most satisfied with religion, transportation and finances (TABLE 14). Since the availability of spiritual resources was equal for both services the positive response for the Acute service may be related more to the meaningfulness of the interaction and visits by the pastoral care workers and other private resources, which is not provided to any extent through alternate forms. The hospital has little if any impact on finances and transportation.

The correlation analysis examined the relationships between the individual domains and life-as-a-whole. Most highly correlated with life-as-a-whole was self-esteem, followed by

health, environment, recreation and finances. The importance of self-esteem as a strong predictor of life-as-a-whole was substantiated by the multiple regression analysis and can perhaps explain the relationship between health and life-as-a-whole. These analyses only partially substantiated the hypothesis that life-as-a-whole would correlate with family relations, friendships, living partner and recreation.

Some other open ended comments offered by patients suggested that they appreciated the care given by staff. More particularly this seemed to relate to the relationships that had developed with staff on the Geriatric service. There was sometimes mention of the feelings of waiting and being 'in limbo' which contributed to unsettled feelings for some of the patients.

In summary, the most significant findings arising from the patient data included the effects of the length of hospital stay on ones' life satisfaction and the importance of self-esteem and perceived health for satisfaction with life-as-a-whole. These, as well as the other mentioned findings, are important for better understanding the psycho-social needs of the panelled patients and they have implications for the development of policies, programs and practices.

CHAPTER IV

RESULTS OF THE KEY INFORMANT INTERVIEWS AND COMPARISONS WITH THE PATIENT SURVEYS

In a social needs assessment it is important to compare the various perspectives in order to provide a fuller description of the current programs and to determine more completely the needs of the patients, considering the options that are viable within a given system. This chapter reviews the findings from the key informant interviews, and compares and summarizes the patient and key informant perspectives.

KEY INFORMANT INTERVIEWS

The key informant interviews were conducted with various levels of staff from both services. The intent was to obtain the hospital's perspective on the psycho-social needs of the patients from a policy, program and practice level and to provide a cross reference to the patient data. The original proposal planned for eight key informant interviews, consisting of four from each service. Only six were available for an interview but this number included both administrative and clinical staff from each of the services so that various perspectives were represented.

Key Informant Perspectives On The Life Satisfaction Of The Patients On The Geriatric And Acute Care Services

Using the eleven items on the patient questionnaire as a guideline the key informants were asked to list the items that they thought their service had the most positive impact on for patients' life satisfaction and the items that they thought their service had the most negative impact on for the patients' life satisfaction. They were also asked to indicate which item(s) the service had little or no impact on for the patients' life satisfaction.

The items that were most frequently considered by key informants as having a negative impact on patients on the Geriatric wards were environment and friendships (APPENDIX IX).

The environment was viewed as being far from ideal because of its lack of privacy, its noise and activity levels, and its institutional atmosphere which was described as "hard" and "functional" rather than "warm" and "comfortable". The staff recognized the need for patients to have better access to telephones so that they could maintain contact with family and friends. As well the long hallways cluttered with carts and linens, the lack of fresh air, and the sharing of personal space, such as bathtubs and bathrooms, were thought to detract from the patients' well being.

In spite of these negative ratings, some of the informants also offered positive comments about the environment indicating that a great deal of attention had already been paid to this issue, attempting to make the wards more comfortable for the patients within the current hospital structure. Frustration was expressed regarding the limitations presented by the ward layouts.

In spite of some of the negative key informant comments about the living environment this was one of the items that the patients rated more favorably. It appears that the service's recognition of and focus on such items as staff/patient relationships and creating a less sterile and more home like environment may have contributed to greater patient satisfaction with this item.

The key informants on the Geriatric service thought that the hospital was not conducive to maintaining friendships and that it had a negative impact on these relationships. The staff thought that the friends would not view the hospital as a living arrangement but as a holding area for patients. Their role as friends and visitors was not defined or encouraged in this setting and so they would feel awkward and uncomfortable on the ward. Another issue regarding friendships was the physical difficulty that elderly friends would have in getting to the hospital. As well, it was difficult for patients to maintain contact through other

means because of inaccessibility to telephones and often difficulty with letter writing.

A comparison with the patient data for friendships indicates that it was not considered amongst the most dissatisfactory items for the patients. Patients rated this item as "mixed". Patients had low expectations of maintaining their previous friendships and recognized that it was difficult for their elderly friends to visit. Some commented that many of their friends had predeceased them. Some of the patients also expressed the wish for better accessibility to telephones.

The key informants for the Geriatric service felt that they had a positive impact on the patients' family relations, health, recreation and self-esteem. They not only considered their medical assessments to be thorough and accurate but thought that they addressed psycho-social issues such as encouraging family involvement through regular family conferences, through individual contact with families and private visiting areas, by encouraging patients to participate in the social programs, and by helping to foster and facilitate relationships on the wards through the pairing of roommates. There was also an attempt to allow for increased choice and decision making regarding meal times, clothing, etc. and staff encouraged patients to bring some of their own belongings to the hospital. It was felt that these activities contributed to increased self-esteem.

In comparing these results to the patient surveys it was found that the Geriatric Medicine service's programs that were designed to address some of the psycho-social needs of the patients did not reflect itself in the overall life satisfaction score but appeared in some of the scores for individual items and some of the open ended comments by patients. In particular the service's recognition of and focus on family involvement likely contributed to greater patient satisfaction with this item. The patients rated their satisfaction with family relations amongst the highest.

Although the staff felt that they had a positive impact on the patients' self-esteem and health these were amongst the most unsatisfactory for the patients. The patients expressed the lack of and the staff also recognized the need for more choice, independence, control and freedom and the opportunities to engage in more meaningful activities. These were expected to contribute to improved self-esteem which was found to be correlated with life satisfaction in the correlation analysis.

The issue of physical health was an issue that was frequently commented on by both the patients and the key informants from both services. The patients were dissatisfied with their health and often considered it a primary source of negative impact on other areas such as

social activities and self-esteem. Yet both services thought that health was the issue that they best addressed and most positively impacted on for patients. Since the staff have addressed patients' medical problems to the fullest or as best they could and yet patients perceived their health as being dissatisfactory there may always be a significant gap in this area that is unresolvable but that continues to dominate the patients' sense of well-being. This represents a basic, significant loss to the patients hence the grieving or adjustment processes must be considered for dealing with these feelings.

Although staff recognized and attempted to address the issue of living partners and compatibility this was still not satisfactory to patients. In fact the level of dissatisfaction with living partner was similar for both services. However the staff on the Geriatric wards felt that they had observed positive relationships develop from the pairing of individuals and that they were attempting to deal with this problem in spite of the constraints of the hospital set-up.

On the whole staff seemed to be aware of the psycho-social needs and wants of the patients and their attempts to improve the current situations for patients resulted in higher patient satisfaction in many of these areas. In particular some of these items included patient satisfaction

with family and environment on the Geriatric Medicine service. This supports the value of the programs geared to increasing the patients' psycho-social well-being. Although some of the positive attempts did not always result in patient satisfaction the staff were well aware of many of the gaps and were continuing to attempt to deal with these.

The key informants for the Acute service thought that their service had a negative impact on patients' recreation activities, family and friendships, environment and self esteem. Sometimes patients were found to be in a room with more than one other person. There was little privacy in the room and a lack of private visiting areas outside the room. This contributed to difficulties in visiting with family and friends and in having an area to consider one's own. Because of the high patient turnover on this service, the unavailability of social programs and the lack of staff attention due to other more "urgent" situations, informants thought the patients were socially isolated and living in an environment with little stimulation. The feelings of isolation and of being ignored were thought by key informants to contribute to low self-esteem and lack of dignity.

The lack of attention given to psycho-social issues was not reflected in lower overall life satisfaction scores for patients on the Acute service but was reflected in lower

scores, as compared to the Geriatric service, in some of the individual domains (TABLE 14). When key informant results were compared to the patient surveys it was found that self-esteem, family, environment and living partner were also rated amongst the most unsatisfactory by the patients. These areas of need are indeed recognized by the key informants but there has been no improvement of the situation at a program and policy level by administration given the difficulties in appropriately integrating the panelled patients into the current hospital system.

The key informants from the Acute service considered their most positive impact as being on the patients' health. This was viewed as their primary role and, although psycho-social issues were recognized, they were not dealt with at a program level but rather sometimes on an individual level by referrals to other resources such as social work or pastoral care.

As previously indicated the patients perceived their health as being the most dissatisfactory item in spite of the staff's provision of good medical attention. Perhaps, more important than the need for a focus on medical attention is the need for assisting the patient in the grieving or adjustment process in dealing with these losses and changes.

The patients tended to rate at the top of their satisfactory items those items that had little to do with the hospital such as transportation and finances which key informants from both services considered themselves as having little or no impact on. Spiritual fulfillment was the third item rated as satisfactory by the patients but this could be partly due to the patients' self satisfaction with this or due to a service offered equally to all patients in the hospital. Those who received pastoral visits were appreciative of this attention and found the interaction to be meaningful. This may be partially due to compensating for a lack of other activities and opportunities for meaningful interaction.

The need for opportunities for increased meaningful interpersonal relationships have practice and policy implications. Panelled hospitalized patients are living in an environment that focuses primarily on acute medical care and less on psycho-social issues and relationships, especially on the Acute service. The favorable responses to and the expressed need for companionship would indicate the need to include these issues in the development of policies and practices regarding the care of this group of people. Currently these issues are not being addressed at a policy level on the Acute service nor are there intentions to do so, in spite of the recognition of this problem. There is an attempt to address them at a practice level but resources are limited and inadequate.

The key informants recognized that their services have strengths and weaknesses and that these have impacts on patients' levels of life satisfaction. For the Geriatric service the key informants thought that they had a positive impact on many of the psycho-social aspects such as the patients' health and on family relations, recreation, living partner, environment and self-esteem and a negative impact on the ward environment and on friendships.

Some of these results were similar to that of the patients. Specifically, patients were most satisfied with their environment and family relations, and had mixed feelings about the recreation activities. Contrary to the comments by staff, patients were most dissatisfied with their health, self-esteem and living partner. The key informants for the Acute service viewed their service as having excellent health and medical care but detracting from patients' family and friendships, recreation, environment and self-esteem. Patients' comments similarly indicated a dissatisfaction with their health, self-esteem and living partner and mixed feelings about family, friendships, recreation and environment.

Open Ended Questions

Key informants were asked 'what would make patients' lives happier'? The Acute informants thought that patients would be happier if they were able to move out of the hospital

more quickly. They recognized their service as being an inappropriate and poor environment for the long-term well-being of the panelled patients due to the medical focus, lack of stimulation and contribution to low self-esteem. The Geriatric informants responded by suggesting that patients would benefit from the hospital encouraging increased independence and decision making, increased individualization and personalization, increased meaningful contacts with others and increased opportunities for meaningful interaction and socialization.

In comparing these responses to the patients' comments it was found that these same items were also of importance to some of the patients. However overall the item that was consistently commented on most frequently by the patients was the wish for better health.

The key informants were asked 'what their service could do to improve patients' hospital stays? The Acute informants recognized the need for increased recreation and opportunities for socialization, increased choice and decision making, primary nursing for the establishment of relationships between patients and staff, increased privacy and increased independence. The Geriatric informants' comments included increased involvement, education, communication and preparation for personal care home placement, increased support and contact for families,

increased meaningful and purposeful activities geared to the needs and wants of the patients, increased opportunities for coming and going outside the hospital setting, more patient involvement and decision making regarding their own care, and improved attitudes towards those who are awaiting personal care home placement.

These comments were similar to those expressed by the patients. Although many of the patients felt that the staff were doing the best they could, when questioned further the most frequent item mentioned was the wish for more attentive staff regarding activities of daily living such as answering call bells, assistance to the toilet and off again, etc. These may not be recognized as significant items to staff but they were significant activities in the lives of the patients and relate to issues of self-esteem, dignity and control as well as that of personal care needs.

Finally, key informants were asked to indicate "what their services did well". The Acute informants felt that they provided excellent medical care, ie. diagnosis and treatment. The Geriatric informants thought that besides excellent medical assessments, treatment and follow-up, they provided a good multi-disciplinary approach to care, considering both the medical and psycho-social needs of the patient. They saw themselves as treating people as individuals and worthwhile beings, using a positive and

encouraging approach for patients to do as well as they could in all spheres. The informants on this service also concluded that they did a good job of assisting patients in planning for their future needs and that, as a result, the decision to panel for personal care home placement was viewed by the staff and patients as being the right decision.

These items were not specifically mentioned by the patients however they may be inferred by some of the comments made by the patients. The most frequently mentioned item by the patients was the good care provided by the staff. This was most frequently mentioned by patients on the Geriatric Medicine service. The staff's philosophies of health care provision, as mentioned in the staff comments, may have contributed to these results. As well, although the primary nursing was not mentioned as the reason for commenting on this item it may be speculated that this may also contribute to these results.

The key informants were asked to rate the patients' life satisfaction and to indicate how much their service contributed to patients' psycho-social well-being. Key informants on both services thought the patients' satisfaction was 'mixed' to 'satisfied'. The Acute informants thought that they contributed 'some' to patients' well-being but the Geriatric informants thought they

contributed 'some' or 'to a great extent' to their well-being.

Comparing the patients' surveys to the key informants' surveys the overall rating of the patients' life satisfaction was found to be similar (ie. mixed - satisfied). However when the patients' responses to the question about their life-as-a-whole was examined in comparison to this item it rated lower (ie. dissatisfied - mixed). These results were similar for both services.

In summary, a comparison of the patient and key informant interviews indicated that even though the hospital's policies and programs do not always fully address the needs of the patients the staff were well aware of many of these needs and were aware of the contributions the hospital could make for increased patient happiness. The attempts made to address the psycho-social issues, particularly on the Geriatric service, likely contributed to greater satisfaction with some of these items. The key informants' remarks and the patient interviews raised similar issues regarding the needs of the patients. This congruency is a step in the right direction.

When comparing the patient and key informant surveys differences were found in the key informants' ratings of

their services and the impacts that they had on the patients' life satisfaction.

The Acute informants viewed their strengths as lying in their provision of good medical care. Although health was considered an important issue for patients it was also rated as unsatisfactory by them and was thought to be the primary reason for their inability to live their lives as they wanted to be able to. The key informants recognized their lack of emphasis on and lack of contribution to psycho-social issues, such as relationships, social interaction and self esteem, at a program and policy level and realized that more attention paid to these issues would result in greater happiness for the patients. The need for a greater focus on the psycho-social issues, especially that of improved self-esteem and family contact, was also supported by the patients' comments and low ratings of their life satisfaction with these items. The key informants recognized the difficulty in providing the patients with this type of care given the diversity of their wards and the scattering of panelled patients and thereby felt that the best option would be the quick movement of patients out of the hospital and into personal care homes.

The Geriatric Medicine key informants recognized their strengths both in providing good medical care and in dealing with many of the psycho-social issues, such as families,

socialization and self-esteem. They also identified areas requiring improvement regarding some of the psycho-social needs such as increased autonomy, family support, involvement in the preparations for personal care home placement and opportunities for meaningful social interactions. The patient interviews indicated a satisfaction with some of these items, especially with family relations and environment, but also indicated the need for increased control and decision-making and a wish for improved health. The recommendations offered by these informants tended to include actions to be taken by the hospital for improving hospital programs and practices related to patient satisfaction rather than quicker movement to the personal care home, although this had also been suggested in one of the key informant interviews.

Although health was often considered to be the primary focus and one of the best addressed issues by staff on both services, this was the item that was amongst the most unsatisfactory for the patients. Since the patients' medical status was stable and they were unlikely to improve further, there may be a need to focus more on the adjustment to the losses and changes associated with their health than on their physical status. This is necessary given the importance of this factor for the patients.

CHAPTER V
IMPLICATIONS OF THE FINDINGS FROM THE PATIENT AND KEY
INFORMANT INTERVIEWS

The information obtained from the patient and key informant interviews have important implications for the development of policies, programs and practices regarding patients who are waiting for a transfer to a nursing home in the hospital. This chapter summarizes the findings and discusses the implications of the findings.

The research question that patients on the Geriatric service will show a higher level of overall life satisfaction than panelled patients on the Medical/Surgical service was not substantiated in this study. The mean life satisfaction scores were similar for both the Geriatric and the Acute services. This indicates that people tend to adapt to a situation regardless of its appropriateness. Possible explanations for this are lower expectation levels for social opportunities of people on the Acute service and the adoption of a 'sick role' whereby patients felt that they were unable to engage in many activities or to do for themselves due to illness. This would be particularly reinforced on a ward geared to medical rather than personal care where the patients' expectations for medical attention would be congruent with the hospital's role.

Acute care hospitals focus primarily on the provision of competent medical care. This medical focus reinforces a 'sick role' whereby patients are expected to cooperate with treatment and remove themselves from their usual social roles in order that they recover. For those who are acutely ill this may be a necessary and realistic step. However the chronic care patients are a unique group of people who, through no choice of their own, will not be recovering from their conditions (Callahan et al, 1966). In spite of this patients often indicated a sick role psyche by expressing their disinterest and inability to engage in social activities due to their illness, by focussing on their physical needs and by their contentment at being cared for in a medical setting that offered little else in the way of socialization.

Perceived physical health and the focus on illness was clearly a major issue for panelled patients on both services. They perceived their health as very unsatisfactory and felt that this impacted negatively on other aspects of their lives. The hospital believed it was doing everything possible with respect to health.

The medical and physical health focus have important implications for change in the hospital's provision of services to these patients. Since nothing more could be done to improve the patients' physical and functional well-being

perhaps the emphasis needs to be redirected from the physical aspects and toward the psycho-social issues that are important for their well-being. Some of these issues include assisting people to do the things that are important to them, increasing the opportunities for improved family relations and friendships and building in methods of allowing the patients more independence and control for increased self-esteem. These issues were identified as important by patients and key informants. Other important factors may include assisting in the adjustment to the patients' health and social changes and losses through individual and /or group social work. Attention given to these issues could help patients to cope with and adapt to the effects of the poor health and functional status and improve patients' self-esteem which was found to be unsatisfactory. As well it could help to reframe the sick role concept in the context of its appropriateness for chronic care patients.

It should be noted that in spite of the similarity in scores for the different services there were some differences found for individual items. The patients on the Geriatric service reported higher satisfaction with their family relations and environment than those on the Acute service indicating differences in satisfaction between the services for certain psycho-social items. This points to the value of the Geriatric service giving attention and consideration to

these issues and the need for these opportunities to exist for all patients.

The correlation coefficients and multiple regression analyses indicated that self-esteem is the variable that is most highly correlated with life-as-a-whole followed by health, environment, recreation and finances. Patients rated their self-esteem as being relatively low and expressed a need for greater control, decision making, choice and freedom. This corresponds to some of the literature regarding the importance of self determination for the elderly's life satisfaction (Vallerand, 1989; Smith & Lipman, 1972; Wolk & Telleen, 1976).

Health, as previously discussed, was also one of the most important variables for the patients and was also one of the most unsatisfactory items. Perceived health has been shown to be linked to life satisfaction in other studies (Wolk & Telleen, 1976; Markides & Martin, 1979; Gfellner, 1989). While health care is being addressed to its fullest by the hospital in concrete ways, there may need to be increased efforts made to deal with the emotional aspects associated with the loss of an individual's good health.

The hospital environment was also positively correlated with life satisfaction and this was found to be relatively satisfactory for patients on the Geriatric wards but not for

those on the Acute wards. This may be linked to the more congenial atmosphere that has been created on this service.

Recreation was correlated with life satisfaction but patients on both services were only moderately satisfied with this. This could be a function of wanting to be left alone, the 'sick role' or of the lack of activities that are important and meaningful to the patients. The sick role theory supports the removal of oneself from social role responsibility during times of illness (Parsons, 1951). As well while some of the literature has focussed on the need for activities (Graney, 1975; Markides & Martin, 1979; Tobin & Neugarten, 1961; Smith & Lipman, 1972) what often seems to be the most important is the quality and meaningfulness of the social interaction and the degree of companionship with others (Bowling et al, 1989; Conner et al, 1979; Liang et al, 1980; Chappell & Badger, 1989). Perhaps the relationship component is missing for the patients as well as the inclusion of meaningful activities.

The key informant data reinforced the differences in policies, programs and practices on the two services, their awareness of the strengths and weaknesses of their services and their awareness of the patients' psycho-social needs. The Acute informants emphasized their primary role as that of medical but were also aware of the lack of attention being given to the patients' psycho-social needs on this

service such as increased opportunities for social interaction, privacy, family and friends, and control and decision making. It was also mentioned that none of these recognized items were being dealt with on a program and policy level nor were there plans to do so at present by administration. They would continue to be addressed on an individual basis by resources such as social work, pastoral care, psychology, etc. However these are often limited resources.

These findings regarding the psycho-social needs of the patients have important implications. In order for the Acute service to attend to the psycho-social needs consideration should be given to approaching this issue at a program and policy level. Grouping these patients into one area would allow for the problems to be dealt with at these levels. The current organization and operation of the wards make it difficult to improve this situation because there is such a diverse mixture of patients on the wards and because panelled patients are scattered throughout the service. A grouping of patients would allow for primary nursing and relationship building, lower patient turnover, opportunities for specific, appropriate and meaningful activities, and more emphasis on family and friends. It would also legitimize the patients' presence in hospital without making them feel like they were 'bed blockers' as this group is often termed and would also de-emphasize the sick role.

Working within the current Acute service system there are opportunities for improving the patients' quality of life at a practice level as well. This can be achieved in a variety of ways. Patients would benefit from increasing staff/patient interaction, even minimally, in a social context separate from the provision of personal care. There is a tendency to focus efforts towards the more active and critical situations. However time spent with the panelled patient can be justified, as these patients do not demand time for other more extensive medical or nursing treatment. Relationships can also be fostered through the increased linking of volunteers with patients. This is a resource available in the hospital upon request. Religious institutions can be contacted to visit their members or perhaps panelled patients can be linked with each other on a one-to-one basis so that they can visit or share mealtime together. More importantly, family relationships can be better maintained by encouraging families to take patients off the ward to quieter places within the hospital or to take patients out on a regular basis. When possible, the pairing of panelled patients as roommates is beneficial for linking long stay patients and their families for supportive reasons and for companionship.

The Geriatric service also viewed the medical issues as a primary focus but they recognized and were attempting to address, with success as indicated by some of the life

satisfaction scores, the psycho-social issues. The staff's comments about the need for increased decision making, independence and control and for meaningful activity were congruent with the patients' comments about their needs.

Many efforts have already been made on the Geriatric service to address the psycho-social issues at a program and practice level. Further study needs to be done on the specific ways in which these can be better achieved. Some suggestions arising from this study included better access to telephones, help with letter writing to friends and family, more privacy, less confinement and more opportunities to go out, being listened to, the sensitivity to and avoidance of undignified situations and more decision making in day to day matters.

Although separate areas can be set up in the hospital to attend to the needs of this group of patients, this may not necessarily be considered the most desirable option. The primary reason is that it creates an extra move for the patients which would be additionally disruptive to them and may further detract from their levels of life satisfaction.

The demographic data that has the most important implications was that of length of hospital stay. Those who had been hospitalized for longer periods were the most satisfied. Perhaps this needs to be addressed at a

government policy level. The best option may be a quicker movement out of the hospital and into the nursing home where these needs can be better attended to. Patients that remained in hospital longer became more settled creating a situation where patients, once settled into an environment, were uprooted to move to the nursing home. Quicker access to nursing homes may help to avoid this situation and may facilitate a smoother transition to the nursing home for the patient. This is not possible in the present system unless more beds are made available. Further study is required to determine which environment contributes to higher patient satisfaction: hospital or nursing home. However the literature has pointed to the negative effects of hospitalization, in terms of physical and mental deterioration. Also because of the higher costs of hospitalization in an acute care facility another option is building more extended care hospitals which address patients' medical, rehabilitation and psycho-social needs.

Finally, the move to the personal care home could be better facilitated by opening the lines of communication and by ongoing preparation through staff involvement in this matter. This is especially important for those whose waiting periods are lengthy and who sometimes lose sight of a possible move. The preparation can alleviate some of the anxieties especially for those who have become established and settled in the hospital system.

Further research on this topic is necessary to substantiate the results of this project. The time and resource limitations had an effect on the sample. Given a longer time frame with which to work, the sample would have been larger and the selection biases could have been controlled for which would have strengthened the results. This study was a useful pilot project which may be used to refine the methodologies for a similar project conducted over a longer period of time and with a larger sample size.

In summary, the recommendations are based on both patient and key informant interviews and they focussed on ways in which the patients' life satisfaction may be improved. Changes were recommended at policy, program and practice levels for consideration by the two services and by Manitoba's Continuing Care Program.

CHAPTER VI

EVALUATION AND CONCLUSION

EVALUATION OF THE PRACTICUM PROCESS

The learning goals that the writer hoped to achieve were two-fold. The first goal was to learn how to conduct a research project from its conception to completion. The second goal was to gain a better understanding of the panelled hospitalized patients. Both were achieved through the practicum process.

At the start, being able to focus and research a topic until it was a manageable and specific project was a significant task in itself. It began with broad topics and, through a number of meetings with committee members, research and many reconceptualizations, was narrowed into a meaningful and pointed area of study. In retrospect the writer can appreciate the importance of narrowing the project to this extent as this added clarity and better direction as the process continued.

The designing of the study and its questionnaires was a new learning experience for the writer. The attention to detail was again only fully appreciated in retrospect. Sorting out the details prior to the data collection made the subsequent steps proceed smoothly and with few problems. A good example of this was the attention paid to the coding system to be

used in the input of the data into the computer which was done during the forms and questionnaire development stage. This preliminary planning made the later stages easier.

The patient interviews proved to be a larger task than was expected which again was a learning experience for the writer. Although the actual interviews were kept as brief as possible, considerable time was spent on activities such as meeting with the social workers, tracking down the patients and returning several times over to obtain a single interview due to patients being occupied with other matters. As a result the time factor is more fully recognized by the writer as being important for anticipating the resources required for a research project of this nature. The importance of maintaining contact and positive relationships with the social workers, as well as providing ongoing feedback, was essential for accessibility to the required information and the patients and for continued interest in and assistance with the project by the staff. The social workers were all found to be exceptionally cooperative and helped to make the writer feel comfortable on the ward and with the patients.

Work at the computer proved to be a 'mini course' for the writer that has resulted in new knowledge gained in the areas of data input and statistical analysis. This experience took some of the mystery out of computers and

emphasized the usefulness of having this resource available to researchers.

On a broader level conducting a complete research project has been of personal and professional value to the writer. It has helped to develop the writer's skills in this field which is relevant for and transferable to involvement in other social research projects in the future. It is also beneficial in developing skill in being able to review critically and understand other research reports. The benefit to the profession lies in the ability for future involvement in research activities.

The sharing of thoughts and feelings by the patients and their willingness to participate in the project was an enriching experience and allowed the writer to gain a fuller understanding of this population. The writer learned that an essential step in obtaining the interview was being introduced to the patients by the social workers. Approaching the patient as a stranger was often unsuccessful but with a familiar person was almost always welcomed. After all, this is yet another intruder for the patient. Also the need for simplicity was reinforced when the letter of introductions provided to patients added to confusion for the patient. This letter was quickly discarded. Finally the practice of interviewing this population was an enlightening experience because it was quickly discovered by the writer

that it was ineffective to conduct the interviews in a rigid manner using structured formats and scales. The responses were better obtained using a more open-ended discussion method while using the scales and interview schedule only as a guideline. This method was more comfortable and understandable for the patients and resulted in more meaningful and in-depth responses.

The interviews with the key informants also helped the interviewer achieve the second learning goal of expanding the knowledge and understanding of the panelled, hospitalized elderly's needs. The information from these interviews contained important information and provided new perspectives to the patient data. All of the key informants were found to be open and honest and provided meaningful contributions. There seemed to be a genuine interest in the project's topic by this group of key informants.

On a broader level the interviews had both personal and professional value for the writer. On a personal level it helped the writer to better appreciate the feelings and needs of this population. This in turn will assist in the development of greater understanding and practice at a clinical level. The information and insight gained through the research adds to the body of knowledge in the field of aging and makes a contribution in an area where little research has been done.

This practicum report has some useful information for consideration by decision-makers and for further research by the hospital. The practicum and its findings have been presented to health care personnel interested in and involved with geriatrics. There are also plans to present the practicum to a group of geriatricians interested in improvements in this field. As well, the report will be submitted for publication in a professional journal. Finally, this study's results would be strengthened by a larger sample size. Plans are to design and implement a larger scale study including multi-hospitals which would also make the results generalizable to other hospitals.

CONCLUSION

This study considered the area of psycho-social needs of panelled hospitalized elderly people by investigating issues of life satisfaction for this population. A needs assessment approach was used for the purposes of providing useful information for program and policy development regarding this elderly population. The design proposed and discussed was the most appropriate given the desired level of knowledge and generalizability as well as the resource and time limitations that needed to be taken into consideration. The results of the study provided a rich and complete profile of the areas of need for this population. Recommendations for program and policy planning have been made.

The most significant findings included the increased patient life satisfaction with longer length of hospital stay, the importance of self-esteem and health for the patients' life satisfaction, and the lack of differences in the patients' overall life satisfaction scores for the Acute and Geriatric Medicine services. The findings also indicated a higher satisfaction with family and hospital environment on the Geriatric service where efforts were being made to address these issues.

The research findings suggested a number of implications and recommendations. First, the length of stay results pointed to the need for a quicker movement out of the hospital setting to avoid a settling in to an inappropriate environment and a reinforcement of a sick role. Second, the importance of self-esteem and perceived health related to issues of control, decision-making, and adjustment to change and loss. These issues could be dealt with at a program and practice level by offering more control to patients in day to day matters, by encouraging and assisting patients to be involved in activities that are important to them, by promoting individualization, and by offering individual and group services that address issues of grief, adjustment and change. Third, the importance of relationships can be better addressed at a policy level where programs and practices are built in to foster and maintain positive family relations and friendships. This has been achieved on the Geriatric

Medicine service with their congenial environment, staff/family relations and encouraging family involvement. This also needs to be addressed for patients on the Acute service.

My own learning goals included learning how to carry out a research project from start to finish and obtaining a better understanding about the social needs of this population. The research experience was invaluable and new knowledge was gained in planning the project, designing the methods and the questionnaires and learning how to use the computer for data analysis. The direct contact with the elderly patients was rewarding and helped me to more fully understand them.

APPENDIX 1

LIFE SATISFACTION QUESTIONNAIRE

I would like you to consider your life as it is right now. Please pick the number that describes your own life as it is now. (Give patient chart).

QUESTIONNAIRE

- | | |
|---------------------------|---|
| _____ 1. HEALTH | THE PRESENT STATE OF YOUR
GENERAL, OVERALL HEALTH. |
| _____ 2. FINANCES | YOUR INCOME AND ASSETS. |
| _____ 3. FAMILY RELATIONS | KIND OF CONTACT AND FREQUENCY
OF CONTACT WITH FAMILY
MEMBERS. THIS INCLUDES
PERSONAL CONTACT, PHONE CALLS,
AND LETTERS. |
| _____ 4. FRIENDSHIPS | KIND OF CONTACT AND FREQUENCY
OF CONTACT YOU HAVE WITH YOUR
FRIENDS. THIS INCLUDES |

PERSONAL CONTACT, PHONE CALLS,
AND LETTERS.

_____ 5. HOUSING

THE PRESENT TYPE, ATMOSPHERE
AND STATE OF YOUR HOME - E.G.,
ROOM WARD, ETC.

_____ 6. LIVING PARTNER

INCLUDES ROOM MATE.

_____ 7. RECREATION ACTIVITY

PERSONAL RECREATION ACTIVITIES
YOU ENGAGE IN FOR PURE
PLEASURE WHEN YOU ARE NOT
DOING NORMAL DAILY LIVING
CHORES OR SOME TYPE OF WORK.
THIS INCLUDES RELAXING,
READING, TV, REGULAR GET
TOGETHERS, CHURCH ACTIVITIES,
ARTS & CRAFTS, EXERCISES,
TRIPS, ETC.

_____ 8. RELIGION

YOUR SPIRITUAL FULFILLMENT.

_____ 9. SELF-ESTEEM

HOW YOU FEEL ABOUT YOURSELF;
YOUR SENSE OF SELF RESPECT.

_____ 10. TRANSPORTATION

PUBLIC AND PRIVATE
TRANSPORTATION - E.G.,

INCLUDING CONVENIENCE,
EXPENSE.

_____ 11. NOW, USING THE SAME SCALE, HOW DO YOU FEEL ABOUT
YOUR LIFE AS A WHOLE RIGHT NOW?

CHART

- 1 - Terrible
- 2 - Very dissatisfying
- 3 - Dissatisfying
- 4 - Mixed
- 5 - Satisfying
- 6 - Very satisfying
- 7 - Delightful
- 8 - Missing

OPEN ENDED QUESTIONS FOR PATIENTS

1. What, in general, would make your life happier?
2. What could the hospital do to improve your stay here?
3. What do you like the best about this ward?

APPENDIX II

STAFF MEMO

TO: MEDICAL/GERIATRIC TEAM

FROM: JUDY AHRENS-TOWNSEND

RE: MASTERS PRACTICUM

DATE: JUNE 13 1989

As discussed at a recent team meeting, my masters practicum on "The Life Satisfaction of Hospitalized Panelled Patients" is currently underway and my next step is to conduct interviews with suitable patients. I am anticipating that interviews will be taking place until the end of August and I would appreciate your assistance with the following:

1. Completion of BASIC DATA FORMS 1 AND 2 (attached) for each new panelled patient. I will need these completed for this, and possibly next, month depending on the number of suitable subjects obtained. Please forward the completed forms to me.

2. Consultation with you regarding the patients' suitability for participation in the study for those patients who are cognitively impaired to some extent.

3. Introductions to patients who will be approached for participation in the study.

If there are any questions regarding the study please be in touch with me.

THANKS

TO: BUNTY, JANE, REVA, AGATHE

FROM: JUDY AHRENS-TOWNSEND

RE: MASTERS PRACTICUM

DATE: JUNE 13 1989

My masters practicum on "The Life Satisfaction of Hospitalized Panelled Patients" is currently underway and my next step is to conduct interviews with suitable patients. I will require some basic data on the panelled patients on your service and would appreciate if you would provide this information to me. As well I will need your assistance in determining which of your patients are suitable for being interviewed by me (ie. able to respond appropriately to my questions). I anticipate that interviews will be taking place until the end of August and I request your assistance with the following:

1. Completion of BASIC DATA FORMS 1 AND 2 (attached) for each new panelled patient. I will need these completed for this, and possibly next, month depending on the number of suitable subjects obtained. Please forward the completed forms to me.

2. Consultation with you regarding the patients' suitability for participation in the study for those patients who are cognitively impaired to some extent.

3. Introductions to patients who will be approached for participation in the study.

If there are any questions regarding the study please be in touch with me.

THANKS

APPENDIX III

BASIC DATA (FORM 1)

NAME OF PATIENT _____

SOCIAL WORKER _____

1. DATE (Y) _____ (M) _____ (D) _____

2. HOSPITAL PATIENT/CHART NUMBER _____

3. M.H.S.C. NUMBER _____

4. BIRTHDATE (Y) _____ (M) _____ (D) _____

5. SEX (M) _____ (F) _____

6. MARITAL STATUS (PICK ONE RESPONSE)

1) SINGLE _____

2) MARRIED _____

3) SEPARATED/DIVORCED _____

4) WIDOWED _____

7. ADMISSION DATE (Y) _____ (M) _____ (D) _____

8. LOCATION OF ADMISSION

1) MEDICAL _____

2) SURGICAL _____

3) GERIATRIC _____

4) PSYCHIATRY _____

5) OTHER (SPECIFY) _____

9. PANELLED DATE (Y) _____ (M) _____ (D) _____

10. PRIMARY DIAGNOSIS ON ADMISSION_____
- _____
- _____
- _____
11. HAS PATIENT EXPERIENCED BEHAVIOR PROBLEMS?
- 1) NO_____
- 2) YES_____
12. IS PATIENT COGNITIVELY IMPAIRED? (CHECK ONE RESPONSE)
- 1) NO_____
- 2) TO SOME EXTENT_____
- 3) YES_____
13. WHERE DID PATIENT LIVE BEFORE HOSPITAL ADMISSION?
- 1) SENIOR CITIZEN HOUSING_____
- 2) APARTMENT_____
- 3) HOUSE_____
- 4) OTHER (SPECIFY)_____
14. WITH WHOM WAS PATIENT LIVING BEFORE HOSPITAL ADMISSION?
- 1) ALONE_____
- 2) SPOUSE ONLY_____
- 3) OTHER FAMILY_____
- 4) OTHER (SPECIFY)_____
15. LOCATION WHEN PANELLED
- 1) COMMUNITY_____
- 2) HOSPITAL_____
- 3) OTHER (SPECIFY)_____
16. CARE LEVEL AT PANEL DATE_____

BASIC DATA (FORM 2)

NAME OF PATIENT _____

SOCIAL WORKER _____

1. DATE (Y) _____ (M) _____ (D) _____
2. HOSPITAL PATIENT/CHART NUMBER _____
3. M.H.S.C. NUMBER _____
4. PRIMARY DIAGNOSIS ON DISCHARGE _____

(TO BE COMPLETED IF PATIENT HAS BEEN TRANSFERRED)

5. TRANSFER DEPARTMENT LOCATION
 - 1) MEDICAL _____
 - 2) SURGICAL _____
 - 3) GERIATRIC _____
 - 4) PSYCHIATRY _____
6. TRANSFER DATE _____
7. SECOND TRANSFER DEPARTMENT LOCATION
 - 1) MEDICAL _____
 - 2) SURGICAL _____
 - 3) GERIATRIC _____
 - 4) PSYCHIATRY _____
8. SECOND TRANSFER DATE _____
9. DISCHARGE DATE _____
10. DISCHARGE CARE LEVEL _____

11. DISCHARGE PLACE (MARK ONE RESPONSE)

1) DECEASED_____

2) NURSING HOME PLACEMENT (LIST SPECIFIC HOME)_____

3) SENT HOME_____

4) OTHER (SPECIFY)_____

12. PRESENT STATUS_____

APPENDIX IV

INTRODUCTION LETTER TO PATIENTS

Dear Patient

My name is Judy Ahrens-Townsend, and I am a graduate student in social work at the University of Manitoba. I would like to study the life satisfaction (general well-being) of hospitalized people waiting to move to a nursing home. I am interested in knowing more about how people feel about their lives and situations. I would like to have the opportunity to interview you. The study will have no effect on the services you receive from the hospital and on your involvement with the nursing home you have applied for.

The interview should take approximately 45 minutes to one hour of your time. People have found the interview to be interesting. The information you provide will be used for scholarly research only and will be entirely confidential. Participation in this study is voluntary.

Your help and cooperation would be greatly appreciated. Feel free to call me (phone or) if you have any questions regarding the study. A brief summary of the results will be made available and sent to all participants upon request.

Sincerely

Judy Ahrens-Townsend, B.S.W.
Phone

APPENDIX V

CONSENT FORM

I AGREE TO PARTICIPATE IN JUDY AHRENS-TOWNSEND'S 1989 STUDY OF THE WELL-BEING OF HOSPITALIZED PEOPLE WAITING TO MOVE TO A NURSING HOME. I UNDERSTAND THAT THE STUDY WILL HAVE NO EFFECT ON THE SERVICES I RECEIVE FROM THE HOSPITAL AND ON MY INVOLVEMENT WITH THE NURSING HOME I HAVE APPLIED FOR.

NAME _____

CO-SIGNED _____

DATE _____

APPENDIX VI

SERVICE_____

KEY INFORMANT_____

TITLE_____

KEY INFORMANT QUESTIONNAIRE

(PERSONAL INTERVIEW FORMAT)

IN MY INTERVIEWS WITH PANELLED PATIENTS IN THE HOSPITAL I AM ASKING THEM TO TALK ABOUT THEIR SATISFACTION WITH A NUMBER OF DIFFERENT ITEMS AS THEY RELATE TO THEIR LIFE AT PRESENT.

HERE IS THE LIST OF LIFE SATISFACTION ITEMS THAT I AM ASKING THE PATIENTS ABOUT. COULD YOU PLEASE LIST IN PRIORITY SEQUENCE (1 - 3) THE THREE ITEMS THAT YOU FEEL YOUR SERVICE HAS THE MOST POSITIVE IMPACT ON FOR THE PATIENTS' LIFE SATISFACTION. (1=MOST POSITIVE INFLUENCE).

THEN LIST IN PRIORITY SEQUENCE (4 - 6) THREE ITEMS THAT YOU FEEL YOUR SERVICE HAS THE MOST NEGATIVE IMPACT ON FOR THE PATIENTS' LIFE SATISFACTION. (4=MOST NEGATIVE INFLUENCE).

FINALLY, COULD YOU LIST UP TO THREE ITEMS (IN PRIORITY SEQUENCE FROM 7 - 9, IF POSSIBLE) THAT YOUR SERVICE HAS NO OR LITTLE IMPACT ON FOR THE PATIENTS' LIFE SATISFACTION. (7=NO/LEAST INFLUENCE).

- _____ 1. HEALTH THE PRESENT STATE OF YOUR
GENERAL, OVERALL HEALTH.
- _____ 2. FINANCES YOUR INCOME AND ASSETS.
- _____ 3. FAMILY RELATIONS KIND OF CONTACT AND FREQUENCY
OF CONTACT WITH FAMILY
MEMBERS. THIS INCLUDES
PERSONAL CONTACT, PHONE CALLS,
AND LETTERS.
- _____ 4. FRIENDSHIPS KIND OF CONTACT AND FREQUENCY
OF CONTACT YOU HAVE WITH YOUR
FRIENDS. THIS INCLUDES
PERSONAL CONTACT, PHONE CALLS,
AND LETTERS.
- _____ 5. HOUSING THE PRESENT TYPE, ATMOSPHERE
AND STATE OF YOUR HOME - E.G.,
ROOM WARD, ETC.
- _____ 6. LIVING PARTNER INCLUDES ROOM MATE.

- ____7. RECREATION ACTIVITY PERSONAL RECREATION ACTIVITIES
YOU ENGAGE IN FOR PURE
PLEASURE WHEN YOU ARE NOT
DOING NORMAL DAILY LIVING
CHORES OR SOME TYPE OF WORK.
THIS INCLUDES RELAXING,
READING, TV, REGULAR GET
TOGETHERS, CHURCH ACTIVITIES,
ARTS & CRAFTS, EXERCISES,
TRIPS, ETC.
- ____8. RELIGION YOUR SPIRITUAL FULFILLMENT.
- ____9. SELF-ESTEEM HOW YOU FEEL ABOUT YOURSELF;
YOUR SENSE OF SELF RESPECT.
- ____10. TRANSPORTATION PUBLIC AND PRIVATE
TRANSPORTATION - E.G.,
INCLUDING CONVENIENCE,
EXPENSE.

NOW THAT YOU HAVE IDENTIFIED HOW YOUR SERVICE IMPACTS SOME OF THE LIFE SATISFACTION ITEMS FOR YOUR PATIENTS, PLEASE ELABORATE ON EACH ONE AND DESCRIBE WHY YOU RESPONDED AS YOU DID.

LET'S TALK ABOUT EACH ONE BEGINNING WITH THE FIRST ONE YOU IDENTIFIED.

OPEN ENDED QUESTIONS FOR KEY INFORMANTS

1. WHAT, IN GENERAL, DO YOU THINK WOULD MAKE THE PATIENTS' LIVES HAPPIER?

2. WHAT DO YOU THINK THE HOSPITAL COULD DO TO IMPROVE THE PATIENTS' STAY HERE?

3. WHAT, IN YOUR OPINION, IS THE MOST POSITIVE ABOUT THIS WARD FOR THE PATIENTS?

PLEASE CIRCLE THE NUMBER (ONE FOR EACH QUESTION) THAT BEST REPRESENTS YOUR RESPONSE TO THE FOLLOWING QUESTIONS:

1. GENERALLY SPEAKING, HOW SATISFIED DO YOU THINK THE PATIENTS ON YOUR SERVICE FEEL ABOUT THEIR LIVES AS A WHOLE RIGHT NOW?

- 1 - TERRIBLE
- 2 - VERY DISSATISFYING
- 3 - MIXED
- 4 - SATISFYING
- 5 - VERY SATISFYING
- 6 - DELIGHTFUL

2. TO WHAT EXTENT DO YOU THINK YOUR SERVICE CONTRIBUTES TO THE OVERALL PSYCHO-SOCIAL WELL-BEING OF THE PATIENTS?

- 1 - TO A GREAT EXTENT
- 2 - TO SOME EXTENT
- 3 - NOT AT ALL

APPENDIX VII

APPROVAL FOR THE USE OF THE LIFE SATISFACTION MEASURE

Judy Ahrens-Townsend

Winnipeg, Manitoba
Canada
R3R 3M8
Telephone

Mr. Frank M. Andrews and Mr. Stephen B. Withey
Institute for Social Research
University of Michigan
Ann Arbor, Michigan
48106
U.S.A.

August 14, 1989

Dear Mr. Andrews and Mr. Withey

I am writing to request permission to use your model of evaluating perceptions of well-being, as found in your book entitled Social Indicators of Well-Being, for the development of a measurement instrument for use in my Masters practicum. I am in the Master of Social Work program at the University of Manitoba, Canada and I am studying the psycho-social needs of elderly hospitalized patients. My instrument would be brief and would incorporate a number of specific life concerns most suited to the elderly patients' present situations as well as questions regarding their feelings about Life-as-a-Whole.

I would appreciate your reply as soon as possible and thank you for your consideration.

Yours truly

Judy Ahrens-Townsend

25 Aug 1989

You hereby have the permission
requested above so long as you
appropriately cite the
original source.

APPENDIX VIII

OPEN-ENDED PATIENT RESULTS

1) What would make your life happier?

<u>RESPONSE</u>	<u>GERIATRIC</u>	<u>ACUTE</u>
BETTER HEALTH	16	4
MORE FAMILY/FRIEND CONTACT	9	5
INDEPENDENCE, FREEDOM, CHOICE	9	4
DO THINGS I USED TO DO, IE. DRIVE	7	1
GO TO NURSING HOME	2	3
GO HOME	3	1

2) What could the ward do better?

RESPONSE	GERIATRIC	ACUTE
MORE ATTENTIVE STAFF RE CALL BELLS, TOILETING, ETC.	5	2
BETTER MEALS	6	0
PRIVACY/LEAVE ALONE	0	2
COMPATIBLE ROOMMATES/ LESS NOISE	3	0
GET OUTSIDE	3	0
FRENCH LANGUAGE	0	1
FEEL LONELY/DO NOT FIT IN	0	1

3) What does the ward do well?

RESPONSE	GERIATRIC	ACUTE
GOOD CARE/STAFF	19	4
AS EXPECTED/DOING THEIR BEST	4	3
GOOD MEALS	2	2
PROTECTION/SECURITY	1	1
PRIVACY/LEAVE ALONE	1	1
OWN TELEVISION	1	0
FREEDOM TO COME AND GO	1	0
RECREATION PROGRAMS	2	0
INCLUDE IN DECISIONS	1	0

APPENDIX IX

KEY INFORMANT SURVEY RESULTS

What items does your service have the most positive impact on for the patients' life satisfaction?

ITEM	GERIATRIC	ACUTE
HEALTH	2	2
FINANCES	0	0
FAMILY RELATIONS	3	1
FRIENDSHIPS	0	0
ENVIRONMENT	1	0
LIVING PARTNER	2	0
RECREATION ACTIVITY	2	0
RELIGION	0	1
SELF-ESTEEM	2	0
TRANSPORTATION	0	0

What items does your service have the most negative impact on for the patients' life satisfaction?

ITEM	GERIATRIC	ACUTE
HEALTH	0	0
FINANCES	0	0
FAMILY RELATIONS	0	1
FRIENDSHIPS	3	1
ENVIRONMENT	3	1
LIVING PARTNER	2	0
RECREATION	0	2
RELIGION	1	0
SELF-ESTEEM	0	1
TRANSPORTATION	1	0

What items does your service have little or no impact on for the patients' life satisfaction?

ITEM	GERIATRIC	ACUTE
HEALTH	0	0
FINANCES	4	1
FAMILY RELATIONS	0	0
FRIENDSHIPS	0	0
ENVIRONMENT	0	0
LIVING PARTNER	0	1
RECREATION	0	0
RELIGION	0	0
SELF-ESTEEM	0	0
TRANSPORTATION	3	1

APPENDIX X

MULTIPLE REGRESSION ANALYSIS

VARIABLE	BETA	SIGNIFICANCE
SELF-ESTEEM	.597155	.0053
FRIENDSHIPS	.280697	.1875
RECREATION	.214053	.2320
TRANSPORTATION	-.147599	.3702
HEALTH	.222155	.3000
ENVIRONMENT	.158487	.4652
FAMILY RELATIONS	-.184545	.3644
FINANCES	-.065195	.7677
LIVING PARTNER	-.029488	.8778
RELIGION	-.029112	.8972

APPENDIX XI

CORRELATION COEFFICIENT

	V69	V70	V71	V72	V73	V74	V75	V76	V77	V78	V79
HEALTH	1.000	.599	.267	.307	.026	.327	.154	-.261	.411	.019	.497
V69	.999	.000	.057	.041	.440	.028	.185	.078	.007	.461	.001
	36	33	36	33	36	35	36	31	35	28	36
FINANCES		1.000	-.049	.133	-.106	.546	.273	-.295	.306	-.171	.356
V70		.999	.393	.235	.278	.001	.062	.064	.044	.197	.021
		33	33	32	33	32	33	28	32	27	33
FAMILY			1.000	.670	.162	-.020	.262	.221	.061	.248	.142
V71			.999	.000	.173	.455	.062	.116	.364	.101	.205
			36	33	36	35	36	31	35	28	36
FRIENDS				1.000	.074	.051	.338	.222	-.002	.303	.246
V72				.999	.342	.392	.027	.129	.495	.062	.083
				33	33	32	33	28	32	27	33
ENVIRONMENT					1.000	.135	.184	.548	.453	.074	.441
V73					.999	.219	.141	.001	.003	.354	.004
					36	35	36	31	35	28	36
LIVING PARTNER						1.000	.250	-.265	.197	-.285	.268
V74						.999	.074	.078	.133	.075	.060
						35	35	30	34	27	35
RECREATION							1.000	.334	.189	.166	.377
V75							.999	.033	.139	.199	.012
							36	31	35	28	36
RELIGION								1.000	.067	.365	.106
V76								.999	.363	.036	.285
								31	30	25	31
SELF-ESTEEM									1.000	-.032	.766
V77									.999	.437	.000
									35	27	35
TRANSPORTATION										1.000	-.067
V78										.999	.368
										28	28
LIFE-AS-A-WHOLE											1.000
V79											.999
											36

APPENDIX XII

PARTIAL CORRELATION COEFFICIENTS

$$\begin{aligned}r_{23.1} &= \frac{r_{23} - (r_{13})(r_{21})}{(1 - r_{13}^2)(1 - r_{21}^2)} \\ &= \frac{.497 - .411 \times .766}{(1 - .411^2)(1 - .766^2)} \\ &= .2302\end{aligned}$$

$$\begin{aligned}r_{21.3} &= \frac{r_{21} - (r_{13})(r_{23})}{(1 - r_{13}^2)(1 - r_{23}^2)} \\ &= \frac{.766 - .411 \times .497}{(1 - .411^2)(1 - .497^2)} \\ &= .7101\end{aligned}$$

$$\begin{aligned}r_{13.2} &= \frac{r_{31} - (r_{12})(r_{23})}{(1 - r_{12}^2)(1 - r_{23}^2)} \\ &= \frac{.411 - .766 \times .497}{(1 - .766^2)(1 - .497^2)} \\ &= .0543\end{aligned}$$

where X = self-esteem
X = life-as-a-whole
X = health

APPENDIX XII

SCHOOL OF SOCIAL WORK
UNIVERSITY OF MANITOBA

SCHOOL OF SOCIAL WORK COMMITTEE ON THE USE OF HUMAN SUBJECTS
IN RESEARCH

NAME: Judy Ahrens-Townsend

DATE: June 1990

YOUR PROJECT ENTITLED:

The Life-satisfaction of the Elderly Hospitalized Patients Awaiting
Nursing Home Placement

HAS BEEN APPROVED BY THE COMMITTEE

None

COMMITTEE PROVISOS OR LIMITATIONS:

You will be asked at intervals for a status report. Any significant changes of the protocol should be reported to the Chairman for the Committee's consideration, in advance of implementation of such changes.

** This approval is for the ethics of human use only. For the logistics of performing the study, approval should be sought from the relevant institution, if required.

Sincerely yours,

Ranjan Roy
Professor & Chairman,
School Committee on the Use of
Human Subjects in Research

RR/km

TELEPHONE ENQUIRIES:

474-9838

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