The Relationship Between Empowerment Care and Quality of Life Among Members of Assisted Living Facilities

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ABSTRACT

The purpose of this study was to examine patient empowerment care and how it affects a person's perception of his or her quality of life in assisted living facilities. Patient empowerment refers to the extent to which a person perceives the amount of control in his or her daily care. Eighty participants aged 65 or older currently living in assisted living facilities will be assessed. Participants were asked to fill out questionnaires about their individual demographics, perceived quality of life, empowerment care, and the geriatric depression scale. This study predicted that patient empowerment care would be positively correlated with quality of life for residents in assisted living facilities. Also, quality of life would be negatively correlated with depression score and positively correlated with marital status. The data found scores on the Geriatric Depression Scale were negatively correlated with quality of life ($r=-.620$; $\alpha=.01$), and the perception of quality of life was positively correlated with perceived empowerment in assisted living facilities ($r= .481$; $\alpha=.01$). No correlation was found between marital status and depression. These results indicate that diagnosis and treatment of depression, and making sure that residents of an assisted living facility feel in control and feel respected by the staff is important for a patient's quality of life.

INTRODUCTION

According to the U.S. Census Bureau (2009), by the year 2030 over twenty percent of all United States residents will be sixty-five or older, a large increase from thirteen percent in 2008. It is also predicted that of those who turn sixty-five this year, over seventy percent will need some type of long term care (LTC) sometime throughout their lives, and twenty percent will need LTC exceeding five years (Voelker, 2008). As the baby boomer generation ages, this creates the largest percentage of people over the age of sixty-five in our nation's history, making residents' health and enjoyment of life in long term care facilities more important than before.

One way to assess resident's perceived enjoyment of life in LTC is through quality of life. The concept of quality of life is defined by the World Health Organization (WHO) as an assessment that measures the physical health, a people's social relationships, psychological health, and the environment affecting people's perceptions about the world around them (2009). An individual's quality of life (QoL) is based on his or her health, perception of care, and how an individual perceives his or her life (Mckee, Houston & Barnes, 2002). Using a QoL assessment, researchers have been looking at factors like space, choice, and empowerment with residents and staff (Faulkner, 2001; Barnes, 2006; Campbell, 2003) to determine if such factors affects quality of life in long term care facilities.

One study examined how the LTC facility's environment, resident's choices and their control of their environment affected the resident's QoL (Barnes, 2006). Barnes (2006) observed thirty-eight different nursing homes for two days each. Barnes found that the variety of spaces in the environment, varying from private, to semiprivate to public, and a resident's choice of locations were highly correlated with a resident's perceived quality of life. In this study there is uncertainty as to the control of the resident to choose which space he/she desired or if the variety of rooms affected the resident's QoL. Several other studies have looked at resident satisfaction and quality of life with the care provided at long-term care facilities. One problem in LTC facilities is that residents sometimes are in situations where they are unable to control his or her care creating negative experiences for the residents (Faulkner, 2001; Grau, Chandler & Saunders, 1995). Another problem occurring in LTC facilities reported by Berglund (2007) in a study of residents, family members and staff, is that staff members do not realize the importance of influencing their own care and to be informed for residents. Berglund also found through interviews with residents and family members, that they were dissatisfied with the care and living conditions of the nursing home and wanted more opportunities to discuss the type of care. Does this lack of control over choices in care affect quality of life?

Campbell (2003) looked at the factors of perceived control and quality of life by interviewing nine registered nurses, five nurse assistants and six residents in a long term care facility about their perceptions of empowerment. Empowerment is when people feel like they have control over their environment, abilities to meet their own needs, solve problems and have resources to do so (Faulkner, 2001). Nursing staff said they wanted to be empowered or feel "appreciated" or "self-fulfilled" in the workplace. Campbell (2003) suggested that if the nursing staff felt empowered in their workplace they would feel a greater commitment to the job, which would also affect the resident's quality of life. However, this does not directly address the needs of the resident in the long-term care facility.

Tu, Wang & Yeh (2006) addressed this problem by having one hundred and two nursing home residents complete questionnaire's about activities of daily living, QoL index scale, empowerment scale, and demographic data. Example of empowerment in LTC facilities is staff members working quietly while the resident is sleeping, or resolve your complaints (Faulkner, 2001). Tu et. al. (2006) found that empowering care was the most important predictor of a resident's quality of life compared to all the factors. This study also found a gap between the resident's needs in the nursing homes and the care provided by the staff. However, to ensure the validity of these results, the study would need to be replicated and tested in other LTC facilities, including assisted living facilities (ALF).

Assisted living facilities are a growing field of LTC facilities, with over 36,000 in the United States. They are defined by the Assisted Living Federation Association as "as a long-term care option that combines housing, support services and health care, as needed" (ALFA, 2009). The goals of assisted living facilities are to provide flexibility of care for individual needs, and to provide a 'home-like' environment. Due to the flexibility of care and the home-like environment it is hypothesized that resident's quality of life would be better than that of a nursing home. Contrary to this belief Franks (2004) found QoL did not differ between nursing home residents and assisted living facilities. Further research is needed to study this growing field of long-term care facilities to determine if resident's perceived quality of life is correlated with factors found to affect QoL in nursing homes.

The purpose of this study was to further investigate the relationship between empowerment care and quality of life as perceived by residents in assisted living facilities to see if patient empowerment care affects quality of life. This study tested the following hypotheses: (1) Selected demographics (i.e., marital status) will positively correlate with quality of life, (2) the scores on the Geriatric Depression Scale will negatively correlate with quality of life, and (3) I predicted that perception of quality of life will be positively correlated with perceived empowerment in assisted living facilities.

METHOD

Participants

Eighty residents' (71% Female) currently living in assisted living facilities from the La Crosse, WI and Rochester, MN area will be recruited to participate (i.e., Sterling House of La Crosse and Onalaska, Meadow Wood AL, etc.). The researcher contacted these facilities around the La Crosse area to ask for permission from the administration before to collect data. The participants had to be over the age of 65, and they ranged in age from 72-99 years with a mean age of 84 years. The participants must have been able to give consent to participate and residents of assisted living facility for at least six months in order to participate.

Procedure and Materials

Prior to the study, potential participants were given informed consent forms to read and sign if they choose to participate. The researcher was present to answer any questions the participants may have. Participants were asked to fill out a questionnaire. These measures include the Geriatric Depression Scale (GDS-short form), the Patient Empowering Scale (PES), and the Quality of Life Scale (QoL), as well as providing basic demographic information (i.e., age, sex, and marital status). The Geriatric Depression Scale-Short Form has been used extensively in past studies. Its psychometric properties have been well established; its capacity to distinguish depressed from non-depressed patients ($\alpha<0.018$) (Brown University, 2009; Friedman, Heisel & Delavan, 2005). The WHO Quality of Life survey (WHO, 2009), which was tested in 23 countries (n=11,830) and found to have good psychometric properties cross-culturally (Skevington, Lotfy, & O'Connell, 2004). The Patient Empowerment Scale (PES) also has excellent psychometric properties (Faulkner, 2001). Overall, the questionnaire took about 15-20 minutes to complete and was be administered by interview. No follow up was needed.

Data Analysis

The data analysis will be done using Pearson R correlation and SPSS. If my hypotheses are supported then marital status will be positively correlated with quality of life, the geriatrics depression scale scores will be

negatively correlated with quality of life, and patient empowerment care will positively correlate with quality of life. This research is important for providing new data on how to improve the quality of life for those currently living in assistant living facilities, and give knowledge on how to improve quality of life for resident's in the future.

RESULTS

The hypotheses were tested using Pearson R correlation and SPSS with the significance set at α=.01. The first hypothesis was that the scores on the Geriatric Depression Scale would be negatively correlated with quality of life. There was a negative correlation between self-reported depression and perceived quality of life (see Figure 1) (r=.693, α=.01). The next hypothesis was that the scores on the WHO Quality of Life scale would be positively correlated with perceived empowerment scale. There was a negative correlation between a person's perceived quality of life and patient empowerment scale (see Figure 2) (r=.481, α=.01). The final hypothesis was that marital status and gender would be positively correlated with perceived quality of life. No significant correlation was found.

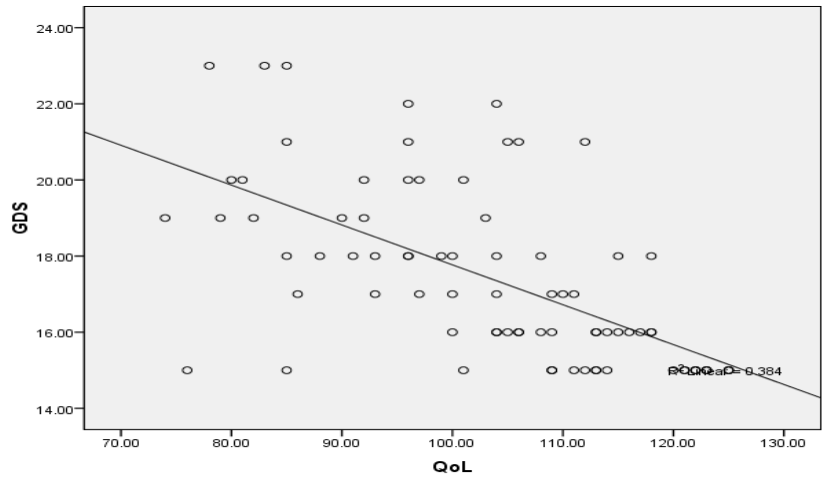

Figure 1. The scores on the Geriatric Depression Scale (GDS) correlated with WHO Quality of Life scale (QoL)

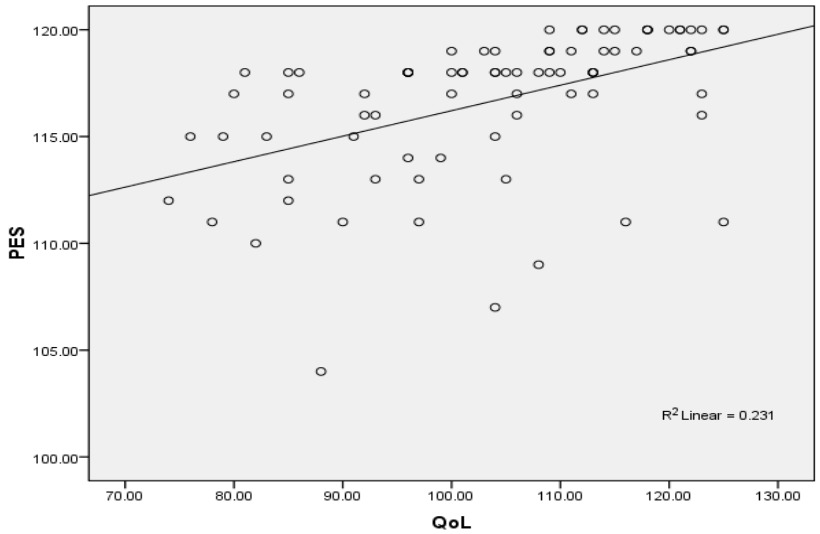

Figure 2. The scores on the WHO Quality of Life scale (QoL) correlated with Patient Empowerment Scale (PES)

DISCUSSION

The purpose of this study was determine what factors affect quality of life among members of assisted living faciliies. This study looked at three factors that have in past research been shown to affect quality of life: self-reported depression, patient empowerment, and marital status. It was hypothesized that self-reported depression would be negatively correlated with quality of life (QoL), patient empowerment would be postively correlated with QoL, and martial status would be postively correlated with QoL.

The current study found that quality of life was negatively correlated with self-reported depression. This data is consistent with previous research on quality of life and depression among long term care facilities (Watson, Garrett, Sloane, Gruber-Baldini, & Zimmerman, 2003). Research has found that depression is high among the LTC residents, and can range from 15 to 20 percent (Barca et. al 2010). Shannon Hughes & David Cohen (2009) in a review of long term care and depression found that long term outcomes of those diagnosed with depression in LTC facilities is generally poor. So in essence, when a person has depression in LTC facilities a person's perception of their lives, and their overall health outcomes are poorer, thus decreasing QoL.

However, the current study gives evidence for depression is being present among asssisted living facility residents. Also, this study shows that depression among residents can have a negative impact on quality of life which is supported by Tu et. al (2006) study with 102 Nursing Home residents. Furthermore, this study shows that depression is prevalent among residents of assisted living facilities. Therefore, the diagnosis and treatment of depression is essential for improving quality of life for residents living in assisted living facilities.

Also, the current study found that a person's rating on the patient empowerment scale was positively correlated with quality of life. So, as a resident felt more in control of his or her care, and respected by the staff, then he or she would be more likely to rate his quality of life as positive. The current study supports previous findings by Tu, Wang, & Yeh (2006). Tu et. al. (2006) found that when 102 nursing home residents filled out questionnaires, empowerment care was the most important predictor of quality of life. Masami (2008) found that when residents were asked about their perceived care, residents of assisted living facilities they often-cited staff and administration in their examples. Also, the study found that a key predictor of a resident's interpretation of treatment or care is dependent on who interacts with them daily. Therefore, as seen in this study, the interactions with staff and perception of care influence a resident's quality of life.

The final hypothesis the current study examined was that quality of life would be positively correlated with marital status. No significant correlations were found. One reason why no correlations were found could be because the different variables of marital status (e.g., single, divorced, re-married, widowed) were not distinguished in the current study. Another limitation was the limited number of the studies population that indicated, "married" in the study. These limitations were probably the reason why quality of life was not significantly correlated with marital status.

As mentioned previously there were several limitations in the current study. The first limitation of this study was that the data was analyzed through correlation methods. Not allowing cause and effect correlations, so from this study it cannot be determined if self-reported depression caused a poor quality of life or a poor quality of life caused self-reported depression. Another limitation of this study is the small sample size (i.e., n=80 participants). Due to the small sample size, the strength of the correlation between the variables was weak. With a larger sample size, the strength of the correlation should be also greater. The last limitation of this study was that most of the participants were Caucasian Americans.

Future research should focus on distinguishing the differences in marital status (i.e., divorced, widowed, single) and how the differences correlate with quality of life. Also, future research should examine patient empowerment care and quality of life. In the current study, the data was significant, however the strength of the correlation should be continued to be examined. Finally, in general future research should continue to look at what factors affect quality of life in assisted living facilities, especially as the population of Americans over the age of 65 continues to rise.

ACKNOWLEDGEMENTS

I would like to thank Dr. Dung Ngo for all of his help and support in this research. I would also like to acknowledge the UW-L Undergraduate Research Grants Program for providing the necessary funds to make my project possible. I would also like to thank the various Assisted Living Facilities and residents in the La Crosse, WI area for participating in my research study.

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