Gaming for Mutual Learning in Elder Care GAMLEC

Compendium on criteria for the quality of life of care home residents: National Report for Lithuania

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Document information

This document contains research results on the quality of life of home care residents in Lithuania, particularly focusing on autonomy, social participation, and human dignity of people in need of care.

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1. Aims of the national report

Mendola and Pelligrini (1979) defined quality of life as the satisfaction achieved by the individual in the social situation by understanding the physical limitations (Gilhooly, Gilhooly, Bowling, 2005). According to Efklides and Moraitou (2013), the construct of quality of life was introduced in 1980, as an indicator of the impact of health problems on people's daily lives. Since that time, the concept of the quality of life has expanded by combining different areas of people's lives such as physical and mental health, psychological state (cognitive and emotional), social relations, economic situation, leisure opportunities and working life.

Quality of life is multidimensional construct and comprises objective and subjective elements. Vaarama and colleagues (2008) present, that objective elements are income, housing, health and mobility, while subjective – life satisfaction and happiness. With references to Lawton (1991) authors named, that quality of life is multidimensional phenomenon, that includes intrapersonal and socioeconomic criteria.

The subjective nature of quality of life reflects the assumption that the specific determinants of quality of life are highly personal (Henrich, Herschbach, 2000; O'Boyle, 1994; cit. Dallimore, Mickel, 2006). Nolan, Davies and Grant (2001) argue, that quality of life is a dynamic and changing entity, varying according to the stage of the life course and reflect a set of shared concerns but is ultimately a subjective and individual experience. With references to Nilsson, Ekman and Sarvimaki, 1998), authors note, that a perception of "good life" in old age relates primarily with "personal relationships" (feeling of embeddedness), "engagement in meaningful activity and a feeling of being needed, links between past and present lives, where the past is viewed positively, as is the future, no matter how short and a philosophy of life based on religious or other strong personal beliefs" (Nolan et.al., 2001, p. 14).

Nolan, Davies and Grant (2001) with references to other authors define quality of life as a degree to which an individual enjoys the important possibilities in her/his life. When people locate themselves with reference to a place and social group, they also pursue their own goals and make personal choices and decisions. Eight basic assumptions that could be considered in the discussion about quality of life of old people living in residential care, relate to this humanistic-existential orientation. That is:

- Everyone, regardless of disability, must be respected equally.
- Any meaningful view of quality of life must reflect a holistic orientation.
- Quality of life is multidimensional.
- Quality of life is dynamic and interactive, with the relative importance and emphasis given to various components changing over the life course.
- Quality of life arises out of an individual's ongoing interaction with her/his environment.
- Quality of life is subjective and changes depending on the individual's personal values, beliefs and interests.
- Quality of life requires a broad conceptualization of health. Health is not just the absence of disease, it is not only physical, but also psychosocial well-being.
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- The personal perspective of each individual is the most important factor in determining the quality of life. The recognition of human individuality and uniqueness is unconditional. Consequently, the more personalized care, the better quality of care in residential home (Nolan et.al., 2001, p.15).

Based on these premises Nolan, Davies, Grant (2001) with references to other authors argue, that that quality of life comprises three major dimensions: **being** (individual's physical, psychological and spiritual identity), **belonging** (the fit between an individual and her/his interpersonal relationships and their physical, social and communal environments) and **becoming** personal aspirations in terms of purposeful activity, instrumental activity, leisure activity and personal growth).

Nolan, Davies, Grant (2001) considers direct relation between quality of life in residential care and quality of care. In this sense, the concept of "care" could be fruitful for a discussion about a quality of life in residential care for older people. Care is now a widely-used concept in welfare state research, and firmly established in the literature by feminist analysis (Daly, Lewis, 2000). Rummery and Fine (2012), with references to other scholars discuss, that the concept "care" could be understood as threefold phenomena. **First**, care could be understood as "a feeling or emotion involving a disposition towards others". For some theorists this dimension is considered as an essential, while others argue that it leads that "care" is "a form of potentially stressful emotional labour". **Secondly**, "care" is considered a form of labour to meet need of other and involves work and certain physical activity. As authors argue, this dimension relates with such aspects as work load, financial reward and opportunity, physical stress and burnout and the costs of care. In addition, incompetency or dangerous actions undertaken in the name of care are likely to have an effect of causing damage rather than resulting in a beneficial outcome for the recipient. **Third** dimension considers "care" as a social relationship. "The care relationship can be intimate, familial and enduring, but may also be occupational or professional, limited in time and focused primarily or exclusively on mental and physical well-being." Summarizing authors' arguments, it is important to consider all three dimensions and to look how these dimensions are connected and linked with each other.

Vaarama and colleagues (2008) even developed a concept of "care-related quality of life", which highlights the important role of care as a resource to improve the life quality of the clients and integrates the concepts of quality of life, quality of care and care management.

Nolan et.al. (2001) argue, that one of the primary goals in promoting quality of services for older people should be to improve and maintain quality of life paying attention to individuals' values and perceptions. Nolan (1997) indicates six senses" (p.17) which he believed might both provide direction for staff and improve the care older people receive. Those 'senses' are focused on the subjective elements of aging and even structural (objective) factors are not included, author argues, that they are important as well. Senses are presented in Table 1.

Table 1. The six senses (Nolan at. Al, 2001, with references to Nolan 1997)

A sense of security	
For older people	Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort.
	To feel free from physical threat, rebuke or censure; to have secure conditions of employment. To have the emotional demand of work recognized and work within a supportive culture.
A sense of continuity	
For older people	Recognition and value of personal biography; skillful use of knowledge of the past to help to contextualize present and future.
For staff	Positive experience of work with older people from an early stage of career, exposure to role models and good environments of care.
A sense of belonging	
For older people	Opportunities to form meaningful relationships, to feel part of a community or group as desired.
For staff	To feel part of a team with a recognized contribution; to belong to a peer group, a community of gerontological practitioners.
A sense of purpose	
For older people	Opportunities to engage in purposeful activity, the constructive passage of time; to be able to achieve goals and challenging pursuits.
For staff	To have a sense of therapeutic direction, a clear set of foals to aspire to.
A sense of fulfillment	
For older people	Opportunities to meet meaningful and valued goals, to feel satisfied with one's efforts.
For staff	To be able to provide good care, to feel satisfied with one's efforts.
A sense of significance	
For older people	To feel recognized and valued as a person of worth, that one's actions and existence is of importance, that you 'matter'.
For staff	To feel that gerontological practice is valued and important, that your work and efforts 'matter'.

Borglin et al. (2005) argue, that how older people experience their quality of life is not very well investigated, while understanding the meaning of quality of life in old age enables

effective nursing caring interventions, supporting and enhancing the older people quality of life.

Research on the current state-of-the-art in research and the public debate in each partner country provided the basis for the compendium. This national report describes the research activities and summarize the main results for Lithuania. Together with results of other national reports, they are integrated into a European compendium on standards of quality of life in care home settings.

2. Methodology and proceedings

In order to achieve the above-mentioned aims, the following methods were applied:

- Desk research in Lithuania concerning the state-of-the-art and public debate on ensuring autonomy, social participation and human dignity of care home residents. National reports as well as scientific studies conducted in Lithuania were reviewed.
- Data were collected using telephone interviewing and written questionnaires. Thus:
  - Five telephone interviews with 2 managers of care homes, 2 vice-managers of care homes and one senior social worker were conducted. Experts, who participated in telephone interviewing, work in care homes governed by different municipalities (4 participants) and one participant is working at care home governed by state. Approximately from 40 to 150 residents live in these facilities. All participants have many years' experience in provision of care services for older people and have Master's degrees in social work or education fields. One participant was a male, others – female.
  - Written questionnaire was made using main questions agreed among consortium. Questionnaire was sent to 8 care homes, who provide residential care for old people. Answers from 5 care homes were received and altogether 8 respondents wrote own ideas about implementations of quality of life for older people living in residential care and issues or obstacles they face. Respondents were from different regions of Lithuania (Kaunas (3), Vilnius (1) and Klaipeda (5). One manager, three vice-managers, one senior social worker and one team, consisting of a manager, vice-manager, social worker and specialists for organising activities.
  - Data of 5 telephone interviews and 6 filled questionnaires were used for the analysis. All together 11 experts and practitioners, who work in care home for older people, participated in the research.

During desk research, key words for the internet search, cross-linking themes and target groups were applied in Lithuanian and English. Themes included concepts: quality of life, autonomy, social participation and human dignity; as regards target groups, concepts: care home residents, old people in need of care and not self-sufficient persons were used. Official statistics portals, national reports and studies in Lithuanian language were used. English academic data basis were also reviewed and scientific articles and books were used for interpretation of data of the research.

Main questions for telephone interviews and in written questionnaires for experts and stakeholder were agreed upon in the kick-off meeting; they were altered and adapted corresponding to the functions, expertise and personal background of the interviewees.

In research in Lithuania we added questions related to a role of social workers, specialists for organising activities, assistants of social workers and nurses. The main questions embrace the following topics:

- In your opinion, what influences, the quality of life of old people in care homes?
  - Let us at first discuss matters of the personal autonomy of residents in care home. Autonomy includes personal independence and freedom of will in one's actions.
    - How – except health issues – may the personal autonomy of care home residents be restrained?
    - Why is it so?
    - How can the personal autonomy of not self-sufficient people in care homes be promoted by nursing staff (*by social workers, activity specialists, assistants of social workers and nurses*)?
    - How can their personal autonomy be promoted by volunteers or relatives?
- Social participation of care home residents is another crucial area for their quality of life.
  - How – except health issues – may social participation of care home residents be restrained?
  - Why is it so?
  - How can social participation of not self-sufficient people in care homes be promoted by caring staff (*by social workers, activity specialists, assistants of social workers and nurses*)?
    - How can their social participation be promoted by volunteers or relatives?
- Human dignity is an overarching issue of high relevance for care home residents.
  - In which areas may the human dignity of care home residents be at risk?
  - Why is it so?
  - What can and should caring staff (*social workers, activity specialists, assistants of social workers and nurses*) do to ensure the human dignity of care home residents?
    - What can and should volunteers and relatives do to respect their human dignity?
  - Do you know about examples of good practice how the quality of life of care home residents was improved? If yes, please describe them.
- Are there any further recommendations how paid staff, volunteers and relatives can contribute to the quality of life of care home residents?

3. Summary of research results for the topics under study

3.1. Quality of life of old people in need of care

Structural features for residential care is important before discussing subjective data of research participants in this research. First, Lithuania's society is aging and the need for residential care is increasing as well. In 2019, 30 percent of population was 65 years and more (Statistics of Lithuania, 2019a). In general, older people in Lithuania live healthy everyday life, even data of subjective health evaluation demonstrate, that only 5 percent of people aged 65 and more score their health as 'good' or 'very good', and 50 percent scored - 'bad' and 'very bad'. In this group, 69 percent of people stated that they have at least one long term illness (Elderly People in Lithuania, 2014). Poor health is one indicator for need of

more residential care. Meanwhile accessibility to residential care is limited by lack of services. In 2018 6071 people lived in residential care, among them a quarter was 85 years and older (Statistics of Lithuania, 2019b). In 2018 residential care was provided in 59 public care homes and in 67 private care homes (Statistics of Lithuania, 2018 c). In 2018 only 1.3% of people age 65+ were living in residential care (Junevičienė, 2020), while the number of those older people who want or need to move to residential care is much higher.

Moreover, informal care of old people is dominant, popular and well known in Lithuania. Therefore, it is not surprising that, according some studies, majority of people (90,7%) trust informal care or care provided by family members or relatives. So formal care provided by public sector (44,2%), parishes (35,3%), NGO (34,4%) and private sector (49,9%) has less trust in Lithuania's society. The same study assumes that public and private providers will be in the most demand among formal service providers in the future. In addition, residential care for the elderly is the least popular among other forms of care (home help, etc.) (Žalimienė et. all, 2019). Therefore, the issues of quality of life of old people living in formal residential care are especially relevant.

Quality of care in residential care is documented in "ORDER APPROVAL OF THE DESCRIPTION OF SOCIAL WELFARE STANDARDS" of Minister of Social Security and Labour. This description regulates the principles and characteristics of the provision of social care to elderly and lays down mandatory quality requirements for long-term and short-term care provided by social care institutions (Description, 2012, No. A1-566). Social care norms apply in accordance with the following principles:

- Protection of the rights of the resident; organisation and provision of social care prohibits the unjustified and unlawful limitation of individual rights. All personal problems are solved with respect, understanding, sensitivity to the person, ensuring and recognising the individual's right to privacy. In exercising his or her rights, a person shall not restrict the rights of another.
- Participation and cooperation. In order to ensure the best interests of the individual, all issues of the organisation and provision of social care shall be dealt with the participation and cooperation of the person himself/herself, his/her family members or close relatives and representatives of the competent authorities.
- The purposefulness of choice and social care. Social care is organised and provided on the basis of a thorough and comprehensive assessment of the need for social care of the person and an assessment of the social care institution's ability to provide these services, recognising the right of the person to choose assistance that is in accordance with his reasonable expectations and legitimate interests.
- Personal autonomy education and social integration. Providing social care, a person is given the opportunity to develop self-expression and skills, promote self-management of his or her own life as far as possible, providing non-offending assistance to the person, encouraging the maintenance or compensation of lost autonomy and the capacity to live in society, and the exercise of their rights and duties, and to maintain social relations with society, family and close relatives.
- Non-discrimination. Social care is organized and provided according to the assessed needs of the individual, which does not depend on the person's gender, disability, race, nationality, origin, social status, beliefs, age, opinions, sexual orientation and other circumstances unrelated to social care.

The implementation of these principles is quite controversial and not always real practice coincides with rules of care defined in legal acts and practitioners face many challenges in implementing care principles in real practice. Our research demonstrates some good examples and points out the areas to be improved.

Borglin with colleagues (2005) argues, that quality of life may consist of three core variables: a sense of well-being, a sense of meaning, and a sense of value, while the most meaningful aspect of the good life is stored in the self. Custers with colleagues (2012) refers to other authors argues, that quality of life in nursing homes is becoming more important in both research and practice. Safety and security, physical well-being, quality of environment, functional competence, meaningful activities, relationships and having autonomy and possibility to choose are among main components that comprise the term quality of life (p.319).

Vaarama with colleagues (2008) based on other scholars' work distinguished nine dimensions or factors that were considered relevant for the frail quality of life of older persons living in the institutions. Among them: demography; socio-economic situation; physical health; psychological health; social networks; living environment; lifestyle and activities; traumatic life events; care.

During our research experts in Lithuania noted that quality of life is multidimensional. For some experts quality of life is at least two dimensional and mainly is mixture of medical care and social care. Quality of life is:

> *Quality of services provided (social and medical), staff qualifications, catering arrangements and employment activities (Vice-manager in care facility, Klaipeda region, Lithuania)*

While manager of care home (Kaunas region) named that: '*quality of care is entire emotional, physical, social and material wellbeing of senior who lives in care home'*. Senior social worker also named: *'that it is physical health and independency, social relations, material and emotional wellbeing and self-realization'* (Kaunas region, Lithuania).

Expert from Vilnius region emphasized emotional wellbeing very much. She told:

> *An emotional factor is a particularly important factor in the quality of life of our people. Majority of our residents have different dementias, so peaceful, cozy home environment is very important. Nutrition is also important, regular, time scheduled activities, organization of a day. It creates not only a safe environment, but also supports good emotional mood. While generally, physical and emotional wellbeing and the meeting of needs is important for quality of life. Communication is the most important, possibility to make decisions as well. And, education and training of the staff is also important. (Vice manager care facility, Vilnius region, Lithuania).*

Many authors argue that quality of life of care home residents relates to quality of care (Nolan et. Al., 2001) and some are talking about "care-related quality of life" (Vaarama et al., 2008). While one Lithuanian expert has opposite view on this matter and argued, that:

> *If we talk about quality of life, we have to talk about quality of life, not about quality of care. Quality of care is too narrow. Quality of care is care norms, hygiene norms and mostly attention paid to hygiene. But, emotional state is not valued. If quality of life is physical, psychological and social wellbeing, quality of care mostly concentrates on physical wellbeing. (Vice-manager in care facility, Kaunas region, Lithuania)*

3.2. Autonomy of care home residents

Autonomy includes personal independence and freedom of will in one's actions. As Custers with colleague's (2012) argue, autonomy refers to the experience when one can choose activities, make decisions, and regulate behavior in accordance with one's goals.

Among restrictions that can disturb autonomy of care home residents experts talked about routine aspects of living in a care home and not involving older people in meaningful activities. That is:

> *Wish to visit city, market, shops, to visit friends, cafe. Unwillingness to eat something ready for breakfast, lunch, or dinner this morning. Unwillingness to make bed, or wish to smoke cigarette in a room after a couple of coffee. (Vice-manager in care facility, Klaipeda region, Lithuania)*
>
> *Deficiency of activities or their inapplicability according to people's abilities, disregard of the client's wishes. (Team of care facility, Klaipeda region, Lithuania)*
>
> *It may not be possible to decide with whom to share a room. Restrictions: schedule (mealtime), having no possibility to go to Church when you wish. Institution has own rules and even if you offer freedom for a person, anyway he/she is put within certain frames. Or there should be much more staff, maybe in that case it would be possible to organize life in more flexible way. (Vice-manager in care facility, Vilnius region, Lithuania)*
>
> *Personal routine of resident is constrained, as well as personal autonomy, private space, problematic relations with the staff, because there are less and less professionals. my Certain organizational culture, which is based on values of the staff, should be created for personal autonomy. The staff has to have positive attitude towards resident; honesty, encouragement of independency of residents have to be a value. Now I see some overprotection, while we have to support resident's independency and dignity. (Vice-manager in care facility, Kaunas region, Lithuania).*

Competency of staff. Rummery and Fine (2012) argue, that the link between competency and work is particularly crucial in the field of professional care. Competency of staff should include competency to create and maintain relevant working relations with the care home residents. Many authors argue, that the relationship between residents and their professional caregivers is a crucial topic in the quality of care for older adults (Custers et al., 2012). Experts in this research name, that lack of competency of staff and especially in case of depersonalization of services could be considered as a restriction for autonomy of the residents. Experts told:

> *Staff still has attitude that care home resident is not competent enough to express his/her needs. Staff is very quick to make decision that old aged person is frail and not able to do this or that. And too rarely staff sees strengths of an old aged person. (Senior social worker in care facility, Kaunas region, Lithuania)*
>
> *Staff is low paid, lacks of competency as well. What to do? To motivate, to create a microclimate in organization, trust staff. Care workers have to respect autonomy of a person. They have to knock on the door before entering a room of a resident. Staff has to ask every residents how he/she would like to be called. Could be by the name or differently. For example, we have a teacher, and she wants to be called a teacher. (Vice-manager in care facility, Kaunas region, Lithuania).*

Rummery and Fine (2012) argue that relationships in care could be multidimensional and could be "warm and cold care relationships" and involving power and dependency. The caregiver is seen as

the active agent helping a passive and obedient recipient. While some authors argue that this approach is both unrealistic and unacceptable. Care is not a simple matter in which the caregiver dominates the recipient. The caregiver, as much as the recipient, loses autonomy through the acceptance of responsibility. The responsibility depends on how the caregiver perceives his or her role. Experts in this study talked on this matter as well:

> *Facing position of resident, resident's wishes, dreams for social workers and others sometimes seems not safe, or 'unknown land' and it takes time. It could be difficult to express own needs, especially when those needs are not reconciled with understanding of the staff. A staff member sees other needs, while person expresses other. (Senior social worker in care facility, Kaunas region, Lithuania).*

Answering the question, why restrictions to personal autonomy exist, experts named, that in old age a network of social relations becomes narrow and even though a person has a possibility to visit town, market, shops or café, they have too few or no friends, with whom they could spent time outside a care home. Experts said:

> *In our care home residents also go to town, markets, shops, cafes with relatives and friends. In most cases, very few friends are left and the same ones are in similar health condition so meetings become less frequent. (Vice-manager in care facility, Klaipeda region, Lithuania)*

Institutional restrictions relate to a schedule of care home: time of getting up and time of going to bed, time for breakfast, lunch and dinner for some people could make problems. Experts said:

> *Most people get up before breakfast, the food is the same, the canteen doesn't offer a choice from several dishes. You can smoke only in the designated area. (Vice-manager in care facility, Klaipeda region, Lithuania)*

Inappropriate organizational culture, not having the aim to pay attention to autonomy of older person could be the reason of such restrictions. Experts talked:

> *Care homes have no purpose, they only care about basic needs (sleep, food and medicine). (Team of care facility, Klaipeda region, Lithuania)*
>
> *Limitation of personal space, when a few resident's live in one room, food - in common areas too. (Team of care facility, Klaipeda region, Lithuania).*

Paid staff and volunteers can promote the personal autonomy of not self-sufficient people in care homes. In Lithuania care homes, assistants of social workers' and assistants of nurses provide personal care. Mostly, their duties are the same only their positions are named differently. Experts talking how those personal care workers can promote autonomy, pointed out, that they must be competent and provide everyday care with some respect and attention. Some experts emphasized meeting physical needs:

> *Assistants have to help people to sit down, transfer from a bed to a wheelchair, socialize, walk inside and outside the care home. Communicate with a person when providing skin care and other very personal care. Also, invite person to try to be as independent as possible (Vice-manager in care facility, Klaipeda region, Lithuania)*
>
> *Some experts emphasized behavior of staff related to paying attention to personal needs of people. One expert told: 'more individualized attention and to devote more time to a person' (Vice-manager in care facility, Vilnius region, Lithuania).*
>
> *Social workers and organizers of different activities are mostly responsible for administrative things and meeting social needs of care home residents. Social workers have to: communicate,*

motivate residents to help themselves, to explain about possibilities of different aid equipment. Also, to involve in different activities, drawing, doing not too complicated duties. (Vice-manager in care facility, Klaipeda region, Lithuania)

All workers' goal, regardless of their duties, must be to integrate residents into the care home community in every possible way. If they have movement disabilities – should be moved with a wheelchair, if they don't know where to go – should be accompanied. (Team of care facility, Klaipeda region, Lithuania)

Every resident's opinion should be taken into consideration, for example – personalizing their living space. Encourage care home resident's self-sufficiency of activities where they can act independently. According to resident's possibilities: arrange the room, get dressed, maybe eat by himself/herself, decide which socks he/she wants assistant to put on and so on. (Senior social worker in care facility, Kaunas region, Lithuania)

Social workers are case managers and have responsibility to assess situation, notice restrictions and develop tools and methods to overcome those restrictions. Almost all experts named, that social workers and other staff members have to encourage a care home resident to express own opinion and engage in planning of his/her life in residential care home. This relates with very important need of a person – competency. Custers and colleagues (2012) argue, that competence refers to the perception that one's behavior results in the intended outcomes and effects.

It is the responsibility of these professionals to identify things that could limit people's autonomy, and to encourage the development of a plan for not losing independence by forming a team and discussing about an action plan. (Team of care facility, Klaipeda region, Lithuania).

When experts talked about possible help from volunteers and families, they emphasized activities that relate with inclusion of volunteers or relatives into care activities. They talked that these persons could communicate with residents, support them in different activities, going to theater, park and etc. Experts talked:

Communicate, ride with a wheelchair, if there are opportunities to go for a walk, watch a movie, visit a museum or go to the sea, park, forest. (Vice-manager in care facility, Klaipeda region, Lithuania)

Relatives can help for the care home resident by working with the care home staff. They can help to discover, to strengthen care home resident autonomy by sharing their experiences, providing facilities which the institution does not have access to. (Senior social worker in care facility, Kaunas region, Lithuania).

Volunteers are crucial in all care home resident's life, because they bring community pulse, they can help to accompany residents into community. Also, innovation and creative attitude for people helps to recognize people's possibilities, for example: IT student teaches care home resident how to use computer or tablet, graphic design student helps to find a pleasure in the art of photography and so on. (Senior social worker in care facility, *Kaunas region, Lithuania)*

Volunteers sometimes are involved in spending time with care home residents, but most important is a special mission of a social worker, because he/she is most needed here. (Vice-manager in care facility, Kaunas region, Lithuania).

3.3. Social participation of care home residents

The social participation of care home residents is another crucial area for their quality of life. Borglin et al. (2005) names, that "satisfied body and mind meant striving for meaningful activities in everyday life, and that helped to maintain the balance between body and mind in terms of health and life activities. This balance gave meaning to the day, implying that an active attitude in the presence of the changes brought about by ageing meant that body and mind could remain satisfied" (p. 210). As authors noted, participation for an older person means – "participate in life", that participation in everyday life gave feelings of being needed and staying in tune with time.

Experts named restrictions of social participation of care home residents related to such structural factors, as living in shared rooms and social factors, such as relations between residents of care home. Experts told:

> *Choice of a living room is problematic. Many residents prefer single room, also they want to choose a floor, if they live in shared room, they want to choose a neighbor. (Vice-manager in care facility, Klaipeda region, Lithuania).*

> *Social participation is limited because of the routine in care homes. Formally there are some care homes' councils. But the spirit is important: when a person is listened to, when they can communicate with each other, they feel confident and finally they can feel like at home. Respect for privacy, personal autonomy is there, but they are not created. (Vice-manager in care facility, Kaunas region, Lithuania).*

Social participation is related to possibility to express personal view and opinion. Experts told:

> *The residents have the possibility to express their views verbally or in written form and we pay attention to this. (Vice-manager in care facility, Klaipeda region, Lithuania).*

> *Most people are demented, their memory and perception is disturbed. They can't leave a care home alone. They need assistance but unfortunately, it is not easy to plan time and to have staff for it. (Team of care facility, Klaipeda region, Lithuania).*

Experts named, that often, staff or structure of services provision imposes restrictions. Experts named, that social participation is restricted if a resident:

> *…does not have possibilities to communicate with friends and relatives through virtual tools; does not have possibility to participate in Church activities and does not have possibility to get information about different initiatives for old people in the community (outside care home) (Senior social worker in care facility, Kaunas region, Lithuania).*

> *Limited possibilities to participate in events that take place outside care home (in town), to visit museums, concerts, church. Person leaves his/her employment, loses relations with friends. Relations with family members also change. (Vice-manager in care facility, Vilnius region, Lithuania).*

Continuity of life course. Restrictions of continuity of life course are considered as important aspect of older people's quality of life. Borling with colleagues (2005) found, that the emphasis is on the importance of the life course, significant others', and their views of death and dying are crucially important. Experts in the research said:

> *Person may not be able to decide for himself/herself which activities or events he/she wants to attend or not attend. It could be difficult to keep day routine, leisure activities, habits, what*

he/she had before moving to a care home. (Senior social worker in care facility, Kaunas region, Lithuania).

Experts in their talk about restriction of social participation explained that there are many reasons why restrictions of social participation of care home residents exists. Some are structural reasons, as layout of the premises and shortage of single rooms.

There are no possibilities for residents to live alone (no space in care home), rooms are in attic, so residents frequently express unwillingness to live in them. (Vice-manager in care facility, Klaipeda region, Lithuania).

Lack of relevant equipment and lack of staff (Senior social worker in care facility, Kaunas region, Lithuania)

While talking about social restriction as having a possibility to choose neighbors, experts said, that they are looking for solutions and usually in such cases they talk with both residents and try to seek for mutual agreement. Experts said:

Neighboring in the rooms are discussed and coordinated only with the consent of both persons and then they are accommodated together. (Vice-manager in care facility, Klaipeda region, Lithuania).

In the towns near the care home, events take place on weekend evenings, but as there are only a few staff members at this time in the care home, that's why the residents lose opportunities to participate in the social life of the communities. (Team of care facility, Klaipeda region, Lithuania).

Relations in care home are crucially important as it relates to the need of relatedness and belonging. As Custers and colleagues (2012) argue, relatedness refers to feeling connected to others or having a sense of belongingness. Relations between professional caregivers and residents and among the residents themselves become most important in care home. Borling with colleagues (2005) argues, that access to significant relations and conditions governing one's life, both contributed to the older people's self-image and self-esteem by involvement in the environment—the world within and around them.

Toxic relations among residents and lack of communality among residents was also revealed by experts as a reason for restriction. One expert named that low self-esteem in some cases becomes a restriction to involve people in some activities. As expert told:

People of very different ages and characteristics live in care home community. Some are benevolent, open, others are rude, biting, willing to make fun of each other. In this way, bullying is often experienced, incomprehension, loud gossip and this prevents self-expression, free communication, constrained behavior, fearing criticism from those who like to do so. (Team of care facility, Klaipeda region, Lithuania)

Competency of staff is very important for different dimensions of quality of care of residents. Noelker and Harel (2001) argue, that in residential care homes, most of the care "is given by nursing assistants and home care workers who receive minimal training and the lowest pay in health care, yet they are the backbone of long-term care services. As an older person becomes frailer and more dependent on these workers, the way they interact with the person as they provide care can enhance or undermine the self, thereby affecting quality of life" (p.12).

The rules of the care home and the staff's attitude to the freedoms of the elderly to freely choose the way of leisure, communication skills: sometimes the staff can create too strong

"frames" and prevent them from feeling free in the care home – too much discipline, urging, reminding, hurrying. All this confuses a person and encourages "closure" within oneself, not wanting to "stand in the way" (Team of care facility, Klaipeda region, Lithuania)

The social participation of not self-sufficient people in care homes can be promoted by paid staff in many ways. Experts said:

Assistants need to ask the residents for their opinions on various issues so that the client feels important, both in preparing and providing another service, interested in human thoughts, encouraging not to be afraid to speak. (Team of care facility, Klaipeda region, Lithuania)

Nurses have to discuss a treatment plan with a person, discussing medications, and regularly arranging a doctor's personal visit for that client. (Team of care facility, Klaipeda region, Lithuania)

Specialist for activities could read them the press, discuss world news, bringing a laptop to show more interesting videos based on what the resident is interested in. (Team of care facility, Klaipeda region, Lithuania)

Social worker has to be aware about the client's needs, asking for opinions, creating opportunities and bringing "room neighbors" to the guests to communicate, encouraging to keep in touch with relatives, organizing their visits. (Team of care facility, Klaipeda region, Lithuania)

Experts' talk revealed that volunteers and relatives could be included in care provision and can provide additional support and care to home resident that staff is not able to provide because of big workload and intensity of work duties. Experts talked:

Volunteers always have ideas. When a new person comes to the care home, the residents usually become more motivated, because they are not yet "used" to the new person. Volunteers can do mutual activities, talk, share their experiences about other countries (international volunteers' case). Residents can relax, take a break from everyday life routine. (Team of care facility, Klaipeda region, Lithuania)

Relatives could visit more often, transfer news from other relatives, tell how other people live. It gives an opportunity for a resident to remain "knowledgeable and not distant" from the people dear to him/her, from relatives, from neighbors. Also, relatives may ask what the person would like to pass on, what to tell when they return home and meet neighbors, resident's friends. (Team of care facility, Klaipeda region, Lithuania)

3.4. Human dignity of care home residents

Human dignity is an overarching issue of high relevance for care home residents. Noelker and Harel (2001) argue, that older service consumers and their family members emphasize qualities of interaction, such as being treated with dignity and respect, as the most important features of long-term care services. However, the environment, structure, and organization of work in nursing homes often do not support the quality of caring that affirm and maintain the older person's sense of self.

Experts during research interviews discussed, that human dignity of care home residents could be violated in many dimensions: medical care, skin care and other intimate personal care, as well as in not provision of relevant information. Experts told:

Human dignity can be disturbed when performing personal hygiene services, medical procedures, providing or collecting information. (Vice-manager in care facility, Klaipeda region, Lithuania).

A person's opinion about how he/she wants to live here is not always asked. For a person to speak openly must be warm microclimate and an atmosphere of confidence. You have to have the trust of the resident, the person feels another person. It is important that a person feels respected, feels like a person. We do not care for the person we have, but we must support him/her to live, then there is a quality of life, not a quality of care. (Vice-manager in care facility, Kaunas region, Lithuania).

Competency of staff was named as crucially important issue. Expert told:

Dignity is disturbed when the staff discuss the residents' problems, character's peculiarities, daily hygiene too loudly and the resident or other residents may hear this. When the staff misconduct with a resident and may have a preconceived opinion about him/her. When the staff make decisions without involvement of a resident, not pay attention what happens inside the resident, in his/her mind or what he/she feels. When do not delve deeper into the needs and wishes of the resident. He/she drowns in the whole, among other 'uniformed residents', although they are all different, different education, with different challenges of life, attitudes, wishes. (Team of care facility, Klaipeda region, Lithuania).

Experts named, that good organization of work, having enough equipment and competency, may help paid staff to promote human dignity.

Nursing staff or assistants of social worker have to close the door or use room curtains or walls when doing nursing procedures. They can ask visitors to leave a room. (Vice-manager in care facility, Klaipeda region, Lithuania).

It is important that dignity is ensured in hygiene services. The resident must have the right to choose whether to take a bath or shower, which requires adaptation of the use according to the state of human health. (Team of care facility, Klaipeda region, Lithuania).

Social workers have to be competent in counseling care home residents and have special gerontological knowledge. Knowledge of the continuity of life course is very important. As Borling and colleagues (2005) argue: 'The ability to view and sum up life from a life course perspective facilitates the verification of a coherent life, helping older people to maintain their self-image and meaning in life and thereby enhance a good life. This underlines the importance of facilitating possibility for older people to tell the story of their lives, as this can be one way to enhance the experience of quality of life. Thus, this also suggests that the use of life review in nursing care may be a profitable way to support older people's adaptation to the changing and challenging circumstances of growing older.' (p. 2015). Paid staff in care home for older people have to be competent to work with older people as well. Experts told:

When communicating with the resident, eye contact must be at the same level for both. Confidentiality should be ensured when providing or collecting information. It is important to speak in clear and short sentences and often listen and ask the resident to say in his/her own words how he/she understood the information. (Vice-manager in care facility, Klaipeda region, Lithuania).

Even before the resident moved into residential house, social worker must find out what kind of person he/she is, what are his/her interests, character, health status. According to this, he/she is selected for the room and the "friend" of the room. Later, if the interests of living together do not coincide, the solution should be sought and the possibility to change the room has to be made. (Team of care facility, Klaipeda region, Lithuania).

The specialist for activities must present the tasks in a very clear and comprehensible manner, if necessary to help with this (Vice-manager in care facility, Klaipeda region, Lithuania).

The dignity of residents with special needs can be guaranteed by specialist for activities offering to such residents' adapted forms of activities, there the resident would feel assured, what he/she would like to do before moving in a care home. Also it is important to leave the right to participate or not in the proposed activities. (Team of care facility, Klaipeda region, Lithuania).

Volunteers and relatives are invited to participate in practices that respect human dignity of residents. Empowering residents, respectful communication, and even to be the "voice" of residents in a case of not enough good care and having no possibility to express it by resident himself/herself. Experts said:

Volunteers and relatives, like all staff, must treat the person with respect. Always ask if he/she can and wans to communicate before you start communicating. (Vice-manager in care facility, Klaipeda region, Lithuania).

Relatives can ensure the dignity of the resident by maintaining good encouraging participation in the activities of the care home and motivating them for achievements, by paying compliments. It is important for the resident to feel valued. (Team of care facility, Klaipeda region, Lithuania)

Relatives avoid expressing their own opinion, but they must be the voice of the resident which is not heard. It is important that relatives would be involved in organization actions, and the position of social worker is also very important, as he becomes a mediator. (Vice-manager in care facility, Kaunas region, Lithuania).

This study indicated that quality of life couldn't be studied directly but through dimensions that, depending on how they are met in relation to the personal value system, contribute to either low or high quality of life. Several areas covering various parts of life were subjects to the evaluation of quality of life: life values, recollection of previous life, activities, health, significant others, material wealth, and home (Borglin et al. , 2005, p.216).

3.5. Good practices and recommendations

Experts offered several good practices how the quality of life of care home residents was improved. Some examples are related to moving from shared room to a single one. Another example tells the story about changes in quality of life after moving into residential care.

Resident "N" came to live in a shared room for two persons, she constantly complained, that a neighbor of the room is snoring during the night. We tried to change her neighbor and move her to another room, but the problems were the same. When she lined up, and got a separate single room, all the complaints and problems ended. (Vice-manager in care facility, Klaipeda region, Lithuania).

A woman had a severe overweight, lived on the 5th floor (before moving into residential care). All year she was not bathed, because could not get into the bath, could not go outside, because there was no lift. After arrival to live in a care home, on the very first day, the worker bathed her in a bath, she was lying in the bath for about 40 minutes. The next day she was escorted to the walk. She was very satisfied, her sleep improved. (Vice-manager in care facility, Klaipeda region, Lithuania).

Working with partially independent resident (after a stroke half of the body was paralyzed) we have applied specialized measures and individual work with him according to the plan drawn up by the occupational therapist. As a result, he started to perform everyday activities on his own: to make a sandwich, dress and perform personal hygiene, he can develop fine motor skills. (Team of care facility, Klaipeda region, Lithuania)

Conference was held in Brussels, where everyone could join and discuss life in a care home. We sat together and discussed, shared our ideas with Brussels. A resident of a care home came from Poland, for example, and our residents were going to Poland. Then we discussed what we can improve. (Vice-manager in care facility, Kaunas region, Lithuania).

Recommendations for staff, volunteers and relatives how they can contribute to the quality of life of care home residents

Based on other studies and accounts told by experts in this research some general and some specific recommendations were elaborated. Custers and colleagues (2012) argue, that studies show the significance of c**aring relationships**, they also indicate that resident preferences concerning the intensity and the role of staff in the caring relationship differ. Authors also named, that the fulfillment of the three needs: belonging, autonomy and relatedness is related to the well-being of residents. Their study demonstrated, that relatedness is the most important need and autonomy and competence are important needs as well. However, there are a lot of individual variations how these needs are met. "Many residents may benefit from making their own decisions or trying to maintain their independence as long as possible, yet some may profit from less autonomy and competence because it is a source of tension for them. Although relatedness seems to be the most important for residents, also with regard to this aspect there are differences in the extent to which residents want to be close to their caregivers" (p. 325).

One general recommendation could be, that administration of care home has to work on organizational culture related to community sense, meetings and team culture. Meetings' culture is especially important for development of mutuality and collaboration. Staff must have a place and time to meet, to discuss, to share information. Care home residents have to be included in these meetings as well.

According to care provision policy in Lithuania, needs for care are assessed. This assessment must be holistic, comprehensive and provide information about every resident, including his/her past life stories, his/her expectations and wishes for life in care home.

Recommendations for staff

Social workers in care homes must be resident's 'advocates', ensuring implementation of people's rights. Social workers must inform residents about their rights, supervise their implementation, encourage residents to participate in management of care home, meetings and events.

Social workers collaborate with other professionals within care home and outside care home. They facilitate residents' efforts to participate in community life or to use services outside care home. Social workers have to evaluate the quality of life of care home residents and observe changes of the quality of life.

Staff has to have knowledge that the theme of death and dying is important to consider. Borling and colleagues (2005) argue, that 'studies about death and dying in old age indicate that older people do want to speak about death and are not as fearful of it as earlier on in life' (p.216).

Staff has to be honest and do work sincerely and have a sense of need to help. As told one expert: very important is a scale of the employee's own values and his/her wish to learn and improve competencies' (Vice manager in care facility, Vilnius region, Lithuania).

The best illustration of recommendations could be found in this account of experts, who participated in research. Experts told:

> *In particular, all staff must work in a team, then quality assurance can be achieved. Only in this case we can ensure physical, psychological, social and cognitive condition. If at least one restriction occurs, the quality of service suffers. Staff should strive to maintain the life style of the resident as close as possible to the style they lived before they arrived. Staff should offer residents to take part in public life i.e. to attend concerts, exhibitions, to go shopping. If necessary, they should offer the services of a psychologist, a physical therapist and an occupational therapist; ensure that the care home and living rooms would remind home like environment. The less residents live in a care home, the more relations become closer, staff has more time to meet every resident. Staff must also consider the individual wishes of a resident. Only by feeling that his/her individual wishes are taken into consideration, a person feels that his/her needs are met, and he/she feels safe. (Team of care facility, Klaipeda region, Lithuania).*

Staff must have knowledge of senile dementia and what these diseases bring to human life. As one expert noted, *'communication, voice tone, sentence formulation, etc. has very important meaning in creating favorable environment or not' (Vice manager in care facilities, Vilnius region, Lithuania).*

Recommendations for relatives and volunteers

Volunteers and relatives can contribute to improving the quality of life by communicating with the residents on topics of interest to him/her, listening to their problems without harming them. It is important for the residents to feel needed and to have freedom to make decisions. As experts told:

> *Volunteers can contribute to the individual needs of the residents, the implementation of desires, because the staff often has many functions to perform at work and do not always manage to pay individual attention 100%, so the role of the volunteer in the care institution is very important. Relatives help a lot, when they make call to the resident even when they are abroad and speak via video – this moment is very pleasant, close and important to the resident. It's nice when relatives come to the residential home for the holidays, this promotes a sense of togetherness and support. (Team of care facility, Klaipeda region, Lithuania)*
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> *And finally, for the development of quality of life of residents it is necessary: to destroy routine, and have as little institutional spirit as possible. (Vice-manager in care facility, Kaunas region, Lithuania).*

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