Ageing and Society **21**, 2001, 279–296. © 2001 Cambridge University Press
DOI: 10.1017/S0144686X01008236 Printed in the United Kingdom

Seniors' experiences of client-centred residential care

JACQUIE EALES*, NORAH KEATING*
and ANNITA DAMSMA*

ABSTRACT
The philosophy concerning long-term care for frail seniors has shifted from a provider-driven, medical model toward a more client-centred, social model. While this philosophy emphasises the decision-making abilities of clients and respect for their values and preferences, evidence suggests that there are difficulties in understanding and implementing the philosophy. Qualitative in-depth interviews were conducted with residents of adult family living and assisted living programmes in western Canada to better understand the elements that residents themselves felt were integral to client-centred care.

Three main themes emerged from the data analysis: (1) the physical setting, people within the setting, and the community were important areas of expression of residents' values and preferences; (2) the decision about where to live influenced whether the residential care environment was congruent with residents' values and preferences; (3) contentment resulted when there was a good fit between preferences and experiences, reflecting the essence of residents' perspective of client-centred care. Choices among models of care, appropriate staffing levels and training, and recognition of family contributions may improve the practice of client-centred care.

KEY WORDS – seniors' residential care, client-centred care, assisted living, adult family living.

Introduction

In the past decade there has been a shift in philosophy concerning care for frail seniors, away from a provider-driven, medical model of long-term care toward an approach that is more social and client-centred (Keating *et al*. 1997). In Canada this shift is reflected in public policy documents such as the National Framework on Aging (Division of Aging and Seniors 1998). This framework has five core principles to

* Department of Human Ecology, University of Alberta, Edmonton, Canada

guide practice with seniors – independence, dignity, fairness, participation and security. These principles are echoed in provincial continuing care policies across Canada. For example, the mission statement of continuing care facilities in Alberta is '… to encourage residents to use their abilities to the fullest extent possible, and to preserve their identity and individuality' (Alberta Health 1993: 11). Similarly, the mandate of Community Care Facilities in British Columbia is to 'promote and maintain the spirit, dignity and individuality of the people in their care' (British Columbia Ministry of Health and Ministry Responsible for Seniors 1999: 1). The central tenet of client-centred care is the focus on the holistic needs of people in care.

While the language of client-centred care has been incorporated into public policy, there is some evidence that there are difficulties in both understanding and implementing the philosophy. This may be due in part to the considerable effort required to reframe existing programmes or to create new ones that realise client-centred practices. Recent evaluations point to challenges in the implementation of client-centred philosophies. Researchers have found that conflicts between clients' wishes and case managers' perceptions of clients' best interests, and failure of care staff to involve residents in realising their choices, are among the difficulties inherent in operationalising the new philosophy (Clemens *et al.* 1994; Whitler 1996). According to Hofland (1994: 33), 'much work needs to be done to put this client-centred approach with its personalised care plans into everyday action'.

The successful implementation of care that is focused on residents can be enhanced through a better understanding of the elements that residents themselves feel are integral to that care. Thus in this paper we present data on the experience of client-centred care from the perspective of seniors living in residential care settings. In choosing the perspective of these seniors, we recognise that meanings held by other stakeholders such as staff and family members are not included. Our aim, however, was to give voice to those individuals whose lives are most touched by the implementation of client-centred care practices.

Literature review

In the past decade the language of continuing care has changed dramatically. Terms such as client-centred, beneficiary-centred, and consumer-directed reflect the new focus on the personhood of individuals who are recipients of continuing care services. There appear to be two key elements of client-centredness: decision-making control, and respect for individual values and preferences. Here we review the state of our knowledge of these two domains, and argue that the latter element may be particularly important to those with reduced decision-making ability.

Control over decision-making has been seen as a key element of client-centred care. From this perspective, clients have the right to be involved in planning for their care (Clemens *et al.* 1994); to exercise choice and control over services they receive (Brown *et al.* 1997); and to make informed decisions (Leutz *et al.* 1997). Brown *et al.* argue that clients 'should have control over the basic decisions of their daily lives … be able to choose the people who provide the most basic and intimate supports to them, and be the ones who define the quality in quality assurance' (1997: 43–44).

There has been a lively debate about the place of decision-making in the lives of frail seniors, especially those in residential care. The focus of this debate has been on attempts to reconcile reduced decision-making ability with the view that autonomy is important (Agich 1995). Some argue that those who care for people in long-term care must 'focus on ways and means to maximize self-determining and decisionmaking opportunities'. (Kenny 1995: 365) Others believe that such enhancement of autonomy is extremely difficult in residential long-term care where 'beneficent intentions can breed unchecked authority over those who are served or helped' (Collopy 1988: 10).

Agich (1995) offers a way of reconciling these two perspectives in the context of residential care. He argues that there are two important types of decisions: important life decisions and tacit decisions. The two incorporate recognition of the importance of decision-making and of the need to understand and acknowledge the holistic needs of the person.

Important life decisions involve conflict or life transitions. These decisions are made under conditions in which there are clear alternatives, costs and benefits are weighed and an explicit decision is made. A relevant example is the decision to move into a residential long-term care setting. This vitally important decision shapes subsequent living experiences.

In contrast, tacit decisions are reached not through the weighing of alternatives but through 'habitual ways of acting and interacting' (Agich 1995: 114). Tacit decision-making is particularly relevant to those in residential care 'because it gives expression to the operative sense of self' (Agich 1995: 115).

Access to tacit decision-making can be obtained through learning what areas are most important to long-term care clients (Kane 1991). The belief is that residents use their life experiences to form the framework by which qualities of the present are evaluated (Gubrium 1993). Thus care provision should be guided by a respect for the reality, preferences, and past experiences of individuals (Hofland 1994; Miller 1997). Knowledge of those things that matter to individual residents can aid care providers in the preservation of personal integrity of residents (Kenny 1995) and provide 'explicit acknowledgement of the need to be faithful to what people really want and believe in' (National Forum on Health 1997: 10). As Kane and Degenholtz (1997: 20) state, 'As we learn what clients' values are, what they perceive as important and desirable in their lives, we also learn about how they perceive themselves and what is important to their maintaining a sense of who they are'.

What are the important value domains in the lives of frail seniors? For researchers who have attempted to define the important value domains, there appear to be two key areas. These are the physical setting in which the individual lives, and the social setting which comprises personal interactions with others (Kane and Degenholtz 1997; Raphael *et al.* 1994; Zingmark *et al.* 1995).

The physical setting is important for the expression of self and for the continuity of life patterns (Collopy 1995). Some believe that it is not the space itself but the potential for personalising that space that enhances the possibility of self-expression. For example, according to Marcus (1995: 11), 'it is the movable objects in the home, rather than the physical fabric itself, that are the symbols of self'. Research in both community-based and residential long-term care indicate that the aspects of the physical setting most valued by seniors are: privacy, freedom, pleasant, stimulating and familiar surroundings, and safety (Degenholtz *et al.* 1997; Marcus 1995; McCullough *et al.* 1993).

Values and preferences related to family, friends and caregivers also comprise an important value domain. Continued connections with people with whom they have longstanding significant relationships, which assist in maintaining individual identity and a positive self-image, are valued by seniors (MacRae 1996). Connectedness to family and friends also has been found to enhance quality of life for nursing home residents (Kane and Degenholtz 1997; Oleson *et al.* 1994).

For seniors in residential care, social circles often become more focused on people immediately within their current living environment (Rubinstein *et al.* 1992). Yet proximity does not necessarily lead to intimacy. In a study of older women's friendships it was found that nursing home residents maintained that they were friendly with fellow residents but did not consider any of them to be close friends (MacRae 1996). However, seniors say that it is important to have company and to be with people who are similar (McCullough *et al.* 1993).

Another important group of people is those who provide care. The nature of the formal care relationship is seen to be at the heart of any understanding of what constitutes client-centred care (Brechin *et al.* 1998). Researchers have found that seniors place high importance on qualities in their helpers which include being caring, likable and friendly (Kane and Degenholtz 1997; McCullough *et al.* 1993).

This brief review of the important elements of client-centred care for frail seniors suggests that both life decisions and tacit decisions are important in the continuing ability to express values and preferences in a residential long-term care setting. Further, one's values concerning the place where one lives and the people in one's life are particularly relevant. These contexts and decisions provided the framework for our conversations with seniors about their experiences in residential continuing care settings.

Methods

Our study focused on two new models of residential continuing care in two cities in western Canada: Assisted Living (AL) and Adult Family Living (AFL) (Keating 1998). Both were new to Canada and were developed explicitly within the client-centred paradigm. The AL complex is a purpose-built single-story building housing 30 seniors in private rooms with bath and kitchenette. AFL Homes are owner-operated private residences of a variety of designs. They house one to four seniors in addition to the owner and her/his family. Seniors have private rooms but often share bathrooms. Residences in both models of care are located in residential neighbourhoods with access to community resources such as churches and shopping.

Residents in these models of care are people over age 65 who had been assessed as needing nursing-home-level care. The province of Alberta has what is known as 'single point of entry' into long-term care. Nurses trained in evaluating people's needs for care, conduct placement assessments. Once someone is assessed as needing residential care, all nursing-home-level settings become possible placements (within the constraints of distance, availability of beds, etc.). The AL and AFL settings are part of the residential care system in Alberta.

Attempts were made to include as many residents as possible. However, we were not able to interview those who could not provide informed consent. Thus, the sample is biased toward those with higher levels of cognitive ability. Seventy per cent of residents who were interviewed had cognitive abilities within normal limits (Folstein *et al.* 1975). Interviews were obtained from 46 of the 70 clients who at the time resided in the two continuing care settings: 30 from AFL and 16 from AL. The median age was 82 years and 34 of the 46 were female.

Qualitative in-depth interviews were conducted primarily in residents' rooms, although some took place in the kitchen or living room in AFL homes. Interviews varied in length from 30 to 90 minutes. Guiding questions for the interviews were informed by Agich's (1995) important life decisions and tacit decisions. Information was obtained about the decision of moving into residential care through questions about how residents came to live in the care setting and the process of choosing a place to live. Other guiding questions were focused on tacit decisions. Residents were questioned about their preferences concerning their personal space, their day-to-day experiences in the place, the people who worked or lived there, and whether the place met their needs. Interview data were augmented with observations of residents in their place and in interactions with others, and by interviewer field notes. All interviews were audiotaped and transcribed verbatim. Transcripts were verified for accuracy by the original interviewer, and names were replaced with pseudonyms to ensure anonymity.

Data from all sources (interview transcripts, field notes, and descriptive data) were analysed to provide a picture of residents' experiences of client-centred care. Analysis of the data overlapped with data collection, hence as analysis proceeded the interviewers asked more focused questions around emerging constructs relating to life decisions and tacit decisions. For example, in addition to talking about important aspects of the setting where they lived and the people in the setting, it became clear that continuity of connections to people and activities in the community were also important. Thus, guiding questions were added about access to old friends, to family members, and to activities that had been part of their lives before moving to their current residence.

A group of five individuals collaborated in the data analysis, including the two research associates who collected the data. Data were analysed using the processes of first-level coding, pattern coding and memoing (Miles and Huberman 1994). Codes were established and revised using an iterative group process of reading transcripts, testing codes, and revising or devising new codes. Inter-rater reliability (over 80 per cent) in coding was achieved by two researchers on three consecutive transcripts.

Results

Three main themes emerged from the data analysis. The first was that the physical setting, people within the setting and the community were important areas of expression of residents' values and preferences. The second was that the decision of where to live influenced whether the residential care environment was congruent (or not) with their values and preferences. The third was that contentment resulted when there was a good fit between their expectations and experience. These themes are interrelated, illustrating the essence and complexity of residents' perspectives of client-centred care.

Physical setting

The setting in which seniors lived was important to all residents since it set the boundaries around possibilities for the continued expression of lifelong preferences. Many selected a place that reflected past experience with other physical environments. Lois had moved into a new home that had fresh bright paint in all the rooms and was immaculate. When asked what she thought when she first saw the home she replied,

> Well, I've always been a clean, tidy person and that [previous] place wasn't that great, so my eyes opened up when I found this place (laughs). (Lois, AFL)

Clarence's preference is in sharp contrast. The house was modest and his room sparsely furnished:

> See, I had a farm … and there I had only a one room shack for a house so I wasn't interested in any great big nice place, as long as I had a warm place to stay. (Clarence, AFL)

For Violet, it was important that the place should accommodate her lifelong smoking habit.

> Well, I was a smoker and I could smoke in the sunroom right there. Yeah, and [care provider] smokes, and I thought, gee, after smoking for so many years and then have to give it up like that, you know, it's hard. (Violet, AFL)

All residents had their own rooms. Having separate space gave them the opportunity to freely make decisions about patterns of use.

> Now I have my own bed with nobody here, just me. If I want the window to be opened, I'll open the window … Nothing like yourself. (Beth, AL)

> I have my own room and I can come and go when I please. I can turn on the TV loud or soft, it don't make any difference. (Clarence, AFL)

In the models of care that were part of this study, residents were encouraged to furnish or otherwise personalise their space. For some, this was an opportunity to have their place reflect connections to their former residence.

> And … like my cousin, she says, 'You know Wanda, when I come to visit here I feel as if I'm visiting you in your house.' I says good because all my stuff I brought, my furniture, is from the house so why shouldn't I feel that way? (Wanda, AL)

Others brought few possessions. Prudence (AL) had recently moved from overseas so most of her furnishings were borrowed from her granddaughter. She brought with her only a 'wee tea pot kettle from Scotland and a bit of heather on it' to remind her of home. Others who had moved from nursing homes or other care facilities previously had disposed of their household possessions and had little to bring with them. For some, like Wesley (AL), most possessions were unimportant. However, he had enjoyed woodworking and had brought some tools and wood from his shop. The tools sat unused in a corner of his room, a reminder of an activity that had brought him pleasure.

Differences in the importance of material possessions are evident in residents' contentment with the number of things that they brought when they moved into residential care. Although Phyllis brought many of her own things to furnish her room, she was not happy with having to leave so much behind.

> I could have cried for a month, all my stuff that I lived with and gathered for 70 years, oh boy, it's hard. (Phyllis, AL)

In contrast, Lynne (AFL) brought little with her. She had placed her possessions in storage and said that 'it didn't matter' if they were returned to her. She was content with her room even though it had few of her possessions.

Safety was an aspect of the physical setting that was important to all residents. Safety included protection against intruders and the security of knowing that help was available if needed. All residents believed that they were safe:

> When I go to bed I always ask the last staff that gets me ready for bed, I say 'Lock the door for safety' and they do that. (Wanda, AL)

> All the doors are locked, the two dogs, they'll not let you in. (Doreen, AFL)

Knowing that there was help available enhanced residents' feelings of security:

> There's people on all night, one person is on duty all night long. With the little device on my wrist [Lifeline] I can call for help anytime, day or night. (Geoffrey, AL)

> If she [the care provider] goes out, she makes sure that somebody is here. She never leaves us alone. (Muriel, AFL)

> It gives you a good feeling to know that you're in a place where they're going to look after you. (Phyllis, AL)

People in the setting

Residents in both models of care were living with people with whom they had no prior relationship. Values and preferences about the nature and closeness of relationships with other residents and with care providers were apparent in residents' discussion of the people who were part of their everyday lives. The main issue was establishing the right amount of social distance.

Some chose their care setting with these values in mind. An AL resident talked about how pleased she was when she learned about the AL residence with its small numbers of people and private rooms.

> I didn't want a big place with a lot of folk in it. I wanted something that was quiet and I could have my own place and I could do what I like with it. (Prudence, AL)

Residents had quite different expectations about their relationships with care providers. Some wanted relationships that were close, personal, and family-like.

> It was a good Christmas. I wasn't left out of anything. I was welcomed into the fold. I went to her sister's and everything, very nice … Oh, it makes me feel good, somebody cares, you're not just a dud sitting there, you know. (Sadie, AFL)

> I feel like one of their own. (Clarence, AFL)

For others, a less personal, more distant, service-oriented relationship with care providers was preferred. When asked the question 'Does your care provider take an interest in you as a person?' Julia answered,

> She takes an interest in seeing that we are fed and our clothes are washed, I mean, but personally, I don't, there's no need for her to take an interest. (Julia, AFL)

Clearly there was no shared view of an ideal relationship with care providers. Residents, however, knew when the relationship was appropriate for them:

> They don't have time to visit with you or talk with you but I don't expect that from them, but they're very nice … I think they give me just enough that I need. (Bonnie, AL)

> I'm being myself, I'm not being phony or anything. (Sadie, AFL)

Similar to decisions about their relationships with care providers, residents differed in their views of appropriate social distance from other residents. Some established new friendships.

> I've made friends with, oh four or five of the ladies and my next door neighbor here, he's a good mixer so we have our sing-songs and we have our church sings. (Phyllis, AL)

Others chose to keep their distance:

> I'm a private person. I don't like putting out too much. I like minding my business and I expect people to mind theirs … These people mind their own business around here. (Davis, AFL)

> I don't get very intimate, no. I speak to them but I don't get very close. (Ruby, AFL)

Residents differed in their views on whether their relationship preferences had been met. Some had found the right fit between their experiences and their preferences. Others had not. With reference to relationships with staff, Geoffrey said:

> I can talk to them and they call me 'Geoffrey' and that kind of thing. I'm quite content. (Geoffrey, AL)

In contrast was Hilda's experience:

> You're pretty much just a number. There's a few who seem to take a little more of a personal liking but in general everyone is rushing here to put in their hours and their work … I would say I'm not content. (Hilda, AL)

Hilda wished that her assisted living complex could be 'more of a social and happy place'. Similarly, Donna was a very social person who enjoyed going out, dancing, and talking with friends. She was disappointed that others did not have the same enthusiasm for social activities. Regarding the other residents, she stated:

> They're company enough to talk to but nothing elaborate as far as I'm concerned. (Donna, AFL)

Community connections

A value domain that emerged from our conversations with residents was that of maintaining community connections. Residents expressed preferences about the nature of their relationships with family members, about connections with friends, and about involvement in longstanding activities. Many found that in this domain it was particularly difficult to maintain continuity with their previous experiences.

Relationships with family members were important to residents. A common concern among residents was that their needs might be a problem for their families. Finding a balance between being too dependent and yet having a sense of continued connection seemed challenging at best.

> I don't want to live in their [my children's] hip pocket all of the time … you can outlive your welcome, if you know what I mean. (Davis, AFL)

> I don't want to be dependent on my children for too much. I depend on them already, for a lot of things. (Nellie, AFL)

Some residents had poor relationships or felt ignored by family members. The move to a care facility reduced family tensions for some but increased them for others. Mary moved from her daughter's home because she believed her daughter was unhappy about her caregiving role.

> She liked to live her own life. It's not nice when you have to look after your mother. (Mary, AFL)

Others felt that, since their move to the care setting, they had lost touch with their families.

> Nobody does anything for nothing for me. (Julia, AFL)

> The kids are so damn busy with their own families, you can't expect them. (Wesley, AL)

Yet for some residents family connections were celebrated and recognised as important in maintaining continuity. Prudence (AL) described her granddaughter as 'full of life' and later said 'she keeps me lively'. Similarly, Doreen (AFL) had just had a visit from a newborn great grandchild and stated that family visits such as these 'keep you in touch'. She also went on weekly outings with her daughter.

> She comes for me here first and then we make up our mind where we go out after that … I enjoy getting out a wee bit. (Doreen, AFL)

Friends were mentioned less often than family members. All who mentioned friends talked of lost relationships. Davis (AFL) had moved to be closer to his family but in doing so had lost contact with his golfing buddies. Hilda said she *had* a busy life but her friends were:

> … all too busy and then of course being way out here [in the suburbs] and [having] such a bad winter, we don't see each other much. (Hilda, AL)

For most residents, their social relationships were restricted to those people who were in their immediate living environment.

The majority of residents appreciated opportunities to get out into the community. Living in a care setting in one's old neighbourhood enhanced people's abilities to maintain involvement in meaningful activities. Muriel (AFL) continued to be very involved in the same church where she had been a long-time member. She attended Sunday services and the regular seniors' luncheon, which she 'never misses'. Beatrice (AFL) also lived in the neighbourhood in which she had resided for many years and she continued to participate in bowling and whist leagues several times a week. Jane had moved into an AFL home from a nursing home. She appreciated how the new programme helped her to regain contact with her community, allowing her to go on weekly trips to the library and shopping mall.

> It gets you back into the community rather than you being separated, which I was before. At [nursing home] you're sort of off in your own world. (Jane, AFL)

For some residents going on outings was valued regardless of the activity. Irene (AL) reasons, 'sometimes I go just for the going out'. For others, the activity itself had to be meaningful. For example, residents differed considerably on their views of the attractiveness of a day programme which most of them attended one day a week.

> It's thought-provoking and it makes you use your brain … It doesn't cost us a cent … and the meals are good so I look forward to going up there. (Violet, AFL)

Other residents were less enthusiastic. For them, attending an adult day programme was neither meaningful, nor of their own choosing.

> I've been there a couple of times but I can't say that I like it. I don't want to get into my history with anybody else. (Carol, AFL)

> I think [care provider] likes to get rid of us, which is only fair. (Julia, AFL)

For some residents there was evidence of a poor fit between their interests in getting out into the community and their ability to do so. 'That's the only trouble here, you're in too much' (Sadie, AFL). Despite her relatively active community life compared to other residents, Donna felt that she 'would like to get out more … but maybe they think that's enough' (Donna, AFL). Yet some residents were content with infrequent outings. Lois (AFL) felt that she 'gets out enough … I never was a going person anyway'.

Discussion

Client-centred care is meant to facilitate continuity, identity and individuality by ensuring that residents have control over decisions that affect their lives and that they live in a milieu in which their values and preferences are acknowledged and supported. To some extent, seniors in this study reflected this perspective. Choice of the care setting was a decision that had a great influence on their lives. The care setting provided opportunities and constraints in their abilities to continue daily habits, interact with people at a comfortable level of intimacy, and to be involved in the community. Thus, being in the right place determined the extent to which the resident's individuality was acknowledged. In this discussion we address these important decisions as well as the tacit expression of one's preferred ways of daily living, and consider whether 'being content' is a reasonable indicator of one's view of client-centred care.

The two models of care in this project came with distinct sets of characteristics. Assisted Living was newly constructed and modern. It had a relatively large number of residents, and organised social programmes inside the residence and in the community, less intense interaction with formal caregivers, and more privacy. In comparison, Adult Family Living homes were private residences with a variety of ages and styles. They had fewer residents, few organised social activities or outings, and often intense contact among residents and formal caregivers. Because this model comprises a number of different private residences, there was more choice about neighbourhood, caregiver style and lifestyle issues such as smoking.

Residents articulated many of their preferences in relation to the important characteristics in the physical setting. These preferences differed considerably as illustrated by the woman who was delighted to find an immaculate place and the man who wanted one that wasn't too fancy as long as it was warm. The contrast offered by the two models of care meant that such choices could be made available to residents.

The setting also created boundaries around options to create desired social distance from others. Assisted Living had a low ratio of staff to residents, making it difficult for staff to develop and nurture close relationships with residents. The task-oriented style that resulted suited only some residents, and those who preferred a more social relationship with staff were disappointed. Once they had moved into a particular place, residents appeared to have relatively little control over the social distance in their relationships with staff. In contrast, residents also had differing views about the nature of social relationships with other residents and appeared to take an active role in developing those relationships.

Residents also articulated values around connections with their communities. Those who were able to stay in their former neighbourhoods were pleased with the opportunities to continue longstanding activities such as church involvement, and to maintain connections with old friends. Most, however, lived at a distance from their former homes and thus had lost contact with friends and former community pursuits. Residents also had strongly articulated preferences about contact with family members. However, their preferred levels of interaction often seemed beyond the reach of residents, suggesting an area in which it is difficult to have congruity between residents' former social patterns and their current reality.

Being content

The essence of residents' perspective of client-centred care lies in what they called 'contentment.' Contentment was a feeling that resulted from a good fit between values and preferences in domains important to residents, and their experiences within those domains.

Some preferences were strongly held by most residents in this study. Similar to the findings of other studies, these seniors wanted to live in a place that was secure from intruders and that provided them with assurance that if they needed help someone would be available. They wanted private space, and the freedom to use that space as they wished (Degenholtz *et al.* 1997; Marcus 1995; McCullough *et al.* 1993). At least for this group of seniors, it appeared that contentment would be increased by incorporating such universals into programme policies.

More often, residents differed in their preferences. Previous research has often assumed that there may be widely shared values related to physical and social settings. In contrast, we found no consensus on the relevant amenities of the residence where they lived, nor the amount of social distance from staff or other residents. The findings further suggest that it may be extremely difficult for seniors to actualise some of their preferences. For example, although residents in this study wanted access to long-time friends, this was a wish that most were unable to achieve. Similarly, while connectedness to family and friends has been found to enhance quality of life (Kane and Degenholtz 1997; Oleson *et al.* 1994), some residents did not believe that they had found that balance.

Agich's (1995) construct of tacit decision-making seems relevant to this study. Residents expressed their preferences through their daily activities. It was evident that, while they had preferred patterns of interacting with their physical, social and community contexts, they differed in those preferences. Yet the notion that long-term care programmes should maximise residents' self-determination (Kenny 1995) was not articulated by these seniors. While their actions indicated preferences, there were clear constraints in their ability to make changes. While, for example, most residents keenly felt the loss of contact with old friends and with former community activities, they were not in a good position to resume contact.

Can others compensate for this lost autonomy? Some have argued that if important life decisions are made with the *values* of the senior in mind, personal control over such decisions is not central (National Forum on Health 1997). For example, the niece of a man who moved into an AFL residence talked about how she and her husband had made the final decision about where her uncle would live. When they discovered the AFL model, they said that they knew it would be right for him since he was a shy man who didn't like to socialise and who liked his private space. He had some cognitive problems and they felt it would be upsetting to him to be in a large place with a dining room and lots of people. They found a home that had a similar floor plan and decor to his own, and reported that he had settled in quite comfortably. This seems a good example of a decision made by family members who know the resident, who are faithful to his past habits, and who are monitoring his transfer to the new care setting.

Such 'beneficent intentions' on the part of family members may help ensure that the long-term care environments that are chosen reflect previous living arrangements. Nonetheless, in the setting in which this research was conducted, there are no processes in place to monitor the circumstances under which such authority over the relative leads to positive outcomes (Collopy 1988). Based on the findings of this study, we believe that the expression of contentment might be a reasonable proxy for residents' belief that their values and preferences are being acknowledged and supported. Evidence from this study was that if residents can continue daily habits of interacting with their home, with people in the home and with their community, they will express contentment with their situation. If there is not a good fit between how they are living and how they would like to live, they will not be content. What can be done at the programme and policy levels to enhance the possibility that the voices of residents are heard and that care is congruent with the vision presented by these residents?

Implementing client-centred care

Choices in types of residential care facilities could make a big difference in whether clients feel content with the physical setting, with their interaction with people in the setting, and with their access to the community. In building a complement of residential care settings, long-term planning could involve designers and architects in discussions about how building designs could incorporate some variety in preferred characteristics such as location, size and housing style while assuring privacy, safety and security for all residents. Furthermore, case managers, charged with facilitating placement in residential care, could facilitate the important life decision of the right place to live. Use of a values assessment instrument (Kane 2000) could allow case managers to know the older person well enough to suggest appropriate settings that may fit with a resident's values and preferences, allowing her to choose a residential care setting from an array of suitable options.

Providing care that preserves identity and individuality requires time and skill (Alberta Health 1993). Fully individualised care may be beyond the scope of most publicly-funded residential care facilities. In other aspects of the evaluation of these models of care, we found that staffing levels were often insufficient to allow staff to get to know residents in a way that would allow staff to individualise services and support values and preferences (Keating *et al.* 2001). Yet, with sufficient resources, issues around preferences in physical, social and community settings could be addressed. Higher staffing levels, for example, could give staff time to learn about residents' preferred ways of interacting with others. Educational resources could be allocated to assist staff to develop skills to interact accordingly. Opportunities to choose the right amount of distance from other residents could be enhanced if social activities were organised, but not compulsory, and if space for more solitary pursuits were available.

The maintenance of community connections is not articulated in the client-centred care philosophy, but was an important contributor to contentment. For residents in this study, community meant involvement with familiar people and activities outside the care setting. Connections with old friends and activities were tenuous at best and difficult to maintain if the senior had moved across town. The move toward building small residences in local neighbourhoods could greatly enhance continuity of community connections. Further, allowing space within purpose-built residences for residents to entertain family members and friends, or have overnight guests, may also facilitate the maintenance of important relationships.

Maintaining connections with family members was an area of some discomfort. From the programme perspective, there needs to be a recognition that families may continue to carry a large caregiving load even after their relative has moved to residential care. Family members may view continued involvement with their relative as very desirable. However, programme policies that encourage family involvement must be worded carefully so as not to engender either guilt among those who for years may have provided care at home, or who worry among residents that they are a burden (Keating *et al.* 2001).

Clearly, there is more to be learned about how frail seniors in residential care can be supported in ways that help them feel content. Implementing care that is focussed on residents is tremendously challenging. We have a long way to go in many jurisdictions in Canada, where choices among models of care are few, and seniors on waiting lists are strongly encouraged to take the first available residential care option, regardless of their preferences. The principles of independence, dignity, fairness, participation and security (Division of Aging and Seniors 1998) would, we believe, be endorsed by the participants of this study. The challenge is to come closer to achieving these goals so that more seniors might say 'I am content'.

Acknowledgements

Data for this paper come from a programme of research entitled Evaluating Programs of Innovative Continuing Care (EPICC). EPICC was funded under Health Canada's Seniors Independence Research Program.

References

Agich, G. J. 1995. Actual autonomy and long-term care decision making. In McCullough, L. B. and Wilson, N. L. (eds), *Long-term Care Decisions: Ethical and Conceptual Dimensions*. The Johns Hopkins University Press, Baltimore, MD, 113–136.

Alberta Health. 1993. *Continuing Care Centres in Alberta's Future Health System: a Role Statement for Alberta's Long Term Care Facilities*. Alberta Health, Edmonton, AB.

Brechin, A., Walmsley, J., Katz, J. and Peace, S. (eds). 1998. *Care Matters: Concepts, Practice and Research in Health and Social Care*. Sage, London.

British Columbia Ministry of Health and Ministry Responsible for Seniors. 1999. *Community Care Facilities Branch Mandate*. http://www.hlth.gov.bc.ca/ccf/home/mandate.html

Brown, S. L., Lakin, C. and Burwell, B. O. 1997. Beneficiary centered care in services to persons with developmental disabilities. *Health Care Financing Review*, **19**, 23–46.

Clemens, E., Wetle, T., Feltes, M., Crabtree, B. and Dubitzky, D. 1994. Contradictions in case management. *Journal of Aging and Health*, **6**, 70–88.

Collopy, B. J. 1995. Safety and independence: rethinking some basic concepts in long-term care. In McCullough, L. B. and Wilson, N. L. (eds), *Long-Term Care Decisions: Ethical and Conceptual Dimensions*. The Johns Hopkins University Press, Baltimore, MD, 137–52.

Collopy, B. J. 1988. Autonomy in long term care: some crucial distinctions. *The Gerontologist*, **28**, 10–17.

Degenholtz, H., Kane, R. A. and Kivnick, H. Q. 1997. Care-related preferences and values of elderly community-based LTC consumers: Can case managers learn what's important to clients? *The Gerontologist*, **37**, 767–76.

Division of Aging and Seniors. 1998. *Principles of the National Framework on Aging: a Policy Guide*. Author, Ottawa, ON.

Folstein, M. F., Folstein, S. E. and McHugh, P. R. 1975. 'Mini-mental state': a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, **12**, 189–98.

Gubrium, J. F. 1993. *Speaking of life: Horizons of Meaning for Nursing Home Residents*. Adeline de Gruyter, New York.

Hofland, B. F. 1994. When capacity fades and autonomy is constricted: a client-centered approach to residential care. *Generations*, Winter, 31–5.

Kane, R. A. 1991. Personal autonomy for residents in long-term care: concepts and issues of measurement. In Birren, J. E., Lubben, J. E., Rowe, J. C. and Deutchman, D. E. (eds), *The Concept and Measurement of Quality of Life in the Frail Elderly*. Academic Press, San Diego, 315–34.

Kane, R. A. 2000. Values and preferences. In Kane, R. L. and Kane, R. A. (eds), *Assessing Older Persons: Measures, Meaning, and Practical Applications*. Oxford University Press, New York, 237–60.

Kane, R. A. and Degenholtz, H. 1997. Assessing values and preferences: should we, can we? *Generations*, **21**, 19–24.

Keating, N. 1998. *Evaluating Programs of Innovative Continuing Care (EPICC): Final Report*. (NHRDP Project No. 6609-1915-602). Author, Edmonton, AB.

Keating, N., Fast, J. E., Connidis, I. A., Penning, M. and Keefe, J. 1997. Bridging policy and research in eldercare. *Canadian Journal on Aging*, Supplement, 22–41.

Keating, N., Fast, J., Dosman, D. and Eales, J. 2001. Services provided by informal and formal caregivers to seniors in residential continuing care. *Canadian Journal on Aging*, **20**, 23–45.

Kenny, N. P. 1995. Empowerment and long-term care. In Sawyer, E. and Stephenson, M. (eds), *Continuing the Care: the Issues and Challenges for Long-term Care*. Ottawa, ON, Canadian Healthcare Association, 365–81.

Leutz, W., Sciegaj, M. and Capitman, J. 1997. Client-centered case management: a survey of state programs. *Journal of Case Management*, **6**, 18–24.

McCullough, L. B., Wilson, N. L., Teasdale, T. A., Kolpakchi, A. L. and Skelly, J. R. 1993. Mapping personal, familial, and professional values in long-term care decisions. *The Gerontologist*, **33**, 324–32.

MacRae, H. 1996. Strong and enduring ties: older women and their friends. *Canadian Journal on Aging*, **15**, 374–92.

Marcus, C. C. 1995. *House as a Mirror of Self: Exploring the Deeper Meaning of Home*. Conari, Berkeley, CA.

Miles, M. B. and Huberman, A. M. 1994. *Qualitative Data Analysis: an Expanded Sourcebook*. (*2nd Edition*). Sage, Thousand Oaks, CA.

Miller, N. A. 1997. Patient centered long-term care. *Health Care Financing Review*, **19**, 1–10.

National Forum on Health. 1997. *Canada Health Action: Building on the Legacy. Final Report of the National Forum on Health. Volume 1*. Author, Ottawa, ON.

Oleson, M., Heading, C., Shadick, K. M. and Bistodeau, J. A. 1994. Quality of life in long-stay institutions in England: nurse and resident perceptions. *Journal of Advanced Nursing*, **20**, 23–32.

Raphael, D., Brown, I., Renwick, R. and Rootman, I. 1994. *Quality of Life Theory and Assessment: What Are the Implications for Health Promotion?* Centre for Health Promotion and ParticipACTION, Toronto.

Rubinstein, R. L., Kilbride, J. C. and Nagy, S. 1992. *Elders Living Alone: Frailty and the Perception of Choice*. Aldine de Gruyter, New York.

Whitler, J. M. 1996. Ethics of assisted autonomy in the nursing home: types of assisting among long-term care nurses. *Nursing Ethics*, **3**, 224–35.

Zingmark, K., Norberg, A. and Sandman, P.-O. 1995. The experience of being at home throughout the life span. Investigation of persons aged from 2 to 102. *International Journal of Aging and Human Development*, **41**, 47–62.

Accepted 31 January 2001

Address for correspondence:
Jacquie Eales, Dept. of Human Ecology 3-02, Human Ecology
Building, University of Alberta, Edmonton, AB,
Canada, T6G 2N1.
e-mail: jacquie.eales@ualberta.ca