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EDITORIAL BOARD

Correspondence should be directed to:

The Editor, Heartbeats
National University of Singapore,
Chua Thian Poh Community Leadership Programme,
University Town,
18 College Avenue East, Singapore 138593

ctpclp@nus.edu.sg

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Improving the Nursing Home Experience: From Admission Processes to Activity Programming

ANNABELLE NG SIOW SHYEN, GLENDA KEE LI TING

Abstract

We studied four nursing homes and conducted interviews with staff members and residents to find out more about their current processes and experiences. A literature review on various care models was conducted to identify a framework that could be used to assess the adequacy of holistic care in nursing homes. Finally, we proposed recommendations on how to improve the nursing home experience, particularly in terms of admission processes and activity programming.

Introduction

As Singapore's population ages, the demand for long-term nursing care has risen and will continue to increase in the foreseeable future. In response, the Singapore government had undertaken measures to increase the number of nursing homes island-wide (Chia, 2014). Nursing homes were also increasing the capacity of their compounds—some had moved into multi-storey homes while others were in the midst of doing so (Singapore Christian Home, 2016; O'Hara, 2014).

Traditionally, most of the research on nursing homes in Singapore had focused on the medical aspects of care delivery and the physical wellbeing of residents. In addition, nursing homes were historically modelled after hospitals, making them larger, more clinical, and less like a home (Watson, 2009). There is room for a more holistic approach to nursing home research, where residents' emotional, social, and spiritual needs are taken into consideration. As such, we aimed to examine the adequacy of holistic care in local nursing homes.

Unfortunately, proposals to build homelier environments for the elderly, such as the Jade Circle project (Lien Foundation, 2015) had been rejected on the basis of financial unsustainability (Ng, 2016). Hence, there appears to be a need for nursing homes to come up with innovative solutions given the constraint of limited resources. We therefore focused on studying and proposing manageable recommendations to

make nursing homes more liveable, instead of suggesting architectural improvements that would tend to be more resource-intensive. Specifically, we examined nursing home programmes (activities, events, and projects that nursing homes ran for their residents) and admission processes.

Methodology

We conducted an in-depth study of four nursing homes and interviewed staff members—nurses, therapists, programme managers, and volunteer coordinators—to better understand the motivations behind existing programme offerings, as well as the advantages and challenges associated with organising these activities. We also interviewed residents to find out more about their experiences and involvement in these programmes. Details about the interview questions can be found in Appendices A and B.

	Nursing Home A	Nursing Home B	Nursing Home C	Nursing Home D
Management style	Operated by volunteer welfare organisation (VWO)	Operated by VWO	For-profit; privately-run	Operated by VWO
Religious affiliation	Catholicism	Buddhism	-	-
Compound structure	Transitioning from a single- to a multi-storey compound	One multi-storey compound; one transitioning from single- to multi-storey	Multi-storey compounds	Multi-storey compound
Number of branches	1	2	8	1

Table 1. Summary of characteristics of the four participating nursing homes

To cover a more comprehensive range of nursing homes, we approached nursing homes that varied in management style, scale of operation, religious affiliation, and compound structure. Table 1 summarises the characteristics of the four participating nursing homes. As Nursing Home C is privately-run, we were able to compare between programmes offered by privately-run and VWO-operated homes.

The inclusion of Nursing Homes A and B, religiously affiliated with Catholicism and Buddhism respectively, also allowed us to examine the role of spirituality in elderly care. In addition, as Nursing Homes B and C had multiple compounds, we were able to glean insights into the different approaches an organisation might adopt in its provision of services.

Literature Review

We surveyed existing literature on nursing homes to understand the different frameworks used to evaluate the quality of care delivery in nursing homes and existing care models.

Frameworks to Evaluate the Quality of Care Provided

Existing frameworks focus largely on evaluating the clinical aspect of the quality of care delivery, which is usually the nursing care received by residents in a nursing home. Many quality assessment frameworks are based on Donabedian's (1988) model of three approaches, which evaluated clinical care based on structure, process, and outcome. Glass (1991) was one of the early proponents of creating more comprehensive measures to assess the quality of care provided by nursing homes. She identified four major dimensions: staff intervention, physical environment, nutrition, and community relations. Another framework used to evaluate nursing home quality is the Quality Assessment Index (QAI), which takes a more quantitative approach (Gustafson, Sainfort, Van Konigsveld, & Zimmerman, 1990). It assesses the quality of care delivery across seven dimensions: direct resident care outcomes, resident care process, recreation activities, staff, facility characteristics, dietary services, and community ties. Each dimension would then be weighted according to its relative importance.

Integrating consumers' and providers' perspectives. While most quality assessment frameworks assess the nursing home as a single entity, Rantz et al. (1999) developed an integrated theoretical model that incorporates the different perspectives of the consumers and providers to achieve a more fine-grained assessment. The model assesses quality based on seven dimensions: the central focus (on residents, families, staff, and the community), staff, care, environment, home, family involvement, and communication. In developing this model, Rantz et al. (1999) used focus group discussions to facilitate interactions and promote disclosure among participants.

These discussions also provided a good opportunity for the evaluators to explore complex processes that involved human tendencies, attitudes, and perceptions.

Two core variables—namely staff and care—were identified from the consumers' perspective. Consumers were often able to vividly describe incidents that involved injuries or lost property, and tended to express negative emotions about these experiences. While these issues were important to the consumers, providers did not raise the same issues. The homeliness and cosiness of the nursing home were also of much greater significance to the consumers than the providers, indicating the importance that consumers placed on having a residence that made them feel comfortable and at ease.

Both consumers and providers, however, agreed that the central focus of elderly care should be on the residents and their families, and not on making profits. In Singapore's context, privately- and VWO-operated homes might differ in their central focus, since private homes would be more concerned with profit making.

The integrated multidimensional model developed by Rantz et al. (1999) is summarised in Figure 1. The model consists of three layers. The first layer highlights that residents, families, staff, and the community are the central focus of the framework. The second layer emphasises care, staff, and environment. The third layer pertains to communication, family involvement, and the sense of home (within the nursing home). In our study, we used this model to discuss the findings elicited from the nursing homes.

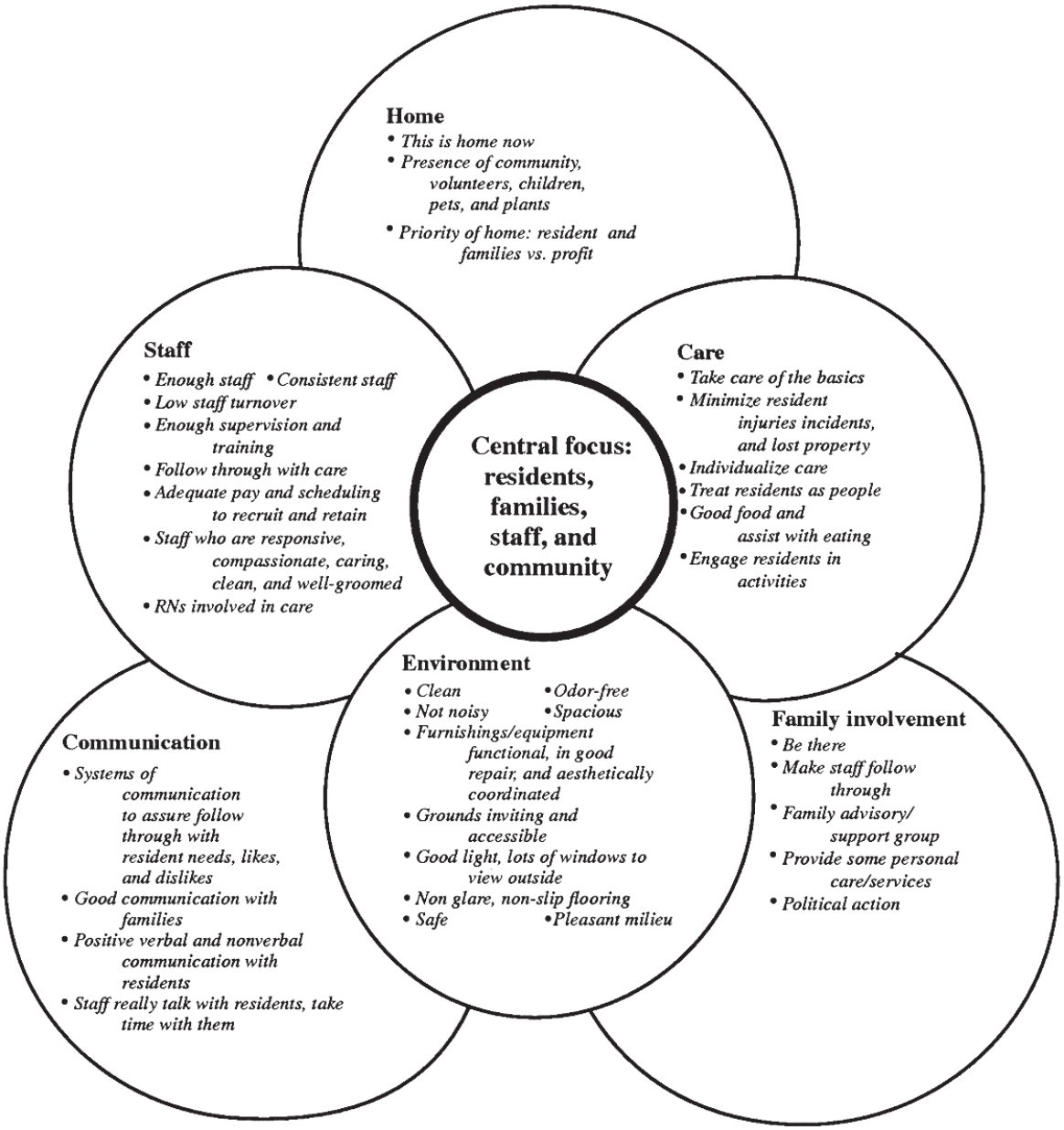

Figure 1. Rantz et al.'s multidimensional model (1999)

Case studies of care delivery models. The emergence of new models of care delivery—such as the Wellspring Model, the Eden Alternative, the Green House Project, and the person-centred care model—accompanied a culture change movement with respect to nursing homes. More importantly, the movement provided overarching goals to address the twin problems of endemic boredom and learned helplessness for residents. It also developed a set of principles that govern resident care practices, organisational and human resource practices, and the design of the physical environment. These principles include creating a homelike atmosphere, fostering close relationships, encouraging staff empowerment and collaborative decision-making, and institutionalising quality improvement processes.

The Wellspring Model. The Wellspring Model (Stone et al., 2002) aims to improve clinical care and the working environment of staff by equipping them with the skills they need to do their jobs, giving them the autonomy to decide how their work should be performed, and empowering them to work as a team towards shared goals. To encourage clinical staff to form professional relationships across nursing facilities, the model proposes the development of a programme for the centralised training of the staff, which could help to foster collaborative work relationships across facilities, instead of competitive ones.

The model also proposes multidisciplinary care resource teams, which would be empowered to develop and implement interventions that improve the care of the residents. This would flatten the hierarchy and develop a more lateral management structure, distributing decision-making throughout all levels of the organisation and increasing recognition of the floor staff's contributions. Information transfer across resource teams would be made possible by conveying knowledge to floor staff, through scheduling regular care resource team meetings.

The Eden Alternative. Another model that emerged from the culture change movement is the Eden Alternative, founded by a geriatrician who witnessed the endemic plagues of loneliness, helplessness, and boredom in a nursing home (Brownie, 2011). The model aims to promote human growth in care environments and strives to empower older people to pursue meaningful lives. According to this model, care is perceived not as a one-way street, but as a collaborative partnership between caregivers and care receivers, who are active participants in giving and receiving care.

The main intervention offered by this model is the inclusion of children, plants, and animals to enliven the nursing home environment and to create an atmosphere reminiscent of home. Contact with animals could provide psychosocial and emotional benefits such as stress reduction, improved mood, increased relaxation, heightened communication skills and sociability, and reduced depression and loneliness in patients. Close and sustained contact would go beyond the scheduled sessions of pet therapy, where residents only interact with animals for a fixed amount of time. Contact would also involve having many stay-in pets such as birds, cats, and dogs, which would be allowed to roam freely. The initiative would benefit not just residents but also the staff, providing them with a source of entertainment. Outcomes arising from Eden Alternative facilities have included reductions in medicine use (especially of

mind- and mood-altering drugs), reduced infection rates among residents, improved sociability among residents, decreased levels of boredom and helplessness, and improved staff retention rates.

The Green House Project. The Green House Project was started with a vision to provide excellent care, where the residents, their families, and staff are involved in meaningful relationships that were founded on ideals of equality, empowerment, and mutual respect (Zimmerman & Cohen, 2010). Each Green House is a self-sufficient home for 10 to 12 seniors, designed to be similar to flats in the surrounding community. Each resident has a private bedroom and bathroom and joint access to a central living area, kitchen, and dining room—where residents share meals at a common table. Family members, friends, and staff are also welcome at mealtimes or for other activities.

The staff comprise caregivers called Shahbazim (who attend to the residents' activities of daily living [ADLs] and housekeeping roles of cooking and laundry), comprehensive clinical teams, and administration support staff. There is usually at least one nurse serving two to three homes around the clock. The residents and staff in the home are expected to collaborate to create a flexible daily routine that meets individual needs and preferences. The absence of a predetermined schedule encourages residents to be independent in deciding how they want to conduct their lives.

The person-centred care model. This concept emerged from progressive changes in thinking about more effective ways of including persons with disabilities (PWDs) into society (Koren, 2010). The philosophical underpinnings of this concept arose from the desire to shift the balance of power between the PWDs and the services on which they rely, as well as a commitment to diversity and intentional community building. Person-centred care is grounded on the belief that PWDs should enjoy the same rights, opportunities, and choices as other members of society and should not be excluded because of their disabilities.

Results

From the interviews we conducted, we understood more about each nursing home and the programmes they offered. We focused on understanding the perspectives of the nursing home residents (the primary consumers) and of the management and

ground staff (the primary care providers). In this section, we present our findings of the programmes offered by each nursing home, and identify the challenges that the nursing homes faced.

Nursing Home A

Nursing Home A provided specialised dementia and hospice care and optional religious programmes. They aimed to regard every resident as a person—not a patient—and to redefine the way they cared for their residents, with the ultimate goal of changing the narrative of ageing. Notable aspects of this nursing home included its approaches towards therapy and towards volunteers.

Nursing Home A was scheduled to move to a new multi-storey compound in early 2017. The new building was designed to have six beds in each room in the dementia ward, and eight beds in each room in all other wards. Wards would also be segregated by gender, with two single-gender wards sharing the common bathroom in between. Each level—termed a 'family' to engender a feeling of intimacy and homeliness—was expected to fit four wards, along with a common dining and living area. Larger corridors and pantry space that could be used for activities were also planned. The additional space meant that more activities could be run simultaneously.

Therapy. A survey was done by the nursing home to scope out the activities the residents enjoyed, in order to plan activities around their interests and to elucidate underlying reasons for why residents enjoyed certain activities. The therapy team planned new activities based on the four needs they identified—social, physical, cognitive, and spiritual needs—and emphasised the importance of understanding their residents in order to plan activities that would meet their needs. During the execution phase, the team encouraged residents to join in the new activities, but were often met with resistance. The residents' hesitation to participate arose from not having had prior exposure to those activities when they had been younger.

Volunteer management. To work towards their vision of creating meaningful experiences with long-term impact, a new volunteer framework was created to take into account both residents' and volunteers' interests. The new framework was meant to foster deeper relationships and transform the volunteering experience from one of dutiful commitment to that of warm friendship. Numerous new projects, termed 'Impact Giving Opportunities', were planned for volunteers to contribute in ways that matched their skills and interests. Volunteers were also encouraged to initiate

new projects that they believed would benefit the residents.

Nursing Home B

Nursing Home B was in the process of transforming its care model with a focus on person-centric care (PCC), where each resident was treated as a unique individual with his or her own needs and preferred lifestyle. Respecting residents' lifestyles involved giving them the autonomy to decide when to conduct their ADLs within practical constraints, and matching the activities to the residents' areas of interests. Residents were also encouraged to regain independence through self-help, so as to minimise the feeling of helplessness and to help restore dignity and pride. The nursing home staff also started to address residents' rooms as 'households' instead of 'wards', in the hope that this change would alter the way residents and staff viewed the home. Staff also refrained from calling the residents 'patients' so as to diminish the perception that the residents were ill.

The home had plans to move to a new compound, modelled after The Green House project, in 2017. Each 'household' would have a common living room, dining room, and activity area, similar to public housing in Singapore. Residents would also be encouraged to wear home clothes and to be independent. A television would also be located in the living room to encourage residents to get out of bed and congregate in a common space.

Person-centric care. Staff members were sent for training on PCC to learn about the motivation behind the concept, and about practical steps to align their daily tasks to the concept. They also had a chance to experience life as a resident through a roleplaying session. To encourage the staff to take ownership of the care they provided and to go beyond their clinical background, they were tasked to run most of the activities for the residents. These activities were usually unstructured, and resources were provided such that residents could take part in them whenever they wanted. The nurses were empowered to take the initiative to create and run the activities, since they knew the residents most intimately and understood their personalities and preferences.

The results were positive, as the nurses were very artistic and spontaneous in designing new activities and spearheading their implementation. Some nurses even went the extra mile to bring their residents on short outings on their non-working days. The nurses were also found to be happier.

The Sparks of Life approach for dementia care. The home was also looking into implementing the Sparks of Life approach for dementia care. The Sparks of Life approach provides simple and practical solutions to daily challenges, focusing on effectively meeting the emotional needs of people with dementia, such as the need to feel appreciated, joyful, loved, and involved. If implemented, this approach could lead to improvements in memory, language, communication, social interactions, and other behaviours.

Volunteer management. Besides formalised therapy and dementia services, the conduct of other programmes depended on the volunteers. Volunteers who came with certain skill sets could create activities that fit their skill sets. Otherwise, activities would first be conceptualised, and then volunteers with the relevant skills would be recruited.

New volunteers were invited for a chat with the staff to understand their objectives for volunteering and to manage their expectations. An orientation was also conducted to familiarise the volunteers with the nursing home's rules, infection controls, and resident profiles. Programmes were then organised by creating interest groups. There were further plans to recruit like-minded volunteers who would enjoy participating with and leading these groups. This could lead to longer-term and more regular volunteers, making volunteering a two-way process where both parties could benefit.

Community engagement. Community engagement came in the form of a senior care centre where seniors living in the community took part in rehabilitation activities. In the evening, the senior care centre served as a gym that was open to residents in the estate. There were also plans to open up more facilities, such as the multipurpose hall, for public use. The first storey of the home also took on an open concept, with no fences surrounding the building. The centre also had plans to engage nearby schools and grassroots organisations.

Nursing Home C

Nursing Home C was operated by a private organisation with numerous centres across Singapore. Their service model sought to integrate Eastern and Western philosophies, and provided for residents' health, social, and psychological needs, as well as support for caregivers. There was a multitude of options to fit the privacy preferences of different residents, from single-bed rooms to open wards. The home

aimed to give the residents the most comfortable experience possible, by developing an individualised care plan for each resident.

Activities. Activities that the centres conducted had usually been proposed by the headquarters. Nurses who implemented these activities at the respective centres then made the appropriate modifications to cater to the unique situation at each centre. Lunchtime was set aside as visiting hours, for family members who had work and who found it more convenient to visit during lunch hours. The home decided not to load the residents' schedules with activities so that more time was available for family visits. Residents could also choose not to participate in the planned activities if they wished.

Volunteer management. The nursing home expressed that they did not attract as many volunteers as VWO-operated homes, even though the residents were still elderly people who had similar needs and desires as their counterparts in other homes.

Family involvement. While volunteer involvement was lacking, a defining factor of the private nursing home was the substantially higher rate of family involvement. About 90 percent of the residents had family members who visited them regularly.

Staff relationship with the residents. The staff's relationships with the residents were also warm and some of the staff saw the nursing home as their second home. Residents also enjoyed teaching foreign staff new languages, and staff induction programmes were conducted to better integrate the staff with the home.

Nursing Home D

Nursing Home D provided hospice care and catered mostly to destitute elderly people, who made up 50 percent of its resident population. Emphasis was placed on the resident's psychosocial and emotional needs through regular meetings with social workers and therapists, while volunteers helped to gather feedback from and assess the residents' psychosocial wellbeing. The home also conducted multidisciplinary meetings with staff from different departments to discuss intervention plans for selected residents.

Staff dormitory. A unique aspect of this home was the presence of a staff dormitory located in the same building as the wards. Since many members of the

staff were foreigners, they were given the option of living in the dormitory, where their meals would be provided by a central kitchen. Having staff members live in the same home as the residents allowed the staff to empathise more with the residents and increased the motivation for them to make the environment homelier and more comfortable.

Therapy. The home had a therapy programme that included activities like Kinect games, reminiscence therapy, mahjong, Chinese chess, cooking and *kopi* (coffee) outings where volunteers and residents could chat over coffee in a nearby coffee shop. A special room dedicated to reminiscence therapy was furnished with traditional furniture and objects related to lifestyles of the past. The traditional decor provided a sense of familiarity for the residents, allowing them to immerse in an environment that evoked memories from their younger days. Many of the residents enjoyed spending their time in this room. Such rooms could enable residents to regain their sense of living at home, despite being in a nursing home.

Activities. Programmes were strategically scheduled, and residents took turns to go on outings to ensure that all residents would be able to participate to some extent. Volunteers were briefed before the start of the activities and had to complete feedback forms to help the staff review and improve the activities in future iterations. Therapists would also ask the residents for feedback, which allowed the home to review their programmes in terms of execution, scheduling, timing, duration, space allocation, resident participation, and satisfaction.

Challenges Faced by the Nursing Homes

Environment. As asserted by the Eden Alternative model, nature plays a very important role in enlivening nursing homes. However, the design of multi-storey homes dramatically reduces residents' exposure to nature. At Nursing Home B's single-storey compound, residents lived in close proximity to nature and were free to enjoy the gardens and greenery around them. Some residents even began feeding the cats and birds that lived on the compound. Their imminent transition to a multi-storey home might significantly reduce their contact with nature, even in the presence of indoor plants and a perimeter garden on one of the levels.

Lack of funding. Certain activities such as handicraft sessions incurred recurrent material costs, but funding for activities was limited. With the government's active promotion of the local arts scene in recent years, more grants were made

available for related activities. Some nursing homes made use of these trends to obtain the necessary funds to introduce new activities and programmes. However, this was merely a stopgap measure and would be neither a sustainable nor an ideal way of ensuring a steady stream of funds.

Manpower shortage. Manpower shortage was a problem that almost all the nursing homes faced. In some nursing homes, nurses were the main personnel organising the activities on top of their usual duties of providing nursing care. This could cause nurses to be overworked, which could lead to burnout and higher attrition rates in the long run.

The homes also faced manpower constraints in transporting the residents to the different venues in which the activities were held. Transporting immobile patients was more labour-intensive for homes that lacked common transporting devices found in hospitals. Multi-storey homes also faced additional delays due to the need to use lifts.

Difficulty in engaging residents. Staff members faced difficulties when trying to encourage the residents to participate in social activities. Some of the residents were unmotivated or questioned the need to participate in the programmes due to their advanced age. As a result, additional manpower had to be deployed to engage each resident individually. The main participants for these programmes tended to be mobile or wheelchair-bound residents; the staff acknowledged that more had to be done to engage bed-bound residents. Such engagement would require adapting existing programmes or developing new ones altogether.

Communication barriers. All the nursing homes also faced communication barriers. Most of the nursing home residents spoke only Mandarin or some Chinese dialect. However, nursing homes in Singapore relied heavily on foreign nursing staff from the Philippines, who tended to speak English, instead of Mandarin or any Chinese dialect (Khalik, 2013). Hence, communication between the nurses and the residents was significantly limited. While nurses were required to attend language courses to bridge this gap, learning a new language requires substantial time and effort. Most nurses and residents eventually came to understand each other through hand gestures and simple phrases. Nevertheless, the communication barriers prevented nurses from building deeper relationships with the residents, since extended conversations seldom took place. Where extended conversations did take

place, these tended to be superficial, constrained as they were by the nurses' limited proficiency in the residents' primary language.

Applying the Multidimensional Model

Analysing the providers' perspectives. Each of the four nursing homes employed different strategies in its provision of care and emphasised different aspects of a resident's wellbeing. In this section, we applied the theoretical multidimensional model developed by Rantz et al. (1999) to the insights gleaned from our study. To reiterate, the model integrates providers' and consumers' perspectives, and identifies seven dimensions of care quality: the central focus (on residents, families, staff, and the community), staff, care, environment, home, family involvement, and communication.

The central focus. The model's central focus emphasised the people involved in a holistic nursing home experience—residents, staff, families, and the community. The needs and desires of residents were especially important as they were the primary consumers of nursing home services and spent an extended amount of time in the home. Families played monitoring and participatory roles, while the staff provided the main care. Nursing homes were also usually situated within communities that could provide volunteers and other supporting services to the nursing homes.

The staff and communication dimensions. The most persistent problems the nursing homes faced tended to come under the staff dimension. The manpower shortage and high turnover rates did not merely affect daily operations; these problems also had an impact on resident engagement, which involved manpower as well. Some problems also straddled more than one dimension: nursing home staff tended to be foreigners who were unable to speak the languages that the elderly residents spoke, and this problem could fall under both the staff and the communication dimensions. However, communication may become less of a problem for future generations of residents who would be better educated and familiar with English.

The care dimension. The care dimension involved basic but important clinical care and psychosocial care. The Singapore government had put in place structures to ensure that residents would be provided with good medical care (Ministry of Health, 2014). While the focus had previously been on medical care, more nursing homes were shifting their focus to include psychosocial aspects such as individualised person-centred care and better nutrition. In this respect, the care dimension would

overlap with the home dimension. Nursing homes were working to improve these two dimensions through person-centred care, innovative layouts for new homes, and better psychosocial care—by building a competent team of social workers and programme managers.

Dormitory-style nursing homes came to prominence in Singapore due to real estate constraints and the government's drive towards standardisation and cost efficiencies (Wyman, 2016). Despite the dormitory-style layout, the nursing homes were usually clean, odour-free, and safe. Some homes had a 'no restraints' policy, and did not restrain residents to chairs even if they were at risk of falling. This policy empowered residents to maintain their physical strength and independence in walking. Softer flooring was also incorporated into the dementia wards to cushion any falls.

While Singapore's space constraints had resulted in small bed areas (minimally 6 m^2) in a ward setting, nursing homes did have common spaces and multipurpose halls where most activities were conducted. Some homes also adopted an open concept where the first floor of the home was not fenced off from the surroundings; mentally alert residents were allowed to roam outside on their own. However, some homes were more cautious and did not allow residents to leave the home alone. This trade-off between freedom and safety presented a need for more innovative strategies to ensure the residents' safety, while maximising independence and choice.

The home dimension. While families were important to elderly care, most VWO-operated nursing homes had residents who were destitute and had little to no family support. The lack of family support could be compensated for by psychosocial support from social workers, nurses, therapists, and volunteers. Those interacting with the residents on a daily basis played a vital role in forming supportive relationships with them. Results from one of the nursing home's surveys indicated that talking to someone was an activity that the residents most commonly enjoyed, highlighting the residents' social and emotional needs.

The family involvement dimension. Although there were no formal family support groups, the staff at some homes organised outings for family members to get to know one another. Private homes, where most of the residents had attendant families, encouraged their families to visit and protected the time that residents had with their families by scaling down planned activities.

Review of analysis. In applying Rantz et al.'s (1999) multidimensional model

to the quality of care in nursing homes, the model's dimensions overlapped in many instances. Systems that involve different groups of people, such as nursing homes, are particularly complex and have many interdependent relationships that need to be taken into account. As such, the evaluation of care quality should not be confined to specific dimensions but analysed as a whole.

Nevertheless, these dimensions were still helpful in providing a framework to analyse the different variables that contributed to the residents' quality of life. Our study focused heavily on analysing structures and processes involved in the residents' day-to-day life from the providers' point of view, and analysing outcomes from the residents' point of view. However, most of the initiatives and programmes in the home were either in the planning phase or had been recently implemented. As a result, we were not able to measure any meaningful outcomes.

Analysing the residents' perspectives. We interviewed 18 residents from three nursing homes. Residents were asked a series of open-ended questions to find out more about their experiences with and sentiments about the home. Their responses shaped our understanding of the consumers' perspectives with regard to the level of holistic care, and were grouped under six dimensions of the multidimensional model.

The care dimension. The care dimension involved the provision of individualised care and the engagement of residents in activities. Hence, our interview questions focused on understanding the residents' participation in the homes' activities, as well as their personal interests and preferences.

Residents were generally aware of the activities that took place in their respective homes, and were able to list some of the activities offered. They mentioned that information was put up on boards in the wards, and that the nurses would inform them of such programmes. Furthermore, given the fixed schedules that the nursing homes followed, residents expressed that the occurrence of these activities became familiar over time. Some residents noted that the existing activities were acceptable, and participated in them to pass the time. On the other hand, other residents did not participate much due to their medical conditions, or simply preferred their own activities. The latter reason tended to be a popular one among residents who were younger and more mobile.

While the nursing homes ran on fixed schedules, there were certain times of the day when residents could more freely exercise their choice. For example,

residents could choose between a few programmes that were conducted concurrently, or opt out of the prescribed activities altogether. However, when asked if they would want more choices beyond what was already offered, almost all the residents interviewed highlighted that they had not previously given such a question much thought. A possible reason for this could be that a majority of the residents benefitted from substantial government subsidies, or had family members who paid for their fees, leading to lower expectations of the quality of care provided. Furthermore, as highlighted by a few staff members from the nursing homes, existing residents largely belonged to a generation that was less educated and less focused on exploring their interests and hobbies.

When asked about their favourite activities, the residents gave a variety of answers, but we noticed that their responses were usually adaptations of what the residents used to enjoy prior to their admission into the home. For example, one resident highlighted that she enjoyed listening to music, since she had used to play the piano. A significant number of residents also mentioned outings as a key highlight among other programmes offered.

The staff dimension. To explore the staff dimension, we asked residents about the level of care provided by the staff at the nursing home. There was a common consensus among the residents that the nurses were consistently busy, and hence were unable to spend much time with the residents. For example, the nurses were unable to bring them out on more frequent walks around the compound. Some residents understood the hectic nature of the nurses' jobs, while a minority expressed dissatisfaction with the nursing staff. Some residents commented that the nurses were inattentive and not particularly thorough, and that there were inconsistent care standards among different nurses.

The environment dimension. Most residents did not comment on the environment of the nursing homes during their interviews. The few residents who commented generally gave positive feedback, describing their nursing home as "clean", "neat", or "quiet". A resident from Nursing Home B (single-storey), which had a significant amount of greenery within its compounds, commented that the presence of nature was good.

The home dimension. Residents were asked about their sentiments regarding and sense of belonging to the home, so as to assess their emotional wellbeing. While

the residents were generally contented with living in a nursing home, there was a prevalent sense of resignation among the residents. Common sentiments were that contentment simply involved getting used to their situation, and that 'life goes on'. A minority of residents expressed even greater dissatisfaction.

Some residents referred to the nursing homes as 'their home', demonstrating a sense of belonging and attachment to their respective nursing homes. Yet, a sense of institutionalisation was still present, as residents used medicalised terms like 'wards' and 'patients' instead of 'blocks' and 'residents'.

The communication dimension. The communication dimension of the care model included quality interactions between staff and residents, as well as systems of communication needed to follow through with residents' needs. As such, our interviews aimed to understand the level of interactions between staff and residents. Interactions with fellow residents were also examined to provide a better understanding of the residents' social wellbeing.

A majority of the residents had at least a few other residents with whom they spoke and interacted, such as neighbours on adjacent beds, or fellow residents that they had met during communal meal times and activities. The residents' interactions with the nurses varied: some residents mentioned that the nurses did chat and joke with them, while others mentioned that the nurses did not have much time for deeper interactions due to their busy schedules. Other residents also cited the existence of language barriers.

Good communication could also come in the form of a proper introduction to the home during the admission processes. This would be especially important in helping residents to adapt to their new living environment, as some residents expressed that they had felt upset and lost in the beginning. Unfortunately, residents expressed that there had been no formal introduction or orientation. During the admission processes, the homes tended to take the more practical approach of only showing the residents where they needed to go.

The family dimension. The presence of family members or relatives at the VWO-operated nursing homes was generally lacking, while the residents at the privately-operated Nursing Home C had family members who visited regularly. When asked about family members or relatives who frequently visited her, one resident shared about a volunteer who visited her every weekend. This response

suggested that support from 'family' involvement could come from people other than the residents' biological kin.

Recommendations

Based on the interviews conducted with the staff and residents, we proposed four key recommendations to help improve the nursing home experience.

Alleviating the Manpower Shortage

Bringing in diverse groups of people to assist the staff could result in a higher level of care, and provide the social support that most residents lacked. Having local volunteers and part-time staff could also help to reduce the language barriers between the residents and foreign staff.

Hiring part-time staff. To alleviate the manpower shortage faced by all nursing homes, homes should look beyond conventional salaried workers to improve the staff dimension of the care model. Firstly, they could introduce a part-time scheme to engage housewives and retirees living in the vicinity. As these groups of people do not have existing work commitments, a flexible, part-time scheme could be an attractive option for them.

Recruiting volunteers. Private nursing homes could also launch a campaign to attract more volunteers, by publicising volunteering opportunities on their websites. This move could help to change the perception that meaningful volunteering opportunities are only available at VWO-operated homes.

Fostering long-term partnerships with volunteers. Nursing homes should also endeavour to make volunteering a sustainable and meaningful experience for all volunteers. Volunteers' interests could be matched with the home's needs, and the volunteers' commitment levels could be moderated. For example, the homes could modify existing corporate social responsibility (CSR) schemes such that stronger long-term partnerships, rather than one-time engagements, could be fostered between the homes and volunteers from private organisations.

To achieve these goals, nursing homes should strive to build an integrated community and tap on institutions and residents located nearby. Increasing the general public's openness towards nursing homes would also be helpful, especially

by encouraging such openness at a young age. To this end, childcare centres and schools could be approached to help shape perceptions about volunteering at nursing homes.

Improving Staff Development

The nursing home staff members are at the heart of the care model, as they spend the most time with the residents. Thus, nursing homes should ensure that the staff are well-trained in their respective functions. Frontline staff such as nurses and therapists should undergo experiential learning to inculcate values such as empathy, instead of merely focusing on technical skills. Networking sessions between the top management of different nursing homes should also be extended to frontline staff, where they would be given the opportunity to share their experiences and challenges with one another. This networking could be done via an online platform, such as a Facebook group. Also, nursing homes could benefit from having staff members who specialise in programmes and volunteer management (National Volunteer & Philanthropy Centre, 2014). Adding such specialised roles would help to streamline operations and lighten the workload of frontline staff, who would then be able to focus on conducting the activities. In turn, this would help to drive the change towards holistic care within the home.

Nursing homes should also ensure that the staff's welfare is taken care of. Psychosocial support and activities could be organised for the staff, who are mainly foreigners and might lack a strong local support network beyond the workplace. This recommendation would be most effective alongside the earlier recommendation of augmenting the existing manpower. Only by bringing in more manpower can the staff have more time and energy to engage in networking, training, and recreational activities.

Providing High-Quality Personalised Care

Understanding the factors that influence each resident's quality of life. Most previous surveys conducted by nursing homes only identified the activities that the residents enjoyed. However, we created an alternative survey (excerpt in Figure 2) that also encourages respondents to think about what they value most in life.

1. **Please rank the top 3 things which are most important to you.**
Mark only one oval per row.

	Choice of doing what you enjoy	Freedom of going where you want to	Having relationships and people to talk to	Independence	Being with your loved ones and close friends	Being free of physical discomfort	Security/Safety	Sense of purpose/having something you care deeply about	Privacy
1st	◯	◯	◯	◯	◯	◯	◯	◯	◯
2nd	◯	◯	◯	◯	◯	◯	◯	◯	◯
3rd	◯	◯	◯	◯	◯	◯	◯	◯	◯

2. **What are the top 3 moods you have most of the time?**
Mark only one oval per row.

	Bored	Sad	Carefree	Worried	Apathetic	Confused	Contented	Happy	Frustrated	Unaware	Peaceful	Neglected	Angry	Lonely
1st	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
2nd	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
3rd	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

3. **Why do you feel this way?**

Figure 2. Excerpt of survey to elicit the factors that influence the residents' quality of life

The survey goes beyond questions about preferred activities, by eliciting the intrinsic beliefs and values that influence the residents' quality of life. If a resident values privacy, for example, this might suggest an introverted personality, in which case the resident might prefer to spend more time alone. Providing a quiet and private space for this resident could improve her/his quality of life more than trying to encourage her/him to participate in social activities (on the presumption that her/his resistance to social activities was not due to depression or other psychological issues).

Many response options could be included to make this survey comprehensive, but this comprehensiveness might be cognitively overwhelming for the residents. As such, fewer options could be included for an actual execution of the survey. Understanding the residents' beliefs and values could allow homes to tailor their interventions to each resident and further contribute to individualised person-centred care. Such personalised care will become even more relevant in the future, as residents become more educated and affluent, and expect a higher quality of life.

Empowering residents by encouraging them to take the lead. Existing activities usually involve a therapist or volunteer leading the session, with the residents as participants. However, more could be done to encourage the residents to take ownership of certain activities. For example, a resident who enjoys and is proficient at making paper lanterns could run workshops for other residents, and even for other people from the wider community. Nursing homes could collaborate

with nearby community clubs to conduct workshops within the home and have able and competent residents lead these classes, empowering residents to take initiative and enabling them to pursue a greater sense of meaning and purpose.

Incorporating technology. As Singapore endeavours to be a 'smart nation', technology would play an increasingly important role in facilitating communication. Nursing homes could leverage such technology in their befriending programmes. According to a survey that one of the nursing homes ran, most residents want someone to talk to. Many volunteers tend to be busy in their daily lives and might not be able to visit the residents frequently. However, if volunteers could use online video platforms to chat with the residents, the residents would have more opportunities to speak with these volunteers. Such a solution should augment—but not replace—face-to-face meetings, which should still occur at least once a month. One of the residents interviewed had kept in touch with an ex-nurse through Skype, demonstrating the potential of technology in helping more residents remain connected with people outside of the nursing home.

Encouraging Greater Family Involvement

Setting up family support groups. Many homes do not have formal family support groups. These homes could encourage residents' family members to initiate and take turns to co-lead such groups. Such support groups could function as platforms for exchanging caregiving tips and organising caregiving workshops. Families could also watch out for one another's loved ones who are staying in the same home, and mutually encourage one another. Volunteers could also involve family members in the activities and outings planned for the residents. In Nursing Home B, the residents' spouses were invited on outings. The feedback for this initiative was positive, as couples enjoyed the time they had to bond.

Improving the Admission Process

Providing an information kit. Some nursing homes in Singapore do not have an information kit or are in the process of developing one. An information kit is a practical component of the admission processes to which family members and residents could refer. Such a kit would be a helpful guide for caregivers and residents on things to look out for during the transition to the nursing home. The kit would also help potential residents make an informed choice about moving to a nursing home, by providing them with details about life in the home.

Many residents might have been referred to nursing homes without fully accepting the change. The information kit could help them better assimilate into their new environment and come to terms with the transition. The kit should also address misconceptions and frequently asked questions about the nursing home, to alleviate the pressure on staff to communicate comprehensively with all the residents and their families on recurrent topics.

Traditional information kits that contain copious amounts of information would not be useful; an ideal information kit would have minimal textual information and more pictorial information instead. Instead of providing information that could be easily found online or from other places, the information kit should prompt residents and their families to think about issues that they might not have considered previously. Such issues include advanced care planning, residents' rights, and even funeral planning. In the information kit that we created for the nursing homes, we included phrases and images that would encourage residents and their families to think about these issues, to avoid unnecessary stress should such situations arise. A residents' charter was also included, as it could inform residents of their rights and responsibilities.

Limitations and Further Research

A key limitation of this study is that the residents interviewed might not represent the entire population of nursing home residents, as they had been preselected by the staff. In addition, we were unable to interview residents who faced difficulties in communicating, such as those who were bed-bound or inarticulate.

Thus, further studies could work on systematically selecting a sample of residents that better represents the demographics of the respective nursing homes. Future studies could also focus on helping nursing homes prepare for the next generation of residents. As the future generation of residents are expected to be more highly educated and exposed to greater choices from a younger age, nursing homes would need to adapt their programmes accordingly. Besides nursing homes that are operated by VWOs and private organisations, future research could also include the newly built government-run nursing homes and evaluate any significant differences in their processes (Wong, 2016).

Conclusion

As the Singapore population ages and people become more highly educated, the demand for holistic care will continue to rise. Beyond clinical care, it is necessary for nursing homes to cater to the psychosocial and emotional needs of their residents. It is encouraging to report that our local nursing homes have put in place several measures to provide for a better environment and standard of living for their residents. In order to overcome existing challenges, homes must continue to innovate solutions to meet existing needs and pre-empt future needs in the ever-changing eldercare landscape.

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Appendix A: Interview Questions for Nursing Home Residents

Awareness of activities and programmes offered

To understand residents' awareness of the programmes available and the channels of information they have, in order to improve the communication of information

1. Do you know what activities are run by the home?
2. Do you know the schedule of the activities?
3. Where, when, and who are conducting or participating in these activities?
4. How do you know this information (through nurses, caretakers, family members, printed timetable, other residents etc.)?
5. How do you get to the rooms where the activities are conducted?

Choice of activities

To understand how much freedom they have in choosing activities and whether they desire more choices, and if so, the type of choices they desire

1. Do you get to decide when you want to perform ADLs (activities of daily living)?
2. Do you get to choose what activities you want to participate in?
3. Which activities are compulsory and which are optional?
4. Do you want more freedom in choosing activities or is the current selection acceptable?
5. Do you prefer to have a fixed schedule of activities or do you prefer to have frequent changes in the activities you engage in?
6. What activities do you enjoy, and why?
7. Are there any activities you would like to participate in but are not available to you?

Emotional wellbeing

To understand their feelings about living in the nursing home

1. How did you feel when you first came to the home?
2. If you felt unhappy, how did you overcome those emotions? Did you talk to anyone about it?
3. How do you feel about staying here now?
4. What are your aspirations? What would make your stay here happier and more meaningful?

Moving around the home (for mobile residents)

To understand the challenges they faced when moving around the home and how much movement they are comfortable with, especially in the larger multi-storey homes

1. Do you prefer to stay in one place or move around the home?
2. For those who can move independently: Do you prefer to move around by yourself or with the help of a nurse?
3. For those who can move independently, what are the challenges you face when moving around the home (e.g. long lift waiting times, navigating narrow corridors, unsure of the locations or how to get there etc.)?
4. Where in the home are you at most of the time when you are awake (ward, dining hall, corridor, activity room etc.)?

Appendix B: Interview Questions for Nursing Home Staff

Demographics of the nursing home (managers)

To have an overview of the nursing home and the interaction the residents have with their family members

1. Proportion of bedbound residents, wheelchair-bound residents, mobile residents
2. Duration of residents' stay
3. Visitation
    a. Proportion of residents with family visitation?
    b. Which family member usually visits? (e.g. spouse, children, grandchildren etc.)
    c. How often do family members visit on average, and how long do they stay?
    d. What do they do while they are here? (e.g. activities, chat etc.)

Awareness of activities and programmes offered (managers, nurses, therapists)

1. What are the daily activities that the residents participate in? Please provide details.
2. Do the residents know about the programmes? How is information conveyed to them, and are they pre-empted before each activity?

Effectiveness of existing programmes

1. What is done well in the way the programmes are run?
2. What challenges or pitfalls do you face in conducting the programmes this way?
3. Do you have any practical or conceptual ideas that might improve the way current programmes are organised?
4. For Nursing Home B: Are there any differences in the way the programmes are run between the single-storey and the multi-storey nursing homes?

a. Do the two homes specialise in taking care of different types of residents? Does this impact the way in which programmes are run?
b. Are there more time delays in transferring residents around in the multi-storey home?
c. Are there any interactions with the local community? (One of the nursing homes is located within a residential area)

5. How does the new individualised care approach work in real life?

    a. Are the preferences keyed into a database? Are they specified on a piece of paper near the resident's bed?
    b. How does the staff get to know the resident's preferences?

Orientation of residents (managers, nurses, therapists)

To understand how new residents are introduced to the home

1. What is the admission process?
2. What information is generally conveyed to the primary caregivers in the admission process?
3. What is the orientation programme for newly-admitted residents?
4. How do the staff assist the residents with coming to terms with their situation and how do they ease their transition into the home?

    a. Are there counselling sessions?
    b. How do most residents understand what a nursing home is?
    c. What are the general emotions, moods, and attitudes new residents have?
    d. How do these emotions, moods and attitudes change over time?

5. What are some questions or information that residents, caregivers, and family members generally ask for?

Moving around the home (nurses, therapists)

1. What challenges do you face when moving the residents around the home?
2. Do the residents prefer to move independently or do they prefer to be assisted?
3. Do the residents prefer to move around the home more or do they prefer to

stay in a fixed location?

Future programmes (managers, nurses, therapists)

1. For managers only: Will the new nursing home operate on a similar model with respect to programming? What are some of the key differences?
2. What challenges do you foresee in the conduct of activities in the new multi-storey home?
3. What advantages do you think having a multi-storey site will have?
4. Do you have any other ideas for future programmes?

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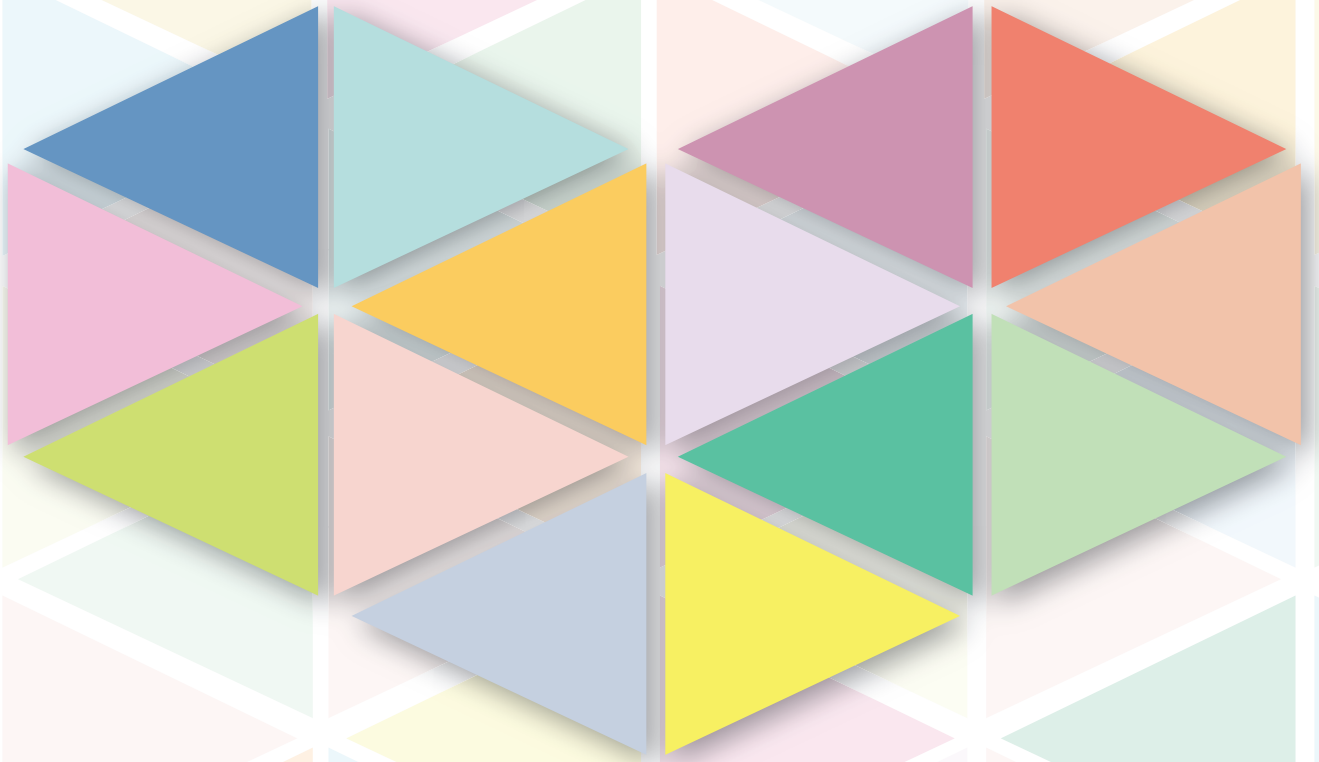

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