Family involvement in and satisfaction with long-term care facilities in Taiwan

SPECIAL ARTICLE

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ABSTRACT

Background. In Taiwan, elderly people are usually cared for by their family. Admission to an institution is usually a last resort. This study analysed the involvement of families in admission of their elderly relatives and their satisfaction with long-term care facilities in Taiwan.

Methods. 88 long-term care institutions in southern area of Taiwan were investigated. Study subjects were new residents who had been admitted for less than 1 month. 231 residents and their families were interviewed.

Results. Admission to an institution was inevitable for some elderly people. The admission process was affected by the needs of the elderly people involved, availability of their adult children, and perceptions about admission. Most families visited their relatives every week and were involved in the care in the institutions. They were satisfied with the institutions. Satisfaction with staff, the living environment, and food was higher than that with participation and social interaction.

Conclusions. Families are substantially involved in caring activities for their elderly relatives after admission. Activities in the institutions and empowerment of elderly people should be enhanced. This should improve the quality of care for residents in long-term care facilities.

Key words: Family; Homes for the aged; Long-term care; Patient satisfaction

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INTRODUCTION

When family members play a strong role in the provision of care and a strong family network exists, elderly people are admitted to long-term care facilities less often. The admission decision usually involves not only elderly people, but also professionals and, most importantly, family members.[1] Nonetheless, even where a family network is present, the decision to institutionalise an elderly person is often a 'family' process.[2,3] The family affects the process of moving into a home and the continuity of care in long-term care facilities.

In Taiwan, most elderly people are cared for by their families.[4] The notion that children have an obligation to assist their parents and other relatives is a widely accepted and internalised value. Since 2007, the Taiwanese government has launched a '10-year long-term care plan' that is an extension of the 'aging in place policy' and emphasises community-based care.[5] The intention is that elderly people with long-term care needs are able to maintain maximum independence and live in familiar environments.

To investigate whether family function and the concept of filial piety has been challenged by demographic and social change, this research examined the extent of family involvement in the admission of elderly relatives to long-term care facilities and their satisfaction with the facilities. The health of residents in long-term care facilities and contributing factors were also examined.

Table 1
Reasons for admission to the long-term care facility

Reasons*	No. (%)
Introduced by friends/relatives	75 (32.5)
Locations (e.g. near own home)	59 (25.5)
Arranged by families	112 (48.5)
No one available to care at own home	89 (38.5)
Too frail to be cared for at own home	88 (38.1)

* Multiple answers allowed

METHODS

This study was carried out from December 2007 to March 2008. It was based on a survey of registered long-term care facilities and included interviews with owners, residents, and their family members. 88 long-term care institutions (including nursing homes and residential care homes) in the southern region of Taiwan were investigated. Study subjects were new residents who had been admitted for less than 1 month. Residents with mental illnesses, severe cognitive impairment or developmental disabilities were excluded. 231 residents and their families were interviewed. The response rate was 33.8%. Information collected included residents' functional status, the reason for their admission, family involvement in caregiving, and satisfaction with the long-term care facility.

A structured questionnaire was used. Activities of daily living (ADL) and instrumental ADL were measured using the Barthel scale. Resident satisfaction was assessed through the residents/families satisfaction questionnaires,[6] using a Likert 5-point scale. Some of the questions for the caregivers were designed specifically to cover issues about their caregiving experiences.

Four interviewers administered the questionnaires. They covered residents' broad health status, family involvement and resident/family satisfaction with long-term care facilities. Open-ended questions were described and collated by hand.

RESULTS

Admission to long-term care facilities

Of the 231 residents, 89% were aged 65 years and older, 49% were female and 60% were widowed or not married. Most residents needed long-term care; many were physically frail or chair/bed bound. They had high levels of physical and mental dependency. More than 30% had Barthel scores of 0 to 20 (highly dependent) and 16.5% of 21 to 40. The mean score was 43.6. They were more dependent than those living in the community. The mean number of difficulties with performing ADL was 3.5 items for those in the long-term care facilities and 1.4 for those in the community (where more than 87% had no difficulties).[4]

Events that triggered admission included a sudden stroke and hypertension (36.8%), falls or accidents (15.2%), diabetes (16%), and increasing frailty (10.5%). Institutionalisation is usually the last resort for traditional Taiwanese. Therefore, dependency appeared to be the main reason for requiring institutional care.

Most elderly people were admitted to long-term care facilities for multiple reasons (**Table 1**). The most common reasons were: arranged by families, no one available to care at own homes, and too frail to care at own homes. Other reasons included the availability of long-term care facilities nearby and introduction by their social networks.

Adult children (63.8%), mainly the elder son, were the most influential people in the admission decision (**Table 2**). Only 11.7% of elderly people made the decision themselves. Almost all families talked to someone before making the decision. For elderly people who were too frail or confused, their spouses and adult children were the people most likely to make the decision. As institutionalisation is somewhat contrary to filial piety,[7] most respondents considered the decision process difficult, stressful,

Table 2
People responsible for the decision of admission

People responsible for the decision of admission	No. (%)
Children of the residents	147 (63.8)
Residents themselves	27 (11.7)
Spouse of the residents	14 (6.1)
Relatives/friends	18 (7.8)
Other family members	2 (0.9)
Professionals	4 (1.7)
Public funding	19 (8.2)
Total	231 (100)

Table 3
Visiting patterns of families to the long-term care facilities

Visiting patterns	No. (%)
Every day	85 (37.6)
Every other day	35 (15.5)
Once or twice a week	92 (40.7)
Once every 2 weeks	11 (4.9)
Once every month	2 (0.9)
Once every 2 months or more	1 (0.4)
Total*	226 (100)

* Total=226 because of missing data

and unfamiliar.

Family involvement in caregiving

Most families were involved in caregiving before admission. The relationships of caregivers to residents were: children, including daughters-in-law (42.8%), spouses (39%), and other relatives such as sons-in-law (13%). About 38% of the caregivers were aged under 50 years, 40% were aged 50 to 64 years, and 22% were aged 65 years and older.

The families generally expressed feelings of exhaustion with caring. 77% of caregivers had lived with their elderly relatives when they provided care. Over half of the families had provided day-to-day personal and functional care, often at great personal cost. Severe physical disability was the problem that challenged families' ability to care most. Co-resident caregivers are more likely to experience a low level of social support than other types of caregivers.[8] This also has implications for their feelings of stress, general health status, and quality of life.

After admission, most families continued to be involved in some caring work, indicated by their frequent visiting (**Table 3**) and participation in the activities of the institutions. Most families visited their relatives every week and were involved in care in institutions, such as feeding and accompanying their elderly relative. Some families hired helpers to care for their elderly relatives in the long-term care facilities.

Most families acknowledged that care in institutions was not as sensitive as the one-to-one care provided by relatives at home. They were not able to continue that care because of their own health or other obligations. After admission, families may feel relief in one way (physically) but may suffer psychologically and culturally. When institutionalisation was inevitable, some families indicated that the source of tension was other relatives in the family network such as siblings.

Satisfaction with long-term care facilities

In general, residents/families felt satisfied with long-term care facilities (**Table 4**). The mean satisfaction score was 3.55. Of the 5 aspects of satisfaction,

Table 4
Mean scores of residents/families' satisfaction to long-term care facilities

Satisfaction aspect	Mean	SD	Min	Max	C alpha
Staff	3.76	0.59	2	5	0.986
Food	3.68	0.63	2	5	0.984
Environment (room)	3.64	0.63	2	5	0.977
Environment (facility)	3.57	0.62	2	5	0.956
Social interaction	3.23	0.57	2	5	0.944
Participation	3.27	0.64	2	5	0.968
Total impression of satisfaction	3.55	0.62	2	5	0.918

satisfaction with staff scored highest, followed by living environment (including room and facilities) and food. Using a one-way ANOVA and post-hoc multiple comparisons, the first 3 aspects of satisfaction were higher than the other aspects such as participation and social interaction. Therefore, activities in institutions and empowerment of elderly people should be enhanced.

DISCUSSION

Institutional care is considered contrary to filial piety. The decision of admission was often made after enormous pressures on the family.

Family involvement in caregiving and filial piety

Caregiving provided by the informal network of families and friends has been the mainstay of care in Taiwan. Approximately 75% of care given to elderly people comes from the informal network, primarily families.[9] In Taiwan, more than 90% of frail elderly people are cared for in their own homes and 83% of elderly people live with their families.[4] When caregiving is needed, families remain the main support.

Even after admission to long-term care facilities, families are often involved in some caring work. This may reflect their uncertainty and stress about the admission. Persistent distress, guilt, and pressure felt over the admission overwhelms families when admission is needed.[10-12] A sense of familial duty is a motivation for primary family caregivers. Family caregivers may tailor their care to fit the needs of the resident and setting.[13,14]

Filial piety often determines which family members undertake caregiving and at what point and to what extent formal services are utilised.[15] In Chinese culture, respect and care for older people is a social norm.[16] The traditional view considers that sending elderly relatives to long-term care facilities is an indication of the children's lack of filial piety or of abandonment.[7]

Cultural values have been changing gradually.[15] The concept of filial piety has also been challenged by the changing world. Although 60% of elderly people still live with their children in Taiwan, the importance of children caring for older people has been weakened in East Asia by demographic and geographic factors, participation in the labour force, and the supply of formal services in long-term care.[17]

Policy makers should not assume that families willingly support older dependent relatives. Family care is not automatic and must be negotiated over time,[18] so caregivers should be given assistance. Spouse caregivers are least likely to receive assistance from others; own child caregivers and friends are more likely to have secondary caregivers.[19] It is important to understand how to support people helping others and how to care for one another throughout the lifespan.[15]

Satisfaction with long-term care facilities

The quality of life of elderly people living in institutions has been studied.[20,21] Satisfaction with institutions plays a substantial role in their quality of life.[22] In general, the respondents were satisfied with their daily life in long-term care facilities. This may be because (1) elderly people may be more respected, (2) they are educated not to complain easily, (3) they feel embarrassed about criticising caregivers with whom they live, and (4) they fear reprisal.[22] Therefore, we examined both resident and family satisfaction with

the long-term care facilities and found that human relationships were highly praised (e.g. the staff's care and kindness). Satisfaction with staff care has a moderate and positive effect on all other aspects of resident satisfaction.[23] Residents' primary concerns were staff and care. In our study, there was high satisfaction with food quality. Good cooking and respect for individual tastes were regarded as respect for the elderly. Good cooking helped residents felt at home.[22]

Nonetheless, there were lower scores for satisfaction with social interaction and participation. These 2 aspects are important because residents prioritise the satisfaction by human contacts within (i.e. management, staff, other residents) and outside (i.e. visits, family, telephone conversation) the institution.[22] Thus, it is not only the visits and care from families that matters, but also the activities participated in (e.g. scheduled, leisure) and respect for the individual (e.g. privacy, freedom). Life satisfaction is higher for residential care–assisted living residents who receive monthly visits at least from family.[24] Greater resident involvement leads to more satisfaction with social interaction.[25] The relationship between the 2 variables is quite complicated and reciprocal. The long-term care facilities in Taiwan should enhance the social interaction and participation of their residents by improving the design of activities, empowering residents, and increasing residents' social contacts with staff and with each other in order to enhance the satisfaction of the residents and their families.

Limitations

This research was primarily quantitative. The qualitative method where older people are encouraged to express their views in detail goes somewhat against their traditional passive role. Nevertheless, the use of open-ended questions was an effective means of obtaining some views. The experiences of people who decided to stay in their own homes were not included. This study focused on long-term care facilities in southern Taiwan only. There are possible geographical differences and the study may not be generalisable without further research.

Further research

The quantitative research design used was based on structured questionnaires. Future research can benefit from qualitative approaches to understand the meaning and experience of caregiving and their response to the needs of elders.[15,26] It is important to focus on issues about family responsibility/obligation and intergenerational relations and look at the variables of family structure, association or patterns of contact, social norms, consensus or similarity and exchange or power.[27] In terms of the residents'/families' satisfaction with institutions, more research is needed to assess how to improve the intangible aspects of residents' needs, as declining health is related to less social support, and in turn, social support and health emerge as the major factors predicting life satisfaction.[15]

CONCLUSION

The decision to admit elderly people to long-term care facilities is made over a period of time and involve different people. In Taiwan, families are substantially involved in caring activities after admission to ensure the comfort of their elderly relatives.

Policymakers have to take account of the long-term care of elderly people in a family context, and that the family role in caregiving may be changing dynamically owing to demographic and social changes. Where institutionalisation is inevitable, policymakers, and institutional care providers need to understand the driving forces of resident satisfaction and to improve aspects that are less satisfactory. It is also hoped that family caregiving can continue, even after institutionalisation, not only to sustain the informal care resource but also the sensitive individualised care provided by families.

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