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Constructing the meaning of quality of life for residents in care homes in the Lebanon: perspectives of residents, staff and family

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Aim. Located in two care homes in Lebanon, the study explores the perspectives of quality of life for a sample of older residents, care staff and family caregivers.
Background. Quality of life for older people living in care homes is traditionally reported in the literature as a Westernised construct and so far little is known about its meanings from an Arabic cultural perspective and context. There is also a knowledge gap about the conditions of older people living in care homes in Lebanon.
Method. The study was a qualitative exploration of perspectives of quality of life of older residents, care staff and family caregivers. Two care homes for older people situated in Beirut took part in the study. Between 2010 and 2011 semi-structured interviews were undertaken with a sample of 20 residents, eight family caregivers and 11 care staff. Data were analysed using the constant comparative method.
Findings. Four categories emerged from this analytical process: (i) maintaining family connectedness; (ii) engaging in worthwhile activities; (iii) maintaining and developing significant relationships; and (iv) holding and practicing spiritual beliefs. The emergence of these categories confirmed the complex, interrelated and multidimensional nature of quality of life for residents and other stakeholders.
Conclusion. The findings supplement an emerging body of knowledge about the composition of quality of life for older residents in Lebanon. Improving the quality of life of older residents will require action in respect of all of the domains identified in study.
Implications for practice. Moving nursing practice from task-based care to relationship-centred approaches was seen as pivotal in helping to develop quality of life for residents living in the participating care homes. The findings have implications for education, nursing practice and research in Lebanon and help start an evidence base for care.

Key words: care home, Lebanon, nursing, older people, quality of life

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What does this research add to existing knowledge in gerontology?

- It is the first paper conducted by a nurse researcher in Lebanon that explores the views of older people living in care homes, together with care staff and family caregivers.
- Provides a basis for understanding the meaning of quality of life from the perspective of Arabic-speaking older residents, care staff and family caregivers.
- Develops a heightened awareness of the importance of spirituality in Arabic constructions of quality of life.

What are the implications of this new knowledge for nursing care with older people?

- Focuses on the importance of nursing care in Lebanon being informed by the views and experiences of care home residents and family caregivers.
- Highlights the value of moving away from task-based care and towards more person- and relationship-centred practices.
- Provides a platform to build practice-based evidence from a Lebanese cultural perspective.

How could the findings be used to influence policy or practice or research or education?

- To enhance cultural awareness through Arabic programmes of education, especially around the importance of spirituality.
- To promote the voice of older people in Lebanese care home environments and encourage a sense of agency in care planning.
- To be the start of a nursing and care home research agenda conducted in Lebanon and alongside the indigenous population.
- To bring the academic community together with policymakers, practitioners and service users to facilitate discussion about research and developments within the care home industry.
- University academics to encourage more students to carry out research in ageing and to urge students and junior faculty members to pursue careers in the field.
- To create multidisciplinary networks at the national, regional and international levels to enhance the quality of research and care related to the care home population.

Introduction

The proportion of older population in Lebanon, that is those aged 65 and above, has increased from 4.9% in the year 1970 to 7.1% in 1995 (Sibai *et al.*, 2004). According to Sibai *et al.* (2004), this proportion is expected to reach 7.8% by the year 2015 and 10.2% by the year 2025. Projections made for the year 2025 predict levels similar to those prevailing in Europe in the 1990s (Crosby, 1993). Due to medical advancements and improvements in public health, the ageing population is expected to grow, especially amongst the oldest-old, that is aged 85 and above (Sibai *et al.*, 2004). As such, the need for intermittent or continuous long-term care services will rise concomitantly (Chemali *et al.*, 2008), and current Lebanese policy suggests that this need is best met through the increased availability of care homes and/or alternative community-based long-term care facilities (Abyad, 2001). Whilst quality of life is a meaningful expression in Lebanon, it remains a sophisticated and complex construct and it provokes considerable debate about its constituent parts (Doumit & Nasser, 2010). This study aims to contribute to the debate by presenting the factors determining quality of life for older people residing in two Lebanese care homes.

Care home and nursing care provision in Lebanon

At present, there are a total of 49 care homes in Lebanon which accommodate a little over 4000 residents (Centre for Studies on Ageing [CSA], 2010). Those residents in long-term care constitute <1.4% of the total number of older people (i.e. over 65 years) in Lebanon (Naja, 2012). Lebanese care home capacity usually ranges between 50 and 100 residents, and the number of older people at present in Lebanon stands at approximately 312 000 (Ministry of Social Affairs, 2010). Assuming an average of 75 beds per care home, the number of beds per population of older adults would be one to 85 older persons. This could be considered a relatively low provision, although higher than the rest of the Arab region given the ageing and population demographic (CSA, 2009), but it must be seen in the context of traditional family structures in Lebanon where older people have significant expectation of help from their children and where the care home is seen as a 'last resort' (CSA, 2010). However, this traditional family structure is now changing from multigenerational to nuclear families. This is due to a number of factors, such as economic constraints, the impact of social mobility amongst the younger population and shifting gender roles (e.g. more women entering the workforce) which is creating a vacuum of care at home and increasing the

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likelihood of admissions to care homes for frail and/or vulnerable family members (CSA, 2010).

The majority of care homes in Lebanon (97%) are privately owned and the remainder are semi-private (Chemali *et al.*, 2008). Whilst public institutions are completely absent, the Ministry of Public Health provides support in the form of 15 000 Lebanese pounds (equivalent to about US $10) per day for 42% of the beds and the Ministry of Social Affairs pays 4000 Lebanese pounds (US $2.7) per day for 20% of the care home residents it covers (Chemali *et al.*, 2008). Charitable and other sources of donations, such as civil society organisations, constitute the second source and make fluctuating contributions that are difficult to predict (Dar Al-Ajaza Al-Islamia Hospital, 2008). There is a lack of 'formal' governmental care assessment/inspection bodies to monitor and report on caring standards. There are no valid operational standards to evaluate care homes. Consequently, care homes are allowed 'free reign' to set their own admission criteria, standards of care and working practices. In Lebanon, staff caring for residents in care homes are mostly untrained in gerontological practice (Chemali *et al.*, 2008) – this includes attending physicians – with nurses, occupational, physical and speech therapists not specifically trained in older people's rehabilitation practices (Chemali *et al.*, 2008). In the absence of a formal definition, the duties of Registered Nurses working with older people in care homes in Lebanon have been described to the first author as comprising: physical care, medical treatment, administering medication and keeping records (personal communication with a care home nurse manager, 2011). Nursing assistants, for their part, undertake feeding, bathing, positioning, transferring and elimination caring duties (personal communication with a care home nurse manager, 2011).

Arguably, such a 'problem' and 'task-orientated' construction of care contributed towards a societal, and professional, view that ageing is aligned to a state of dependency and that the work itself is unrewarding (CSA, 2010). Fortunately, such negative stereotypes are being challenged in light of the shift in the demographic trends and greater public understanding about the contribution of older people to society and their role in the family. In turn, the scientific community has responded by adopting a more positive view of ageing over the last decade. Both researchers and policymakers have shifted the focus from the negative characteristics of ageing to an examination of this stage of life as a successful experience, with a view to enhancing the well-being of care home residents (CSA, 2009). This shift is reflected in the incorporation of 'geriatrics' into the curricula of medical schools, residency training programmes, fellowships, social services and nursing schools. In the long term, such interventions will promote this specialty and encourage physicians, and nurses, to work in the sector; ideally, this will improve the delivery of health care to the older people.

As the majority of care homes in Lebanon are understaffed (Chemali *et al.*, 2008; personal communication with the director of nursing home A, 2011), they rely on volunteers from the local community to provide entertainment activities and additional 'hands-on' care. These volunteers enrich the lives of care home residents and offer personalised support to each individual, thus improving the quality of life of the older residents. However, their services are intermittent. There is therefore a discrepancy between the existing conditions of care experienced by older people living in care homes in Lebanon, and the ideal/good practice models put forward in Western society/literature by researchers and commentators such as McCormack (2004), Nolan *et al.* (2004), Owen (2006), Faulkner and Davies (2006), Faulkner *et al.* (2006) and Brown Wilson *et al.* (2009). For example, Brown Wilson and Davies (2009) have demonstrated that the type of care delivery adopted by staff influences the type of relationships between residents, families and staff. Specifically, the development of relationship-centred care in care homes involves negotiations that take into account the needs of everyone involved, as well as the context of the wider community. This means that the contributions of residents, families and staff are equally valued, encouraging each person to make a contribution to the wider community of the home and enhance feelings of well-being and quality of life (Brown Wilson & Davies, 2009; Brown Wilson *et al.*, 2013). Whilst the importance of relationship-centred care in care homes in Lebanon is beginning to be acknowledged, it poses a considerable challenge due to the paucity of guidance provided to staff about how enabling relationships can be developed.

Quality of life

Quality of life is a multifaceted construct that is applicable to a diverse range of people in a diverse range of circumstances, situations and environments, such as the care home (World Health Organisation Quality of Life Assessment Group, 1995; Kane, 2001; Zimmerman *et al.*, 2003; Natan, 2008). A wide range of international studies have shown that older people in many countries are consistent in the domains they identify as being important for the quality of their lives (Bowling *et al.*, 2003; Kane, 2003; Brown *et al.*, 2004; Robichaud *et al.*, 2006; Hjaltadóttir & Gústafsdóttir, 2007; Murphy *et al.*, 2007; Varricchio & Ferrans, 2010). These domains include the following: (i) health; (ii) psychological well-being; (iii) social relationships; (iv) emotional

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well-being; (v) activities; (vi) home and neighbourhood; (vii) financial circumstances; and (viii) spirituality and religion. The domains identified by older people in this study overlap significantly with the findings on quality of life from the general ageing literature.

Whilst these studies are important contributions to understanding and practice (see for example: Bowling *et al.*, 2007; Degenholtz *et al.*, 2008; Harmer & Orrell, 2008; Kelley-Gillespie, 2009), gerontological nursing literature that addresses care home residents' perceptions and perspectives of quality of life predominantly follows a Western discourse and paradigm. For example, when the keywords 'Lebanon' and 'Quality of Life' are applied in combination with the MeSH terms 'nursing home(s)', 'care home(s)', 'residential home(s)', 'well-being', 'nursing', 'care' to all relevant search engines, including PsychoINFO (1980–2012), PubMed/MEDLINE (1980–2012), CINAHL Plus (1980–2012) and Cochrane (1993–2012), only one study was found. This study was conducted by Doumit and Nasser (2010) and assessed older residents' psychological and physical health status in relation to institutional structures, processes and skills. The paper did not focus on the interpersonal and relational dynamics that occurred in everyday care home life.

Traditionally, in Lebanon, the physical and medical domains of care have routinely been placed at the top of indicators of quality service and care provision (Doumit & Nasser, 2010). However, this hegemony is starting to be challenged, and more personalised constructs of resident choice, privacy and dignity are beginning to be aired (Chemali *et al.*, 2008). Accordingly, the question about what constitutes resident quality of life in Lebanon is both timely and helpful in that it would address a significant gap in the literature and help tailor support systems. As far as the authors are aware, this is the first study to outline the underpinning categories of quality of life as experienced by care home residents in Lebanon and as informed by staff and their visiting caregivers, and the first conducted by a nurse.

Study design

As so little evidence existed prior to the commencement of the study, a qualitative approach was taken with the aim of describing and exploring quality of life in such a way as to be able to capture perceptions and conceptualisations of phenomena without seeking to impose criteria or definitions that may not be culturally coherent for those participating. The overall study design followed a classic grounded theory approach (Adra, 2013) with data analysis informed by the constant comparative method and theoretical sensitivity to the topic under discussion (Glaser & Strauss, 1967; Glaser, 1978). By theoretical sensitivity, we are referring to the continuous immersion in the study data by the first author, the familiarity to the topic area owing to her professional background and the duration in the field of studies (over 1 year) which, when combined, helped to inform the depth of data analysis and decisions over theoretical sampling. The findings shared in this paper constitute the four underpinning categories of quality of life that emerged from the data and were consistent across all three participating groups: older residents, care staff and family caregivers.

As this study was conducted between the American University of Beirut (AUB), Lebanon, and the University of Manchester, United Kingdom (UK), ethical approval was necessary from both institutions before the study could commence. Both sets of ethical permissions were obtained, but the Institutional Review Board at AUB recommended that a witness be present during the process of gaining consent to participate, as the study focused on a vulnerable population that may be living with a dementia. In the event, all participants gave written consent to take part in the study. Assurances of confidentiality and anonymity were provided at the time of entry into the study and are continued into this article and in the presentation of quotations.

Study participants

The sample recruited for the study comprised of older residents ($n = 20$) in two care homes in Beirut, which we have named care home A and care home B, staff members drawn from across the two care homes ($n = 11$) and nominated [visiting] family caregivers ($n = 8$). In care home A, a social worker served as an access point to the residents, staff and family caregivers, and in care home B, recruitment was undertaken through the help of the nurse manager. The two participating care homes were located in the city of Beirut where both people with – and without – dementia resided. The two participating care homes were selected on the basis of their geographical accessibility to the first author's place of work/domestic residence, contrasting bed size and willingness of their administrations to participate in the study.

Care home A is well known in the community for admitting older people who are 'complex', and it is a not-for-profit organisation. The care home is divided into four sections where men and women live separately, with a total population of just under 260 residents. The beds are in permanent occupation, and nursing services are provided by 57 nurses of whom one-third are Registered Nurses; other care staff include nursing assistants and a team of social workers.

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Care home B has a 70-bed capacity and is also classified as a not-for-profit organisation. Its activities are carried out by a multidisciplinary team of healthcare professionals including 40 full-time staff members including Registered Nurses, nursing assistants, social workers and two medical doctors. In both care homes, residents are visited twice daily by a geriatrician and a comprehensive 'geriatric assessment' is conducted weekly. It is the Registered Nursing staff's responsibility to monitor and dispense any prescribed treatments. The main objective of care home A and care home B is to ensure health, medical and nursing and social services care to older people living with frailty and/or dementia in their facility.

The two participating care homes are amongst the few in Lebanon that run relatively comprehensive services for residents, including rehabilitative, preventive and curative approaches. Both care homes have open visiting hours during the day for family members, but enforce regular visiting hours for other visitors. This is done so that meal times, bathing routines and other regularly scheduled activities are not interrupted. The majority of the residents were from low-income families and relied on funds from the Ministry of Public Health to pay towards their place in the care home.

Older residents

The sample comprised 11 women and nine men, aged between 65 and 91 years with a mean age of 73.7 years. Most of the residents had chronic health problems such as hypertension and heart failure. The main reasons for admission were failing physical health and family members' anticipated inability to provide care at home. The residents were all lucid, able to participate in a conversation and to express views on their living circumstances, as well as to reflect on their life story. They had lived in the care home for a period of 10 months to 9 years and all spoke Lebanese/Arabic. The decision on whether participants would be approached to take part in the study was made in consultation with the geriatrician 'in charge' of the resident, the family caregiver, the director of the care home and the nurse manager. Therefore, to facilitate the older persons' participation in the study, the first author was guided by (i) the clinician's judgment that the person was competent to participate; (ii) involvement of the family in the decision-making process; and (iii) the researcher's own assessment of capacity to consent.

Staff members

Eleven staff members were interviewed in total between care homes A and B. The majority of participants were Registered Nurses (n = 8), two of whom were nurse managers, whilst three of the participants were licensed practical nurses. Eight of the participants were female and three were male, with an age range of between 23 and 50 years and with clinical experience ranging between one and 14 years. As a step towards achieving maximum variation in data, the first author interviewed nurse managers, Registered Nurses and practical nurses. All were permanent paid staff of the care home, had been employed at the care home for at least 6 months and spoke Lebanese/Arabic as their first language, and caring for the residents was the main focus of their work. They were identified with the help of the nurse manager in both care homes.

Family caregivers

Participants had relatives in one of the two participating care homes. We defined a family caregiver as the person most involved in care of the resident, visits the care home regularly and has the authority to speak with care staff on the resident's behalf. The eight family caregivers who agreed to take part in the study ranged in age from 32 to 70 years. Whilst all had cared for their older relative prior to admission to the care home, they had visited their relative in the care home for a period of time between one and 6 years. Family members were identified with the help of the social worker and the nurse manager.

Data collection and analysis

Interviews with all participants started with the following question: 'What do you understand by the expression 'quality of life?', Once participants shared their accounts, open-ended probes were used as needed to clarify any issues and open up new lines of discourse. Participants were encouraged to provide additional detail and vignettes to illustrate their points. This allowed a rich understanding of participants' knowledge to emerge in the conversation and a focus on Lebanese culture and quality of life. All interviews were carried out by the first author in Lebanese/Arabic, specifically in colloquial Lebanese (the participants' mother tongue), and were conducted in a private location at the care home. Interviews were digitally tape-recorded and lasted between 35 and 60 minutes.

The audio-taped interviews were transcribed and translated into English by a nurse holding a Master's degree in Nursing and fluent in both languages. The first author listened to the recordings, checked the transcriptions word by word for accuracy and contextual meaning, and edited them again where necessary. The final set of transcriptions (Arabic–English) was checked once again by an academic colleague at AUB who was proficient in both languages. In

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the presentation of quotations in the findings section, the care home location is identified by placing the letter A [representing care home A] or B [representing care home B] at the end of the code.

Constant comparison was applied to the collected data which consisted of the concomitant and concurrent coding and analysis of the collected data (Glaser & Strauss, 1967; Glaser, 1978). Ongoing data analysis fed the data collection and theoretical sampling processes which followed (Cutcliffe, 2000; Birks & Mills, 2011). Consequently, data collection was influenced by analytic interpretations and discoveries and organised into descriptive categories (Glaser, 1978). In analysing the data, each interview was initially read as a whole by the first author and then line by line. Holistic reading allowed the identification of main statements on the participant's experience to be seen in context and prior to any fracturing of the data through the coding process. This provided an opportunity to interact with details embedded in the data and to grasp the underlying meaning of these experiences.

In classic grounded theory, and in the reported study, theory and theory development are grounded in empirical data and in acts of everyday social life, although it is important to highlight that in classic grounded theory development, it is not the data which are important, but the conceptual category (or conceptual property of the category) that is generated from it (Glaser & Strauss, 1967; Glaser, 1978). As Glaser and Strauss (1967) explain, a concept may be generated from one datum which then merely becomes one of a 'universe of many possible diverse indicators for, and data on, the concept' (p. 23). Crucially, in classic grounded theory, it is the indicators that are then sought for comparative analysis, and there are seen to be four stages in this process: comparing incidents applicable to each category; integrating categories and their properties; delimiting the theory; and writing the theory (Glaser & Strauss, 1967).

In the conduct of the constant comparative method, writing theoretical memos is seen as an ongoing, unrestricted process that begins when first coding the data and is an essential step in helping the analyst to interpret and find links/meaning in the data (Glaser, 1978). For example, in the reported study, when comparing the first two transcripts, conceptualising and diagramming the relationships in the data between the two staff members and their constructions of quality of life enabled the first author to begin to document theoretical codes that were subsequently shaped, developed and refined as further interviews were conducted/directed to explore these phenomena. In developing such codes, classic grounded theory is based on a concept-indicator model which provides 'the essential link' (Glaser, 1978 p. 62) between data and concept and results in a theory generated from data. By diligently following these processes, it is the constituent properties of the four categories that emerged to underpin a grounded theory model of quality of life in Lebanese care homes that are shared in this article (see Adra, 2013 for additional information).

In the findings that follow, we have coded family caregivers as F; care staff as S; and residents as R. As previously highlighted, the suffix A or B relates to the care home where the interview was conducted with the number referring to the assigned participant in the study.

Findings

Maintaining family connectedness

The delivery of care by family members did not end once the older person was admitted to the care home. Rather, it was a continuous process that took a different direction after admission. The data revealed that both family caregivers and staff had an important role to play in helping older residents adapt to life in the care home. Instead of providing 24-hour care, the family caregiver now assumed the role of assuring quality of care within the care home setting and wanted to actively participate in this process, as this experience attests:

> My responsibility is to see that he is cared for. I come to visit him every day to let staff know that someone is watching. Although here they have good services to be honest and they watch for their residents. (Interview: F8-A)

Family involvement and advocacy were linked to positive outcomes for both the residents and the family caregivers. Family caregivers experienced a sense of worth in terms of possessing special knowledge about their older relative and whilst they did not consider themselves authorities in the provision of nursing care in general, they did see themselves as experts in the needs, values and expectations of their relative. A sense of purpose and worth was experienced in actively contributing to the quality of life of their older relative as seen in this extract:

> You know, my brother has some difficulty in swallowing and chewing solid food, and we used to give him soft diet at home... So when we brought him to this care home I told the nurses about his problem and now they always give him soft diet and whenever I am not here during lunchtime they supervise him very closely. (Interview F5-B)

Staff valued the family caregivers' knowledge of the older residents and frequently discussed it with them so that this

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biographical knowledge could be incorporated into the care plan. Staff asked family caregivers how they had performed care at home and whether the cared-for person had any special interests and/or certain likes or dislikes about food or any other aspect of care. One staff member reported:

I suppose a home from home environment is important. If you ask any of the older residents where they'd like to be, they all want to be at home, so I think it is very important to keep the environment homely. (Interview: S6-B)

Family caregivers considered that it was their responsibility to visit, to keep up contact and to perform other essential connecting tasks, such as bringing outside information in to their relative, updating their relative about the day-to-day life of other family members, as this example shows:

My daughter got married and she delivered a baby girl, so I brought them here so my aunt could see them and we all sat in the garden. My aunt was so happy to see them. (Interview: F1-A)

Maintaining family ties, rituals and routines assumed considerable significance. Family caregivers ensured that their relative was aware of life outside the care home and thereby maintained cherished routines in their relationship. The family caregivers' ability to cope with caring in an institutional context was significantly influenced by the opportunity to reminisce about family memories and family traditions. Arguably, such sharing actions promoted a sense of family connectedness and purpose to being at the care home.

Engaging in worthwhile activities

There were similarities between the participating groups (residents, staff and family) about their views on what made activities worthwhile and meaningful. Most participants used the term 'enjoyment' as a measure of the meaningfulness of activities. Conversation with family and friends and singing were some of the most common activities during which this phenomenon was experienced. Activities were also seen to be meaningful when they addressed the residents' psychological needs. Residents spoke about the feeling of being useful, concern for others and their identities, autonomy, and belonging as indicated in comments such as 'anything that's needed... I wouldn't mind doing it', and 'just to learn that they know you're there' highlighting the importance of being included.

By engaging in activities the residents considered to be worthwhile, they were able to maintain a sense of self, their personal dignity and continuity with the past. Moreover, the data suggest that providing worthwhile and stimulating activities for the residents plays an important part in their physical, emotional and psychological health and well-being. Just as older residents and family caregivers valued the importance of meaningful activities to the quality of life of residents, staff believed that activities fostered feelings of belonging to the care home community. Friendships developed and residents gained a sense of accomplishment and feelings of self-worth, as these two examples indicate:

Activities like exercises? Yes, I love to exercise. I used to play tennis a lot. I was a very active person. There is this physical therapist who comes and teaches us exercises. I try to participate as much as I can and I do feel good about it. Participating in these activities help me keep busy and active, maintain interest in life, and mingle with other people. (Interview R2-A)

Activities that fulfill the psychological needs of the residents are significant. The more the activity contributes to reinforcing a sense of self, the greater its meaningfulness for the residents. Outdoor activities are particularly enjoyable to the older residents, especially when the outing connected them with people and places reminiscent of their past life. The goal of the activity is to communicate with the resident and to make some connection that can enhance the personhood of the resident and bring out the best in that person. (Interview S7-B)

Regardless of their personal health or circumstances, residents repeatedly expressed the need to 'have something to do'. The three groups of participants all mentioned the importance of 'keeping busy' in relation to well-being. This process occurred when most of the participants underlined the centrality of stimulating activities to their quality of life, including reciprocal activities such as helping other residents, which also made them feel valued. Thus, the pursuit of meaningful and worthwhile activities was important to residents for retaining their interest in life and in keeping themselves busy and active.

Maintaining and developing significant relationships

The three participating groups valued the significant role played by family and friendly relationships. For the residents, close bonds with others in the care home created a feeling of continuity between past and present circumstances and they defined friendly relationships with staff on the basis of the latter's caring attitude and behaviour:

I know that I am comfortable in here and that the employees are so sweet. They love me and they treat me as if I were their mother or grandmother. They are very gentle when they're handling me. Well, I am thankful to all. (Interview: R7-A)

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Whereas staff perceived the significance of relationships on the basis of the degree of reciprocity they experienced with their residents and on the basis of the emotional connection they established with them, family caregivers determined the significance of relationships between their older relatives and the staff according to the positive effects of the staff members' behaviour on their relatives' well-being. All groups spoke about the need for points of connection, but they mentioned inadequate staffing and workload as barriers to the staff's devotion of time to meaningful one-to-one relationships:

> ... Lack of time we have to converse with the residents and lack of continuity of care represent a problem in forming meaningful relationships with them. I try to talk to every single resident every day for 10 minutes at least. I sit down and listen to what they have to say but I think I should give them more time. You know these residents suffer from loneliness; when you give them enough time and attention they feel they are respected. Respecting them is the least we can do to these residents. If possible, there should be more professional nurses on duty to take care of the residents so that we have enough time to get to know residents and personalise care. (Interview: S5-A)

Residents and family caregivers explained that it is essential that staff be attentive and caring with residents and fully listen to what residents are saying and communicate effectively. They also considered that developing a close relationship with staff rested mainly on having a confidant whom they saw as sharing their concerns, having their best interest at heart, acting on their own initiative and being reliable.

From a staff perspective, feeling connected formed the pivot of a close relationship with residents. The development of this connection is consolidated by possessing knowledge about the residents and reciprocity in exchanging life stories and personal information. It is this life knowledge that enabled staff to understand the residents' needs and emotions and to deliver care that satisfied their needs. Staff also understood reciprocity as a mutual togetherness, a commitment and a partnership created between older residents and themselves as this extract conveys:

> I wish Schools of Nursing would raise awareness in nursing students about this growing population in our country. Imagine that they give birth to us, help us to start our lives and now we are helping them to finish theirs. My mother and father helped me face the world and succeeded; they helped me build myself and start on my own, and now I am helping them to die in return. Do you see the difference? (Interview S7-B)

Family caregivers employed different strategies to foster the integration of their older relatives in their living environment. The aim of these strategies was to adjust their actions/inter-actions to the new conditions under which their advocacy role was to be exercised. Family caregivers described a close relationship between staff and residents in terms of a caring attitude displayed by staff members, including a genuine sense of concern and a focus of attention.

Holding and practicing spiritual beliefs

Spirituality referred to the affirmation of life in a relationship with God, self and environment. It was depicted as the drive for meaning and a sense of purpose in life. It provided residents with a sense of connectedness and was characterised by certain identifiable values with regard to self, others and life. Spirituality also involved the act of being connected with a divine being through the act of prayer and worship. Holding and practicing spiritual beliefs provided a sense of purpose, meaning, spiritual nourishment and renewal which generated quality of life.

Older residents reported that God played a central role in providing the strength enabling them to deal with daily challenges. Their spirituality was seen as a source of emotional support, a positive influence on health, and contributing to life satisfaction and quality of life. They discussed how it alleviated their worry which is known to cause adverse effects on a person's health. Most of the residents explained that they were spiritual all day and prayed for their families and communities throughout the day. Spirituality was also directly connected to the residents' emotional well-being and positive attitude towards life as one resident reported:

> When you truly put your faith in God and let him direct you in your life you will be able to face any difficulties you find yourself going through. I have confidence that his almighty can guide me. Thank God, I am a strong believer and I love praying. I love to be honest and tell the truth all the time and this is very important for my quality of life. (Interview: R9-B)

Residents, staff and family caregivers spoke of spirituality as preserving continuity with the past, shaping reflections on life, guiding present thoughts and actions of the residents, and providing them an active strategy to face difficult times. According to them, religious beliefs acted to buffer feelings of helplessness engendered by perceptions of the uncontrollability of the illness(es). The residents constructed their beliefs as giving them a sense of hope, purpose and control, with prayer providing a vehicle for emotional expression:

> Spirituality helps me to combat perceptions of helplessness. Praying is like a coping mechanism for me. It helps me deal with my difficulties and problems. It's a of comfort, well-being, security, sense of

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belonging, and purpose. By reading the Bible and talking to God I am able to cope with daily hassles and stresses. (Interview: R5-B)

All participants emphasised continuous religious beliefs as the main factor ensuring continuity between past, present and future. Consequently, spirituality was seen to play an important part in the residents' ability to cope with illness and stress, and maintain well-being. For older residents, spirituality played an increasingly important role in determining quality of life, especially towards the end of life.

Discussion

Traditionally, working with older people has not been seen as a rewarding occupation in Lebanon (Abyad, 2001). This lack of professional standing is reflected in medical and/or nursing curricula in universities across Lebanon where structured and planned gerontological education is minimal, and where it exists, it is focused mainly on physical needs rather than an holistic approach to care (Abyad, 2001; Sibai *et al.*, 2004; Hospers *et al.*, 2007). Arguably, this is contrary to the values of the Western literature/countries where a positive trend is seen in recognising older people as individuals, promoting independence and taking into account goals that reflect life aspirations (Reed & McCormack, 2012). There have been precious few studies conducted in Lebanon that address the meaning and realities of care home life (Doumit & Nasser, 2010) and prior to this work none, to our knowledge, that included the voice of the older resident. To help commence a research agenda, this study has generated four categories that contribute towards the meaning of quality of life for older residents in care homes in Lebanon, namely maintaining family connectedness; engaging in worthwhile activities; maintaining and developing significant relationships; and holding and practicing spiritual beliefs. We will now compare and contrast these findings with the existing literature which is primarily derived from a Western perspective.

The exploration of quality of life in a care home milieu by other researchers (see for example: Nolan *et al.*, 2003, 2004; Davies & Nolan, 2006; Hauge & Heggen, 2008; Bowers *et al.*, 2009; Murphy *et al.*, 2009; Cooney, 2011) has identified factors similar to the ones shared in the present study such as family connectedness and advocacy, forging partnerships, maintenance of a homely environment and safety and security. As an example, the importance of family and staff members working together to meet the personal needs of the older resident was seen in this study. When staff and family caregivers had trusting relationships and strong interpersonal communication, they were better at meeting the resident's individualised care needs. Family caregivers asked for relationships of reciprocity whereby they wanted to express their ideas freely and were willing to listen to staff members in return. Similarly, they expected care staff to lend them a 'listening ear' and take into consideration their comments, thoughts and suggestions. The finding about the importance of family members' visits indicates that it is desirable to promote an open-door visiting policy with an opportunity for residents and visitors to access private spaces to respect privacy. Consequently, care homes are expected to make an effort to engage family members in the everyday life and culture of the care home and promote a trusting relationship between all parties (Ryan & Scullion, 2000; Davies & Nolan, 2003, 2004, 2006; Nolan *et al.*, 2003; Brown Wilson & Davies, 2009).

At the turn of the century, Bowers *et al.* (2001) depicted care as 'relating' whereby staff relied on personal relationships built on the care routines to meet the little needs that mattered to the residents. In many ways, this is comparable to 'maintaining and developing significant relationships' as shared in this article where caring relationships, as far as the older residents and their family caregivers were concerned, depended upon the care staff's empathy, trustworthiness and engagement with their relative (see also: Sandberg *et al.*, 2002; McGilton *et al.*, 2003). In a later paper, McGilton and Boscat (2007) framed such relationships through close and personal ties between care staff and residents. In the context of this study, this scenario became evident when residents and staff described their relationships from the perspective of the care delivered and of each person's contribution to the relationship. Reciprocal relationships resulted from the staff members' negotiations of options with their colleagues, older residents and family caregivers. Indeed, as previous studies have reported, a fundamental aspect of quality of life in residential care is being able to develop new relationships and maintain existing ones (Murphy *et al.*, 2006; Brown Wilson *et al.*, 2009; Bradshaw *et al.*, 2012).

Family caregivers in the study also suggested that the care home should be 'homelike' and that residents should be involved in decision-making and have choice and control. This need for care home environment to be more 'homelike' has previously been identified by Murphy (2007), but there is a challenge to this understandable ambition when care homes are constructed and designed, as in this study, for as many as 260 residents. Developing a more person-centred environment may require a significant public policy shift in Lebanon – much as the United Kingdom experienced in the 1990s with the decommissioning of the asylums that perpetuated and normalised task-based care in large-scale environments – but this does seem a distant aspiration at present.

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The significant contribution of spirituality to quality of life found in the study suggests that there is a need for care homes to create opportunities to support and enhance spiritual practices. Participants spoke openly about the meaning and importance of spirituality in their lives, with many stating that without it 'you have nothing'. Spirituality, although complex and often ambiguous, has a definite impact on who we are, what we become and how this is accomplished (Williams, 2008). Moreover, previous research findings suggest that spirituality has been linked with positive states of well-being, a reduction in depression and morbidity and an increase in the lifespan of older adults (Wallace & O'Shea, 2007; Mackinlay & Trevitt, 2010; Burack *et al.*, 2012). Much remains to be done to further understand the context of this aspect of care provision, its links to quality of life and cultural identity.

Despite the limited educational and research base for older people in Lebanon, the findings of this study support previous research from the West that report quality of life as a complex phenomenon related to all aspects of human life and closely associated with a person's living conditions (Robichaud *et al.*, 2006; Murphy, 2007;., Cooney *et al.*, 2009; Bradshaw *et al.*, 2012; Crespo *et al.*, 2012). One aspect of this dimension is through the provision of meaningful occupation and activities that is directly connected to the biography of the resident with an opportunity to be exposed to new experiences (Ice, 2002; Kalis *et al.*, 2005; Timonen & O'Dwyer, 2009). As seen in this study, activities also create an opportunity for the establishment of relationships and the perseverance of self.

Finally, on the whole, older residents in this study with a long-term condition still viewed themselves as enjoying a good quality of life, a finding that is synonymous with those of Lewis (2011) who argued that older residents' emotional well-being and spirituality kept the person from thinking negatively about their health status. Indeed, the four reported categories in this study can potentially be applied to clinical practice when, for example, nursing staff can be encouraged to take into account the views provided by residents and family caregivers, such as encouraging increased family involvement and considering it as a measure of good practice. The four categories can also be considered to have utility at a number of levels adding to knowledge and understanding of quality of life, whilst also having the potential to inform policy and practice in nursing and care home practice. In addition, further empirical research in Lebanon should be encouraged to build on the reported findings and extend the applicability of quality of life indicators for all stakeholders (Robichaud *et al.*, 2006; Low & Molzahn, 2007).

Study limitations

The findings of this study are limited by sample size and setting, namely two care homes in one city of Lebanon. The sample is comprised of the more able residents, and it is therefore unknown whether the findings apply in the same way to all residents. Moreover, the two care homes participating in this study were sampled based on their geographical accessibility and the willingness of their administrations to take part in the research and may not represent the 'typical' care home in Lebanon. Participants in the present study were interviewed only once and this affected the opportunity to 'check out' participants' interpretations of the data collected. Whilst the constant comparative method compensates for this to a degree, the limitations of interviewing once have to be acknowledged. One way forward in developing the presented categories may be to collect data over a longer period of time to capture some of the key transition points and relevant interactional dynamics.

Conclusion

Up until the reporting of this study, contemporary care home research literature has lacked a Lebanese perspective on the meaning and construction of quality of life. The findings from this study bring new insights into how residents experience quality of life in Lebanese care homes and show the importance of maintaining family connectedness, activities, relationships and spirituality in care homes. The findings of the reported study also underscore a need for greater personalisation in Lebanese care homes and triangulation of viewpoints with each care partner relating to one another as equals. Managers, nurses, and doctors need to accord respect to the residents' views during everyday contact and move away from task-based care provision to one based on relationships and human connection(s). The findings also contribute to the existing literature by allowing a deeper understanding of the way the older residents experience good quality of life in Lebanon and the way it can be facilitated by care staff. The cultural context of spirituality and its integral connect to human life requires further study and understanding.

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Implications for practice

- Focuses on the importance of nursing care in Lebanon being informed by the views and experiences of care home residents and family caregivers.
- Highlights the value of moving away from task-based care and towards more person-and relationship centred practices.
- Provides a platform to build practice-based evidence from a Lebanese cultural perspective.

Contributions

All authors have made an active contribution to the conception and design,acquisition of data, analysis and interpretation of data. All authors have critically reviewed the content of the paper and have approved the final version submitted for publication.

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