IMPROVING QUALITY OF LIFE OF OLDER ADULTS LIVING IN A LONG-TERM CARE FACILITY

by

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Abstract

Over half of the residents in long-term care have a diagnosis of dementia. Maintaining a good quality of life is important, as there is no cure for dementia. Quality of life may be used as a standard for caregiving and, as a framework for practice to enhance service provision. The purpose of this four month practicum was, to explore quality of life as seen and experienced by residents living with dementia in long-term care, factors that influence quality of life, as well as the approaches used to improve quality of life.

This practicum report details my experiences in long-term care social work at Simon Fraser Lodge in British Columbia. The practicum goals were set around professional understanding of dementia and quality of life of older adults in a long term care facility. While the focus of the practicum was on developing, improving, and understanding my role in social work, it was also a medium for my developing ways of improving quality of life of older adults. The medical and psychosocial models of disability were used as a basis for understanding the practical experiences encountered in this practicum. This report and practicum experience focused on personal growth as a social work student and ways of improving quality of life of older adults living in Long-term care facilities.

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Dedication

I dedicate this practicum report to God Almighty my creator, the Alpha and Omega, the First and Last, Ancient of days, Lion of the tribe of Judah, my strong pillar, my source of inspiration, wisdom, knowledge, and understanding. He has been the source of my strength throughout this program and on His wings only have I soared. I also dedicate this practicum report to my late sister; Teolanozuni Amamkwe Ituah, I remember you every day; my love for you can never be quantified. Continue to rest in the arms of God Almighty.

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To my parents (Mr. & Mrs. Amamkwe) words are not enough to express how much I love the both of you. You taught me all I am today, for your prayers and continued love and care; I say Thank you, and your labour of love will never be taken for granted.

To my eldest brother and family (Dr. &Mrs. Benjamin Onyenwosa), I say may the good Lord continue to bless you and cause his good face to shine upon you for evermore. You saw me in Nigeria and gave me another chance to live again, I am forever grateful for all you have done.

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Chapter One: Introduction

Long term care (LTC) is provided or recommended for older people who are unable to take care of themselves in their own home due to various health and social reasons. Quality of life (QOL) is found to be an important and significant interpreter of mortality, choice, physical dependence, and service utilization among older people (Ho et al*., 2002). LTC residents are more likely to experience a reduced QOL due to health issues or conditions, changes in living environment, rigid daily routines, and different social interactions (Kane, 2003). In health and social services, the ideal goal is to promote a better QOL for older adults (Holtkamp et al*., 2000; Rönnberg, 1998; Wong et al*., 2004).

QOL has become a general term and often spoken of in terms of a range of settings, contexts, and environments. Its usage has become commonplace in day to day living because it covers most aspects of life.   QOL is a multidimensional concept, which cannot be explained or expressed in medical terms alone and meaningful if measured in a holistic or all-inclusive context. QOL contains both subjective and objective elements; therefore, it is of great importance to put both into account or consideration when measuring the concept (Kane, 2003).   A good QOL is apparently a paramount and important goal for each long-term care (LTC) facility. QOL is specifically applicable for residents in LTC facilities who may be considered one of the most vulnerable groups in society today given their age, declining health, and levels of dependency.

Many older adults in LTC feel powerless or unable to criticize the level of care they receive in LTC due to declining health, impairments, cognitive decline, or other various conditions. Despite policies and regulations to ensure that good and minimum satisfactory standards of care are followed, there is still evidence that the quality of long term care services for older adults does not meet the expectations of their families, the public, and or

the residents in the facility (Organization for Economic Cooperation and Development (OECD), 2005).

This practicum at Simon Fraser Lodge (SFL) was challenging yet a fulfilling experience that opened my eyes to learn a lot about LTC, Canadian society, and myself in general. I learned how to be an effective and productive social worker in order to enhance the care that older adults with disability, dementia, or chronic health concerns receive in LTC facility. Throughout my experience, work across departments was compared to gain an understanding of how continuity of care for the resident is maintained. While the opportunity to learn and contribute across several departments at SFL was an important part of this practicum experience, the practicum was undertaken with a particular interest and focus on QOL and disabilities and how residential care social workers view work with persons with dementia and with seniors experiencing a range of disability issues. Gregorian (2005) uses the term predictable chaos (p.5) to describe the day to day plan of social workers, while Dhooper (1997) points out the importance of adaptation as a core social work quality. Additionally, the practicum experience at SFL gave me insights on how family members (e.g., spouse) are supported to cope with having their loved one in a residential facility, the guilt of separation, and their continuing role in care as a family member.

Description of Practicum Setting

The practicum placement took place at Simon Fraser Lodge (SFL), a 130 bed residential care facility in Prince George, British Columbia, Canada. This practicum started on March 10, 2016 and continued until July 12, 2016; approximately 560 hours for four months, Monday to Friday, 8.30am – 4.40pm

SFL is one of Northern Health's contracted residential care facilities. The Northern Health Authority (NHA) oversees all health care in BC from Quesnel north to the Yukon

border, and from Haida Gwaii on the west coast to the Alberta border (Northern Health, n.d.). Geographically, it is by far the largest health authority in the province. NHA has the highest projected population growth rate of seniors anywhere in BC (Northern Health, 2010).

SFL is a modern care facility that specializes in dementia care and is working to create a community wherein adults experiencing dementia and other disabilities have choices about how they live, integrate, and contribute to the residential care facility community. My practicum supervisor was an experienced social worker with a Master of Social Work degree.

SFL is a two-storey wood frame structure with residential character and appeal. It was first built in the 1950s as a private hospital and later extended in 1992 with the addition of a special care unit and again in 2000 to add a transitional care unit. Recently, in 2010, the original private hospital was reconstructed and transformed SFL to a fully modern and well-appointed care environment (Northern Health, 2010).

SFL is a senior residential facility with 130 publicly subsidized beds. In SFL, there are two types of accommodation: fully private rooms and private rooms with shared bathrooms. The room furniture provided includes a night table, dresser, bed, lamp, and chair. Residents are required to bring small personal items such as photos and mementos to beautify and personalize their rooms (Northern Health, 2010).

 In the facility, there are common areas for dining and recreation. There is a general kitchen and laundry area that is accessed and used by staff only. The type of care services offered range from complex care to specialized dementia care. Thirty one rooms are designated dementia special care beds. Optional services (i.e., dentistry, chiropractic, and hair salon) are available, if required, at a fee (Northern Health, 2010).

SFL specializes in dementia care and is known for providing exceptional care and a home-like setting focusing on safety, quality, offering choice, staying connected to the

community, cultural beliefs, and accountability. The overall SFL goal is to create a community where adults with disabilities have choices on how they live, integrate and contribute to the community within a residential care setting. The Lodge, as it is commonly referred to, provides a safe, gentle-care environment that promotes personal health and independence. Staff at SFL work closely with the families and a variety of community networks to ensure relationships are supported and needs are met as best as possible. SFL responds to the changing needs of many seniors. Their services include nursing recreational and rehabilitative services, occupational therapy and physiotherapy, social work, dining service, volunteer services, comfort fund, nutritional support, and long term care (Northern Health, 2010).

The majority of the work during my placement took place in the social work unit, which is responsible for

- provision of, or referral, for mental health services;
- advocating, and coordination of discharge planning;
- provision of individual and family counselling;
- documentation of resident's psychosocial status;
- information on community resources;
- advocating with and for residents to ensure greater choice, quality of life, and quality of care;
- psychosocial assessments;
- crisis intervention;
- admission and discharge planning;
- follow up with resident and family as needed;

- and education related to illness including teaching coping and problem solving skills to maintain or enhance psychosocial functioning;
- as well as support to access funded supports and suitable placements.

Social work is also positioned to provide distinct systems perspectives in understanding the family, SFL, and the community at large. At SFL, the social work department helps steer complex systems to ensure services are identified and accessed. Furthermore, social workers provide information relating to adult abuse, neglect, and crisis intervention as needed.

Learning Goals and Objectives

My overall goals for the placement were to:

- increase knowledge, skills, and abilities to effectively practice social work with an older-aged population.
- gain an understanding how continuity of care for a resident is maintained throughout the facility and how care providers view, work, and contribute to the quality of life of adults experiencing a range of disability issues living in their care.
- gain an understanding about issues related to adult guardianship and adult protection.
- gain an understanding about dementia and the unique care requirements within SFL.
- become familiar with dementia and the associated challenges.

Becoming accustomed to this type of environment, along with all the learning that took place was challenging at first but as I progressed in my practicum, I knew that SFL was the right placement for me.

This report consists of five chapters. In this Chapter, I introduced the perceptions of long term care (LTC) social work, practicum learning process, and description of practicum setting. Chapter Two focuses on the theoretical orientation of SFL and my background as it

relates to LTC facility social work. Chapter Three provides a literature review on key aspects including information on older adults, a brief description of the role social workers play in LTC, and ethical challenges regularly faced in LTC facilities. Chapter Four includes learning experiences, outlines my activities, and how I met the goals, and provides further information on the experiences I gained from LTC social work. Chapter Five focuses on the implications of social work practice as a social worker specific to LTC, and a conclusion of my practicum experiences.

CHAPTER TWO: Theoretical Orientation

This chapter features the theoretical orientation of the practicum setting and, following that, how I positioned myself as it relates to the placement. According to Stephen (2005), approximately one in six adults in British Columbia live with disability. In Canada as a whole, 14.3% of the population was living with an activity-limiting disability according to 2006 statistics (Statistics Canada, 2010). This report only includes ''adults and children whose daily activities are limited by physical, mental, or other health related condition or problem'' (Statistics Canada, 2010, p.6). Despite the challenges of providing accurate statistics, the Statistics Canada report made it clear that older adults are more likely to experience an activity limiting disability. Because our population is aging, disability issues will become increasingly important for social workers to consider. Llewellyn and Hogan (2000) describe a number of models used in disability studies. Although they stated the limitations of focusing on theoretical models, they recommend that models can help understand information and ways of working or carrying out research.

Simon Fraser Lodge Orientation

Simon Fraser lodge (SFL), the practicum site, is one of Northern Health's contracted residential care facilities, and uses a medical model blended with psychosocial model. These models influence how those working in the medical field along other professionals conceptualize their work and relate with residents.

Medical Model

The medical model views disability in terms of ''diagnosis and solution in medical knowledge'' (Barnes, Mercer, & Shakespeare, 1999, p.21). Since the medical profession deals with people who are ill, the sick role has traditionally been given to people with disabilities, even if they are only interacting with the medical profession to obtain proof of disability in

order to receive financial benefits (Quinn, 1995). Bracht (1990) points out that people with chronic diseases or disabilities are not always in poor health, but will likely have episodes or poor health during which time treatment is required. Under the medical model, the person with a disability is seen as the victim of a tragedy, and in need of others to provide care (Barnes et al., 1999). The medical model system acts in the role of relieving the individual or family suffering caused by the disability (Hiranandani, 2005). Rehabilitation and cure are the goals under this model, with professionals providing the expertise to ''overcome, or at least minimize, the negative concerns of the individuals disability'' (Barnes et al., p.21).

Most health organizations employ the medical model. Mackelprang and Salsgiver (2009) define this as involving a focus on pathology, and an emphasis on fixing the problem. Beaulaurier and Taylor (2001) argue that medical therapy for people with disabilities became much more noticeable after the Second World War, bringing social workers into close contact with people who have disabilities. The goal of this work was to restore a person's physical functioning to the extent that a return to paid labour was possible, even if that meant "altering patients in ways that made them more physically capable of dealing with an unaltered world'' (Beaulaurier & Taylor, 2001, p. 71) While physical rehabilitation is an important part of the medical care that people receive, if the focus remains on restoration or cure for too long, the person may start to feel de-valued if the medical interventions are ultimately unsuccessful in fixing the disease or disability (Beaulaurier & Taylor).

It is logical that doctors and residential care givers follow the medical model at times, especially immediately after an accident or injury. Fook (1993) suggests that making decisions for a person can be justified during a crisis, but as soon as the immediate situation is dealt with, the individual's opportunity to make choices must be restored and encouraged. This includes decisions about medical care. Beaulaurier and Taylor (2001) point out that social workers have an important role to play in helping people with disability take control

over their medical decisions as soon as possible, with the goal of ensuring they can do as much as is possible or appropriate independently before they leave the hospital to their homes or residential care facility.

Social workers must coexist, interact, and even work within systems influenced by, or even dominated by, the medical model. Collaboration with the medical model is possible but social workers must not lose their unique perspective (person-in-environment and holistic approach) or they cease to function as a social worker (Beresford, 2004).

Psychosocial Model of Disability

The psychosocial model is a unique model of practice that looks at individuals in the context of the collective effect that psychological factors and the surrounding social environment have on their physical and mental wellness including their capability to function. This approach is used in an extensive range of helping professions in health and social care settings (Ruddy & House, 2005).

Psychosocial model aims and goals are to restore, maintain, and enhance the personal and social functioning of residents by reducing complaints and improving functioning related to mental disorders and/or social problems by addressing the different psychological and social factors impeding the resident. It is also used as a method of improving the resident's quality of life through mobilizing strengths; supporting coping capacities; building self-esteem; changing or transforming dysfunctional patterns of thinking, feeling, and relating to others; linking people to needed resources; and lessening environmental stressors.

Under this model, social workers strive to change societal barriers while also providing advocacy, interventions, and educational needs to residents. Gregorian (2005) suggests that the interaction between the medical and psychosocial models of disability is a

continuous challenge for residential social workers, particularly regarding interdisciplinary team meetings.

Situating Myself in Simon Fraser Lodge (SFL)

A disability lens (Llewellyn & Hogan, 2000) blended with a seniors' policy lens (Jansen 2011) was used to inform my understanding of differences between the medical and social models of disability. I developed an awareness of the range of experiences older people with disabilities have when interacting with social workers, and how social workers utilize their skills to work with this population.

Quinn (1995) suggests that social workers who work with residents and family with disabilities should consider accepting a structural framework that looks at solutions within environments and systems first and individual lacks only if a problem persists. Bracht (1990) points out the challenges that family members of the person with dementia may experience, which include stress, caregiver concerns, guilt, and relationship problems.

Mailick (1990) differentiates between how a client and family react to the ''crisis of diagnosis'' (p.108) and their adaptation to the longer term of dementia. During the first phase, Mailick (1990) points out that the social worker must assist with expression of feeling, access to information, information of resources, and acceptance of the diagnosis during the initial stages. Social workers have a role to play in the early phase of diagnosis, as well as when the illness changes over time.

Coming from another country and having a different view and understanding about age related sickness, diseases, care, and disabilities aroused my interest to know what amounts to the quality of life of older adults living in a Canadian residential care facility. This practicum gave me that opportunity and also to be more culturally sensitive. In my home country Nigeria, it is the responsibility of the children to take care of their parents when they

are old. It is seen as a curse for any child to put their parent in a residential care facility regardless of their disability, old age, or health related situation. In my culture, when our parents are getting old, it is seen as a time to give back for all their care and love towards you. Most adults in my country, when asked about what amounts to their quality of life, respond ''to live with my children when I am unable to take care of myself and to die in arms of their children'' (personal thoughts).

Various employment experiences have also allowed and given me the opportunity to interact with the health care system and different funding agencies on behalf of and with clients who have various disabilities. This experience ranged from writing notes to doctors about issues that clients have had difficulty communicating directly to their doctors, to sitting in during assessments for provincial disability benefits, and determining homes that suit adults with disability. I have also had the opportunity to hear stories from family members of adults with dementia, spinal cord injury, brain injury, and fetal alcohol spectrum disorder (FASD) about their experiences in care facilities and rehabilitation including ongoing challenges accessing appropriate care and having the kind of quality of life they desire. My position as a person that has worked with adults with disabilities impacted how I worked within the system and my practicum placement.

While it may not be obvious to the clients that I come into contact with, that I have worked in this field, my knowledge of disability issues, quality of life, and oppression from a personal perspective will inform how I perceive situations within community social work. My learning and ability to perform community social work is impacted by my personal experience. I have a unique position, having worked in the field with adults with disability. This background gives me the ability to interact with people directly from a social worker perspective and without the labels and stigma often put on people with disabilities, but with

the intimate knowledge of what it means to live with disability and struggles in attaining or getting the quality of life desired.

My personal experience and culture coming from a different background stirred an interest in exploring the quality of life of older adults with disabilities and how the psycho-social needs of the older adults receiving care are taken care of and addressed. I was interested to know how I could use my social work understanding to work within the system to aid communications between residents, professionals, the funding agency, and residential care facilities to improve the experience and care that older-aged adults face on a day to day basis. My previous work experience has allowed me to see different parts of our residential care structures and how they operate, I was inquisitive to know how social workers stay true to social work ethics while working within this system of care and how they cope while dealing with adults with disability living in residential facilities that mainly deal and operate on the medical model. I did this practicum having at the back of my mind how medical and social models of disability are combined within social work practice, in particular concerning older adults with disabilities, dementia, and chronic diseases.

Going for my placement, my intention was not to investigate or to judge the system, but rather to learn, build my skills, recognise and understand how it works, and if there are areas in the of level of care that could be improved to better assist the needs of older adults.

Practicum Learning Situations

There were a number of situations that impacted the knowledge I gained during the practicum experience. Experience working with older adults with different disabilities, diagnoses, and mental health issues were influenced by the referrals, presenting cases, and waitlist during the time of the practicum. Shadowing my supervisor and other staff on different cases and situations provided exposure to cases otherwise not possible. The four

months' time frame of my practicum helped me to set goals that were realistic and could be met within the timeframe and set hours for practicum. I worked with my practicum supervisor, to set and review a realistic number of files, types of files, and activities throughout the practicum that would work within the timeframe of my practicum.

In this chapter, identified the main theoretical orientations influencing the practicum. The following chapter provides a literature review of key aspects related to older adults and QOL.

CHAPTER THREE: Literature Review

This chapter provides highlights from the literature pertaining to older adults (demographics, disability, and other conditions including dementia), the medical and social models of disability, residential care, and quality of life.

Older Adults

Older adults, defined as those aged 65 years and older, are the fastest growing part of the Canadian population, consisting of 15.7% of the Canadian population as of July 1, 2014 (Canadian Broadcasting Corporation News, 2015). The population of older adults will continue to rise and grow across Canada. By 2063, it is estimated that between 24 and 28 percent of Canada's population will be aged 65 and older (Statistics Canada, 2013). In fact, Statistics Canada reported that there are now more seniors aged 65 years and older in Canada than children aged 14 years and younger (Canadian Broadcasting Corporation News, 2015). This record rate of population aging has generated a significant policy problem for Canadian provincial governments, who continue to struggle to find how to provide the most suitable, best and cost-effective health care for older adults.

Research shows that throughout the developed world, not only are people living longer, but they are doing so in better physical and cognitive health (Christensen et al., 2013). While a high percentage of Canadian older adults report living in good health well past the age of 65, more than 25% are restricted in their ability to do or carry out daily living activities due to chronic or age-related health conditions (Canadian Institute for Health Information, 2011). Older adults are regular and frequent users of physician and acute care services relative to other population segments, but these services are only part of the required care range needed to support health throughout the aging process (Canadian Institute for Health Information, 2011).

Most adults over the age of 65 have at least one chronic health condition, and age is the main determining risk factor for different diseases, including neurodegenerative conditions such as dementia (Niccoli & Partridge, 2012). Many older adults suffer from chronic health conditions such as dementia for which there is no cure and frequently require long-term, non-physician care. Dementia is a progressive disease of the brain affecting cognitive functioning, including deficits in memory, personality disorders, learning, impaired reasoning, orientation, language, comprehension, and judgement (Feldman et al., 2008). The risk of acquiring dementia increases exponentially with age and is assessed to double about every five years after age 65. After age 85, the chances of developing dementia are nearly 50% (van der Flier & Scheltens, 2005). Furthermore, because of longer life spans and the increasing population of older adults, it is predictable that both the occurrence and prevalence of dementia will climb intensely as the Baby Boom generation progresses through old age. In terms of incidence, the rate of new dementia cases in Canadians aged 65 and older is likely to rise from 103,728 per year in 2008 to 257,811 in 2038. In terms of prevalence, in 2008 it was estimated that there were 480,615 cases of dementia in Canada, representing 1.5% of the population. By 2038, this number is likely to grow to over 1.1 million cases, signifying about 2.8% of the population. Based on recent policies and utilization rates, the increasing incidence and occurrence of dementia are estimated to result in a tenfold increase in demand for LTC services (Alzheimer Society of Canada, 2010). According to a report by the World Health Organization (2012), dementia is rated as the second highest disease contributor to years lived with a disability worldwide, contributing over 7.4 million years of dependence and disability among sufferers.

The most prevalent symptoms people with early dementia may show are problems recalling recent events, difficulty carrying out familiar tasks, learning new tasks, changes in attitude or mood, character, behaviour, personality, impaired judgment, decreased social

relationships, reasoning, difficulty finding or choosing words, finishing thoughts, or following directions, and although the chance of developing dementia increases with age, dementia is not a normal part of aging (Wolfson, 2010). As is obvious by the high percentage of different level of care days used for individuals with dementia, their unique care needs cannot often be met in private homes particularly at advanced stages of the disease. Many people with dementia may need around the clock supervision and care, which may not, for a variety of social, personal, and financial/economic reasons, be provided by family members, spouses, children, or informal carers.

Quality of Life (QOL)

There is a solid belief within the literature that QOL is fundamentally a multi-dimensional concept and concerns well-being (Gerritsen, Steverink, Ooms, & Ribbe, 2004; Mozley et al., 2004). For the purpose of this practicum report, the World Health Organization's definition of QOL is used. This definition views QOL as "a person's insight or perception of life in the culture and significant systems in which they live and in connection to their values, morals, hopes, principles, hopes, standards, goals, and fears. It is a comprehensive perception exaggerated in multifaceted ways by the individual's mental health, emotional or mental state, level of freedom or independence, social relationships, and relationships noticeable to their surroundings" (WHOQOL Group, 1993, p. 153). The World Health Organization Quality of Life Group went further to define QOL as '' individuals' sensitivities of the positions in life in the setting of the culture and value systems in which they live and in relation of their goals, hopes, values, expectations, and concerns'' (Chan & Pang, 2007, p. 16). It is important to note that QOL can be affected by social class, past involvement, experience, gender, and age group (Gerritsen et al., 2004).

The WHO authors interpreted QOL as a self-appraisal of interrelated personal, physical, and psychological aspects as well as the social environment. The process of assessment includes weighting of these aspects by the chronically il1 older adult. Quality of life (QOL) according to studies is found to be a significant judge of mortality, physical dependence, and service utilisation among older people (Ho et al., 2002).

Quality of life (QOL) should be raised to an important and priority goal for LTC rather than an afterthought to quality of care. "Quality of life" can be measured on either an objective or subjective basis (Thappa & Rowland, 1989). Considerable research has been dedicated to the definition of quality of life in residential care settings. These studies range from surveys to face-to-face qualitative interview methods shown to assess the quality of life characteristics from resident and staff points of view. Quality of life, as a multidimensional concept, has been well defined and measured in a number of different ways; however, most studies use a qualitative approach (Mozley et al., 2004).

There is an agreement that quality of life and the determinants that contribute to QOL can be measured using objective indicators and subjective perceptions (Mozley et al., 2004). Objective indicators include such factors as: adequate food, shelter, clothing, income, and admittance to medical care (Hulsman & Chubbon, 1989). The residents cited less importance on their physical functioning alone, suggesting that physical function was less significant if their philosophical, emotional, and spiritual needs were satisfactorily met (Mozley et al., 2004).

Long Term Residential Care

Residential care is provided for older adults who are incapable of living in their homes due to health, financial, and social reasons. The standards for admission to residential care facilities have been improved in such a way that only those with high level of complex

disability and those who are unable to provide consent on their own behalf are qualified for public subsidies (Cohen, Tate, & Baumbusch, 2009). In 2012, the admission criteria were reviewed and established that a client must have one or more of the following health or disability issues to be eligible for a funded LTC bed: 1) severe behavioural problems on an ongoing basis, 2) moderate to severe cognitive impairment, 3) physical dependence with needs that require 24-hour nursing care, or 4) clinically complex multiple disabilities that require dedicated skilled care from a variety of health professionals (British Columbia Ombudsperson, 2012).

Recent studies reveal about half of the residential care residents in Canada have dementia (Alzheimer's Association, 2008). This demographic will continue to increase with the aging populace and with the subsequent increased number of seniors with dementia. Residential care facilities will, therefore, be confronted with a dramatic increase in demands to meet the needs related to residents with dementia. Kitwood (1997), among other experts in dementia care (e.g, Dewing, 2004; Lyman, 1998; Sabat, 2006), condemns the traditional and old model of dementia care in residential facilities in that it handles biomedical problems and complications but does not address residents' psychosocial needs, wants, and improve their quality of life.

The vast majority of older people receiving care in the residential facilities are cared for in high quality, safe, and caring settings. There is, however, evidence to suggest that a small percentage of seniors in residential homes live in inadequate physical environments and experience a loss of personal freedom and choice. These concerns, in combination with staffing issues, may lead to seniors living in residential care settings to be neglected and or physically, psychologically, financially, or sexually abused (Goergen, 2004; Pillemer & Moore 1989,). However, the full extent to which seniors in residential care experience neglect and abuse is unknown.

Influences on the Quality of Life of Older Adults

An individual's physical and social environments have a substantial role to play in the QOL. This is also true for residents of LTC facilities. LTC surroundings and locations can directly and indirectly influence certain domains, e.g., comfort, meaningful activities, and functional competence. Residents may also rely on the design and layout of the facility setting for mobility to compensate for sensory losses or cognitive impairments (Parker et al., 2004). Therefore, it could be said that the LTC setting or surroundings affect all aspects of the residents' QOL. A study by Kane et al. (2004) used resident reports of QOL to differentiate between nursing homes and found that while resident characteristics clarified a considerable amount of the variance between homes, there was a significant facility effect. The study results found that nursing homes can affect various aspects of QOL including choice, comfort, privacy, activity, food, relationships, security, spiritual well-being, autonomy, and independence.

The design and layout of an LTC setting is also explicitly important for residents suffering from dementia. In particular, persons with dementia benefit from home-like environments, stimulation, easy access, and safe space (Parker et al., 2004). Other significant principles important or relevant for residents of LTC with dementia are related to aesthetics, appearance, way finding, safety, security, accessibility, functioning, and stimulation (Parker et al., 2004). Additionally, gardening is an important part of the physical environment of an LTC facility as it brings a change of activities for the residents as well as giving some residents a feeling and sense of a homelike environment. It provides motivation and "diverse sensory encouragement, including sound, color and fragrance" (Barnes and the Design in Caring Environments Study Group, 2002). However, residents may be controlled or restricted from accessing the therapeutic effects of a garden due to fear of the resident wandering out of the facility and residents' safety. This increases issues about the relationship between health

and safety and acceptable risk, and the importance of balancing issues and concerns for health and safety with risk (Parker et al., 2004).

Certain domains of QOL can be influenced by personality traits more than others. Kane (2003) found that spiritual wellbeing, security, and individuality had a strong relationship with personality, while personality had little or no effect on factors such as functional competency, autonomy or enjoyment. When specific personality behaviours such as agreeableness and neuroticism were studied, the results showed that high levels of agreeableness were associated with a high QOL. On the other hand, a lower QOL in domains such as comfort, meaningful activity and autonomy was linked to neuroticism (Kane, 2003). It has also been studied that social assessment and a positive attitude play substantial roles in QOL assessments. Residents who make descending evaluations with people who are worse off than them in some way report a better QOL (Beaumont & Kenealy, 2004). This finding was supported by Bowling, Banister, Sutton, Evans, and Windsor (2002), who found that individuals who were more positive, who made downward social evaluations, had higher self-efficacy and those who appraised themselves at a lower risk of undesirable health and life situations were more likely to report a good QOL.

The Seniors Policy Lens in Canada

A senior policy lens is a fact-based methodology that is used to develop frameworks aimed at enhancing and providing the medical and social services to the elderly. Mental illness is common among older adults. Notably, this is attributed to complications that result from old age. The elderly may require constant support to enable them to accomplish their day-to-day goals. At advanced ages, seniors are not actively involved in economic activities directly insinuating that their social lives and well-being are dedicated by policies in place (Goldbloom & Bradley, 2012). It was on this basis that the seniors mental health policy lens has been developed.

Components of the Seniors Mental Health Policy Lens Toolkit

The seniors mental health policy lens is divided into four parts. The first part describes the basis, which informed the development of the seniors policy plan. Particularly, the core argument for these policy development notes that seniors are more susceptible to mental and chronic diseases than the lower age groups. It is also worth noting that the previous seniors policy was developed without considering the views of the elderly. Obviously, this led to the gaps, in that it did not live to serve its intended purpose to benefit seniors. The second part outlines the procedures to be followed in coming with the seniors mental health policy lens and measuring its performance. The third part deals with the provision of the policy with guidelines on how to implement it. The fourth section deals with the interpretation of the seniors policy, which is achieved through the use of attachments (David, 2007).

The recent development of a seniors policy lens is a milestone reached in addressing the concerns of older adults. For many years, seniors have been neglected and side-lined when it came to policy development and implementation. Evidently, this will go a long way in ensuring that there are adequate policies in place to guarantee the seniors' welfare (MacCourt, 2008).

Uses and Applications of the Seniors Policy Lens

Seniors policy aims at investigating and coming up with the effect of current or proposed legislation on the general well-being of the elderly. Furthermore, it sets out research to develop and implement programs for elders that not only address the mental health of the seniors but consider their general wellbeing (Kirby, 2008). The policy lens carries out an examination of the application process in an effort to ensure that seniors receive quality and timely service. Canada has made it mandatory for various stakeholders to recognise and

consider the seniors' mental health program operations. For example, it is a requirement that all service providers must put in place systems that do not discriminate against the elderly.

The seniors policy lens acts as a reference in designing and developing new packages and guidelines for the elderly. It is on the basis of this policy lens that review and revisions of existing strategies for unlikely negative impacts on the elderly are made. Interestingly, within the framework of the current strategies, weaknesses are established giving room for developing holistic policies (Salokanga & Joukamaa, 2001). The policy ensures a basis for comparing existing senior programs with the view of the elderly. Particularly, this is necessary because some of the policies may have been developed without the seniors' input.

 It is through the current seniors policy lens that response to elderly needs is referenced. The seniors policy lens in Canada is tasked with public education about the mental disorders that are common among the elderly. It is important to remind policy makers that seniors have contributed to the growth of this country in one way or the other, policy makers should put in mind their well-being in all major activities to prevent side-lining them. (Druick & Kotsopoulos, 2008).

Policy Directions in British Columbia

The BC government introduced two important policy changes to residential care in 2002. The process for creating a new LTC facility prior to regionalization involved the government in providing funding and know-how to non-profit groups. However, critics note that the request for proposal (RFP) method is both time and labour-consuming and, as such, favours large private corporations or large, well-funded not-for-profits (Cohen, Tate, & Baumbusch 2009).

A report by British Columbia's Auditor General (2008) took the provincial government's leadership in the continuing care sector seriously. Auditor General John Doyle also decided that the Ministry of Health was not "sufficiently satisfying its stewardship role

in making sure that the home and community care system has the capability to meet the needs and wants of the population." (P.4). Doyle was keen and pointed out that the Ministry is obligated to better plan for future ability in all areas of home and community care, gather more complete data for development purposes, and be clearer in their reporting of this data to the public. Doyle's report also highlighted the need to complement legislation covering LTC facilities in BC (BC Auditor General, 2008). While, the majority of BC's LTC facilities are licensed under the Continuing Care and Assisted Living Act, about 29% of facilities are licensed as private hospitals under the Hospital Act. There are significant but understated changes among these two pieces of legislation. Facilities licensed under the Hospital Act are not subject to random inspection and are not obliged to survey standardized incident reporting protocols for LTC facilities. The Hospital Act also requires that all prescription and non-prescription drugs be delivered at no extra cost to residents. While residents in facilities licensed under the Continuing Care and Assisted Living Act take all or most prescription medications covered by provincial pharma care, they are likely to pay for non-prescription medications out of pocket (British Columbia Ombudsperson, 2012).

The report by the British Columbia Ombudsperson (2012) also raised alarm about this inconsistency in the legislative framework, suggesting harmonization of the assistance and safety accessible to all LTC residents. Among 176 approvals for BC's home and community care system, the Ombudsperson also proposed that the BC Ministry of Health create a reliable process for determining the funding of LTC facilities and work with the Regional Health Authority (RHA) to determine if the current budget for residential care is adequate to meet population wants

In reply to the Auditor General and Ombudsperson's reports, the BC government released a report entitled Refining Care for BC Seniors: An Action Plan (Ombudsperson, 2012). There is indication that in some RHAs the emphasis has moved away from assisted

living and back to LTC, because of the policy legacies of the Continuing Care Renewal of 2001-2002 are revealed in the fact that in 2008, BC had the lowest number of residential care beds (including LTC and assisted living) per 1000 adults aged 75 and older.

Current Policy Context

Today, extended health services such as LTC continue to be in something of a policy vacuum (Jansen, 2011). While the federal government funds LTC indirectly through transfer payments and directly through the administration of programs by the Department of Veterans Affairs, no national criteria, principles, or high level coverage standards exist (Canadian Healthcare Association, 2009; Jansen, 2011). Provincial LTC programs exist as a patchwork, with substantial provincial differences in accessibility of services, public financing, eligibility criteria, out-of-pocket payment, and data collection and reporting standards (Jansen, 2011).

While the over-all organization and administration of LTC services has continued mostly unchanged, recent years have seen a significant change in the perception and care needs of LTC residents. Some witnesses have noted that, in recent memory, some LTC residents had only one to two easily managed chronic conditions, and that ensuring adequate resident parking spaces was an issue of substantial concern facing LTC managers, concepts that are basically strange with today's resident population (Lieberman & Doupe, 2014; Samuelsson, 2011). Delaying entry to LTC means that residents most often enter with numerous chronic conditions and require great support or assistance with activities of daily living such as feeding, toileting, social communication/ interaction, and mobility (Samuelsson, 2011). LTC clients or residents on average have a shorter length of stay than in the past, because they are mostly admitted closer to end of life.

Costs

Fees charged to residents for publicly subsidized LTC are generally based on the cost of room and board and not the costs of care required. At least from an administrative standpoint, health care costs, such as the salaries of health professionals and limited medical supplies, are funded through the provincial ministry or department responsible for LTC. Residents are also most often expected to pay out-of-pocket for other expenses such as clothing, eyeglasses, hearing aids, dental services, transportation, over-the counter medications, dietary supplements, and any required co-payments for prescription drugs. In many cases, personal hygiene and care items must be supplied or paid for by the resident. A certain quota of the resident's monthly income is frequently set aside and held in trust by the facility to be used for these "extra" expenses, and low income, heavily subsidized residents are given a small monthly "comfort allowance" in most provinces. Extra fees are sometimes evaluated when private or semi-private rooms are requested (Canadian Institute of Health Information, 2013b).

Maximum monthly rates for residents differ greatly across the country, fluctuating from a low of $1674 in Ontario to a high of $3390 in New Brunswick. There are also considerable differences in how resident capability to pay is considered; some provinces use flat fee systems, others use income testing, and still others use combinations of income and asset testing (Canadian Institute for Health Information, 2013b). The average monthly income for married elderly couples (before taxes, but after transfers such as Old Age Security in 2011 was $5317 (Statistics Canada, 2013), so the maximum fees represent a considerable economic burden for those who require placement in LTC.

There are also ideological variances in the explanations of how rates are determined. Some provinces, such as, Ontario, Nova Scotia, Alberta, and PEI, are careful to describe a

clear delineation between the accommodation rate paid by residents, and the health care rate paid by the government. Other provinces, such as Newfoundland, Labrador, New Brunswick, and Saskatchewan, do not: rather, they emphasize the total costs of running the facility.

Senior Policy Problem

Survey data has revealed that most seniors would prefer to live in the community for as long as they are able (Bayer & Harper, 2000), and residential care rates represent significantly higher cost to governments than home care or assisted living alternatives. However, this goal has ignored the reality that there is a certain percentage of the older adult population (i.e., the very frail, those with advanced dementia) for whom this may not be possible.

Given the expected factors that are estimated to drive increased requests for LTC as the demographic shift unfolds, provincial governments will need to observe and study how best to provide QOL to seniors who need it while making an allowance for investment in other parts of the continuing care continuum.

This chapter provided a review of the literature pertaining to older adults, quality of life as well as LTC and policy directions. The next chapter discusses my practicum learning experiences.

CHAPTER FOUR: Learning Experiences from Practicum

The multifaceted nature of the LTC facility environment made it difficult to articulate specific goals prior to entering the practicum. However, in the learning contract I predicted and enunciated some general activities and specific goals in consultation with my practicum supervisor. In this chapter, I provide a summary of what I did and what I learned over the course of the practicum, linked to both general activities and specific goals.

General Activities

Shadowing

The first week of my practicum started with me shadowing my supervisor, nurses, dietician, care aides, recreational supervisor in different departments. This included going to interdisciplinary and family meetings, reading client assessments, and observing as my supervisor went through the process of public guardian and trustee (PGT) referrals, and helping the residents decide what resources they need. My supervisor got me involved quickly. She had me complete tasks that helped me to better understand her job; these included: writing up and updating chart notes after each encounter with clients or their family members, sending referrals to the PGT, locating specific information in the charts, learning how to fill out forms and gradually involving me in all day to day responsibilities performed by LTC social workers.

I was able to spend time over the course of a month with nurses, care aids, and the dietician under the supervision of my supervisor. Not only was the time of my practicum interesting to me, but also it gave me the opportunity to see, learn, and experience another part of social work. I was able to learn the way a LTC facility works and how the social worker works together with other professionals to find solutions to challenging resident problems. I also worked with a few nurses as they approached different residents for the

continuation of their care like administering medication and checking of blood pressure. I also shadowed the whole process of their care from care aides and how each department focused on a different aspect and task related to a resident; this helped me to develop my own skills and style based on the workers I observed while on practicum.

Admissions, Discharge Planning and Referral

Admission and referral involves a wide range of activities including helping residents understand and know the facility, providing tours around the facility, making referrals to community resources, completing forms for those referrals, liaising with the hospital and family members to ensure all the resident's needs are and can be met, orientation to the facility, and generally ensuring the resident and family members that they are safe and will be given the best quality of life. To be effective, the social worker needs to be flexible because plans change to fit and accommodate the resident's changing physical and mental health situation in getting used to a new home.

During the course of my practicum, I found that providing orientation for the resident and family was important because it removes the fear and thought if this facility is the right place for them or if the facility is like home to them. These are questions that sometimes run through the mind of some spouses and their children. Sometimes it can be confusing for people who have not experienced a move into a LTC facility before and the individual and their family may need to hear information several times before they fully understand. Giving information early in a resident's stay was also important so that the resident and their family could begin to think about what they wanted to do, and how to handle situations.

Discharge planning involves a wide range of activities, which include helping the resident understand housing options, liaising with home support services, providing referrals to community resources and or completing forms for those referrals, and liaising with other

social workers to ensure resident's needs can be met upon discharge. Duffy and Healy (2011) point out the importance of flexible discharge planning for older adults in particular, because their physical and mental health can change significantly in a short time. I had this experience with a resident that was admitted in the special care unit of the facility. This resident was very violent before she was admitted to the facility, however within two months, there was a significant improvement in her health and she demanded to return home to her husband. She was then discharged after consulting with her family doctor.

As I progressed through the practicum I did lots of referrals to the PGT, Home and Community Care for possible temporary rate reductions (TRR), and Community response unit for some residents that needed counselling. Referrals to the PGT where made when the social work department noticed and suspected mismanagement of a resident's money. This included mismanagement by their power of attorney or if a resident's ability to manage their money was questionable. The PGT is usually the last resort on the list after consulting with resident's family. Referrals to Home and Community Care were done when residents were unable to pay their facility rent because they have other bills to pay outside the facility (e.g., medications, house insurance, hydro and so on). Referrals were made for a temporary rate reduction through Home and Community Care to Northern Health. Sometimes residents were approved for six months' rent reduction and, if their situation remained the same, a renewal of the TRR was applied for at the end of six months. Different referrals were done to meet residents' needs upon request.

Actively Participating in Interdisciplinary Team Meetings

Care conference meetings occurred once a week. The purpose was to ensure that team members had the same up-to-date information on residents that included medical, emotional, therapeutic relationship, and social issues. Additionally, care conferences were also held once

a year for each resident. For residents who were newly admitted to the facility, these meetings provided an essential opportunity to share information. The meetings provided an opportunity for doctors, pharmacists, recreational team, nurses, and social workers to share information they had on each resident in other to give them their desired quality of life.

At first, it was difficult for me to participate in these meetings, partly because of shyness and the fear of saying something wrong and I did not know the residents nor had contact with them directly. This made me feel that I had less to contribute. As time went on, however, my supervisor helped me to be actively involved with tasks and a case load of different residents. As I worked independently with residents and their family members, I had more to say and felt able to contribute in a positive way. This made me look forward to attending care conferences because I had direct contact with the residents and their families.

Grief and Loss Work with Residents and Families

I had the opportunity to work with families regarding grief issues. For example, I worked with a resident on grief issues following the death of his wife who had been in hospice. The resident was able to talk to me and verbalized how he felt during this time. This work was difficult but really interesting to me because, in some cases, it involved me helping family members and spouses with counselling options when they were feeling guilty, when they were finding it difficult to understand their loved one's diagnosis, or had difficulty leaving their parent or spouse in LTC. A number of families who had recently brought their parent or spouse to the facility also needed counselling or closure. This work was challenging for me because I have a different view and understanding about LTC coming from Africa and how we take care of our parents when they are old and full of age. I was very careful to ensure that I kept my own personal thoughts out of the discussions. It was very important for me to respect where these residents and family members were at in the process of

understanding their diagnosis and I learned a lot from sitting with them and their families in providing the needed support that they require in other for their parents or spouse to have a good quality of life.

Assessment

Assessment is a crucial part of LTC social work because it provides the information that social workers use to carry on with all other aspects of their work. It took time for me to develop my skills to approach assessments with new residents in a relaxed manner that permitted me to gather the required information without sounding and feeling like I was scrutinizing the person. Shadowing my supervisor during this process helped me to become comfortable in doing assessment on my own.

An assessment needs to be detailed and to cover a number of basic or required areas, Common aspects of the assessment included: living situation before coming to the facility, financial incapability, community resources, history of medical issues, formal and informal support systems, recommendations, and care plan. The details of what was included during the assessment process varied from department to department within the facility but the same general topics or more were covered in all assessments. Social workers, however, were not able to see all residents because of time constraints. Some typical indicators of the need for social work follow-up included family dynamics (e.g. where children or spouse are having the guilt of leaving their loved ones in LTC), lack of informal supports, power or attorney (POA), need for substitute decision maker and health care decision maker.

My written assessments were fairly brief until my supervisor told me the importance of writing in full details, keeping in mind that other people were going to read and make decisions based on what I have written. I learned to put more information because I recognized the importance of being able to read a fully- articulated assessment. In the later

part of my practicum, I developed the pattern to write any information thoroughly in order for the next worker not to go through the stress of seeking information that was not written in the assessment.

Psychoeducational and Education Work with Residents and Families

Some of the work I did during my placement involved providing information and education. Sometimes it was to staff about residents' social situations or to residents and their families about the policies of the facility or their diagnosis. The level of care that some residents need is sometimes confusing to families and some staff. I, therefore, spent a lot of time outlining the services that are offered within the facility and available to residents and their families especially around care. While I developed a level of comfort with the common diagnoses people at the facility had and the different levels of care, my knowledge was not enough to have adequate or in depth conversations about different situations with families or residents. Some families wanted me to give them more details about their situation in the facility, advice about treatment options for their loved ones and parents, in those situations, it was helpful to explore ways of having the discussions with my supervisor. I found that families often asked me for more specifics on their situations or for advice about treatment options, which social workers are not qualified to give. This process helped me reinforce my own learning and was a helpful way to improve more knowledge on what amounts to each resident's quality of life. I appreciated the educational part of the placement because it helped me strengthen my own learning and was a tangible way of responding and assisting residents.

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Specific Goals

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Under the direction of my academic supervisor and practicum supervisor, I developed specific goals for my practicum. While these were changed and improved during the process

of my practicum, this provided an opportunity for me to stay on track with my learning and to keep track of my progress during my practicum placement.

Knowledge of Medical/Social Issues Faced by Social Workers in LTC

I attended different workshops offered by the organization during my practicum, especially those associated to public guardian and trustee, conflict resolution, information sessions, and social work team meetings. I was also able to expand my knowledge in different areas by asking questions and listening during familiar discussions.

My goal was to develop an understanding of the following topics: dementia, quality of life, PGT, and information on services offered by other LTC facilities. I paid close attention during inter disciplinary meetings, care conferences and discussions with health professionals, nurses and care aides, social workers in order to attain as much knowledge as I could learn from them.

Knowledge and Use of Community Resources

I developed a good knowledge of community resources used by LTC social workers. My initial goal was to meet and arrange tours with the following resources: hospice, two LTC facilities, an adult day center, and a homeless shelter. I was able to visit hospice, homeless shelter, a CLBC run senior home, and a private facility. These visits were very useful because it gave me insight on how different facilities and older adults describe what amounts to their QOL. I was particularly impressed with SFL and how they offer choices to residents and their families, their positive approach on different levels of care, how families were actively involved with residents, how they understand what amounts to each resident's QOL, and how they work together as a team to give each resident a good QOL.

Knowledge around Adult Guardianship, PGT and Adult Protection

I was able to review and attend workshops regarding adult guardianship, power of attorney (POA), and public guardian and trustee (PGT). This area was a new experience for me because I never knew social work was involved in the area of PGT and POA. I met with the manager of PGT during one of his visits to SFL; I was able to ask a few questions about PGT and their involvement regarding a particular resident whose case I was handling. The following day I attended a workshop with my supervisor where PGT team members explained to us their involvement and the referral process for older adults in LTC facilities. I was impressed with the team work and their level of explanation and answers during this workshop. My supervisor and I found this workshop very important because it helped solve some of the questions we were having little or no answers to then. The workshop gave me a better clarity and understanding as to when to make referrals to the PGT. I also had the opportunity to go through some of the written legislation and copied most relevant sections in order for me to review them as needed when the time arose. It is impossible to gain all understanding, a complete knowledge of POA, referrals to PGT, and adult guardianship in a duration of four months practicum but my supervisor was always present and gave me all the opportunity to ask questions, she involved me in cases and situations that will give me a better learning experience in the areas I seemed confused.

Communication and Intervention Skills

At first, I found it was really difficult for me to speak to residents on my own. I had a conversation with my supervisor regarding the fear of not having the right answers to questions asked by residents. My supervisor was encouraging and advised that I always meet with her to discuss potential questions a resident might ask before meeting with the resident. She also told me that I could tell the resident or their family member that I can ask or find out

about any questions they had if I was not sure of the answer. With time, my confidence grew and the fear of saying something wrong gradually disappeared. I became more confident to meet residents; knowing at the back of my mind that my answers could brighten up their day and, in most cases or situations, my answers gave their family members a great relief knowing that they had someone to talk to. Until the last week in my practicum, I continued to shadow my supervisor on particularly complex cases or complex family dynamics; this gave me the time and opportunity to familiarize myself with her ways of handling and working through certain difficult procedures with residents and their families. My supervisor is a full package of experience and her willingness to share with me gave my practicum a whole new way and pattern of learning.

An important part of my practicum also involved meeting with residents independently or with my supervisor to discuss and access what services were needed or area that new residents were seeking answers about. Helping new residents settle in to the facility comprised a lot of my practicum work. I read residents' files and contacted their POA, if need be, to make sure that residents' files were up to date. After each meeting, or after having a conversation with a resident and their family member, I wrote up my notes and also charted on their file. At the end of each meeting with residents, I discussed the outcome of my conversation with my supervisor. Sometimes during conversation with my supervisor, she pointed out areas of concern that I should have raised and discussed with the resident. She also made me aware of areas that I needed to follow up on. In all, this made me recognize information that needs to be explored further. This practicum experience opened my eyes to how important all information is and at what point information needs to be investigated, considered, explored, and scrutinized with a critical eye.

As my practicum progressed, my supervisor increased my caseload although she was available to talk to me whenever I needed help or at a crossroad to ensure that I was not

missing important aspects of a situation. Daily meetings with my supervisor were very helpful because it gave me the confidence of having someone to talk to when I felt stressed in situations or I needed to consider a suitable choice of options.

Practicum, As I Experienced It

Based on my work experience, some families do actively become involved at mealtimes and special events like birthdays. For example, they provide bathing support, emotional support, assist while feeding, pass on important information or knowledge of the resident's preferences and habits, and bring in homemade treats and clothes for residents. It is reasonable to think that family members will be more willing to partake in mealtime activities if management and staff have a positive attitude and acknowledge the importance of their involvement. Perhaps family members would visit more often if the facility environment is more welcoming. Basically, family participation at birthdays, mealtimes, and social visits plays a significant part in keeping residents feeling socially connected to their family members at all times thereby removing any form of social detachment, loneliness, and feeling from residents.

At the end of each day, I had planned as a part of my daily schedule to write my entire document and do journaling. However, due to the nature of work at SFL, this was very hard to do because it was hard to foretell what could happen on a daily basis. I planned time during weekends at home to do my journaling. This helped me a lot because I found it to be a time to reflect on the challenges and areas that I needed to improve or ask questions about. I used this time to also deal with any stress from my day to day practice; I observed my own growth in learning how to perform my social work duties within the LTC facility. I used observation as a primary tool for gathering information while shadowing my supervisor and asked questions when I felt lost during the course of my observation. I had additional

interactions with other professionals especially nurses, physiotherapists, occupational therapists, dieticians, and the recreational team. The communication I had with other professionals provided me with important opportunities to learn and understand the different roles professionals have to improve the QOL of each resident in the facility. I gained this experience by shadowing different professionals for few weeks, doing assessments with them, reading their notes on residents' charts and observing their work during interactions with resident. This gave me a strong respect for the significant role they play.

My focus was on how I could improve my understanding and ability to perform tasks as a social worker within the context of disability in LTC. My anticipation was to grow a greater understanding of myself and skills as a social worker, the LTC setting provided me a chance to assess my own work and growth while paying attention and learning from different professionals on how to improve the QOL within a LTC facility.

LTC Facility (SFL) Social Work as I Experienced It

LTC facility social work is comprised of different activities. Everyday brought something new, although certain situations recurred on a daily basis. Each unit had different activities or schedules planned monthly; they usually had care conferences every week where members of the interdisciplinary team meet to discuss a new resident or old resident on their care, social issues, emotional issues and medical issues. These meetings provided opportunities to know the level of care each resident received to ensure holistic care and planning is carried out for each resident.

During the course of my practicum, I experienced some situations that challenged me. Each one provided an opportunity to learn from the circumstance and develop my own skills in managing difficult requests or situations. For example, the first situation involved a resident that that was deemed incompetent and was diagnosed with dementia, her being

violent and agitated made it challenging for her husband to provide adequate care at home yet her husband was unwilling to make the decision for her to go into a LTC facility. When her husband finally agreed to admit her into a LTC facility, I observed that the relationship between her husband and her children was complicated and I spent a lot of time phoning and having individual discussions and meetings with various family members. Some of the challenges I faced were gathering information from everyone involved, trying to contact the POA. When there are complex family dynamics, it can be difficult to know whom to talk to in the family because every member of the family wants to make decisions and see things go their own way.

Another situation involved a resident that was diagnosed with dementia whose physical limitations made it challenging for her husband to take care of her. Her husband also had a brain injury. She was behind in the payment of rent at SFL due to credit card debt. I contacted her husband about the payment and a possible TRR; he declined and said he would be going to the bank to make sure he gets money before his wife's creditors take the money out of her bank account. I discussed this situation with my supervisor and she had a meeting with the resident's husband. Coordinating the process took significant time; I was able to observe this process in action while shadowing my supervisor and I learned a lot about the importance of consulting with my supervisor when faced with a challenging situation.

As I progressed in my practicum, I found that these uncommon or difficult situations are in fact common in the LTC environment. Yet, that was the first time that I have ever experienced it and worked through it with the help of my supervisor. It was an important case to learn and I appreciated the opportunity to develop my social work skills.

Physical environment. SFL is a very busy place that I looked forward to going to every morning when I woke up. There were always a lot of visitors and staff moving from

one unit to another, meal carts, residents, wheelchairs, rooms were constantly changed

depending on resident's needs, new admissions, and cleaning carts, bingos and the fiddlers

playing every Thursday morning. I always listened to the fiddlers play because it was a time

for me to release and get a breath of new energy. It gave me so much joy seeing residents

smile, dance with one another, and care for each another. Whenever I missed a day at the

facility, I felt I had lost a lot because I constantly had this reminder at the back of my mind

that my presence could console or answer a very important question to improve the QOL of a

resident.

Outdoor activities. Outdoor activities help and encourage residents to mix with

other residents and people outside the facility and were seen by residents as significant for

knowing what was going on in the community or around the facility. It was the more able

residents in the facility that were involved in these activities if they so wished. Sometimes it

depends on the mood and willingness of the resident that determines the type of activity to be

done on different days. Some activities that were carried out within the facility were made

easy because of the security system used within the facility. Facilities had to safeguard the

surrounding of residents as in all facilities, there were some residents who were confused and

had inclination to wander around. Facilities, therefore, had to have a device or security

system to make sure residents who were a concern or residents who have tendency to wander

could not leave the facility unnoticed. Many facilities had a security keypad system, which

could only be operated by staff and sometimes-family members have the codes to the unit

where their parents are. Many residents that are more able who require leaving the facility for

a walk or visits could not do so without a staff member helping or facilitating their exit and

re-entry into the facility. Substantial planning had, therefore, to be done before leaving the

facility especially when residents are leaving with their children or spouse. SFL had, with the

permission of residents' relatives, to put an electronic tagging system around the wrist of

residents that had the tendency to wander around. The electronic tag would set off an alarm if they tried to leave the facility.

Recognition of people. Due to large number of staff, family members, the recognition of individual residents was a great challenge for me at SFL. I tried to remember residents' names; my supervisor helped me with this by calling staff by their names, introducing me to residents and by calling residents by name whenever she met them. Gradually I was able to recognize and remember names of residents and staff. Additionally, it was difficult for me to call residents by name because in my culture addressing your seniors by their names was regarded as a sign of disrespect and lack of parental training. We addressed our seniors by saying Ma or Sir and kneeling down when talking to them; this process showed that you were trained properly by your parents and that you also wanted to live long. I did not tell my supervisor this because I was also uncomfortable calling her by name. When time went on, however, I managed to put my personal beliefs and habits aside. I was able to recognize residents by their faces and called residents by name and came to terms that I cannot hide behind this as an excuse when pursing my career as a social worker. Doing my practicum in a LTC environment built my courage and self-confidence because it gave me the opportunity to think outside the box before making any judgement or decision.

Relationships. As easy and simple as it may sound; nurtured relationships improve QOL. Regular visits of children, spouse, family friends or neighbors mean a lot to older adults. The sense of guilt and feelings of rejection gradually blow away when residents have frequent visitors and this is something I observed daily in SFL. SFL encouraged and respected family relationships.

Privacy. Privacy in SFL is well respected because it gives residents a sense of respect and control to be alone when they wish, to be together in private with others

residents when they also wish. According to Westin (1967) in a seminal work, four aspects of privacy are: solitude, intimacy, anonymity, and reserve. Furthermore, he recommends four reasons why these types of privacy are needed: to exercise self-sufficiency and maintain individuality; to attain emotional and open release particularly important during times of loss, shock, or sorrow; to conduct self-evaluation, which compels private information managing and reflection; and to achieve limited and protected communication. Pastalan (1970) also supports the importance of privacy and its purpose in LTC, he stated that LTC environment and rooms should be designed in such a way that each older adult realizes such privacy, which is obviously more easily achieved in residential settings with private rooms and baths (Kane, Baker, Salmon, & Veazie, 1998).

Choice and control. Quality of life in residential care homes is a multifaceted issue that may be determined by a senior's independence, choice, control, individuality, and autonomy, in the residential care facility where they are residing. Environmental adaptation seems to be a way to develop the quality of life of residential care home for older adults with disability.

Opportunities to choose, especially from among different options, can meaningfully influence a resident's sense of well-being. Improving personal control in everyday life and giving personal responsibility enabling choices that empowers residents. With future choice and control improvements guaranteed for older adults, meaningful change will take place in the provision of accommodated care for older adults

LTC residential providers must become active and proactive in anticipation of improvements modifications, by changing new organizational models and methods of service delivery to boost uncertain resources and maintain quality of life and of care for older adults.

Spiritual well-being. Finally, though indefinable and related to both psychological and social well-being, spiritual well-being cannot be ignored as a domain of QOL (Olson & Kane, 2000). Religious and spiritual activities help to reframe stressful happenings in a way that inspires the resident naturally to deal with life stressors. Spirituality can also encourage a resident toward the use of effective coping tactics. Moreover, these ideas, however poorly measured, have been connected with health outcomes.

This chapter provided a review of my practicum learning experiences. The next chapter discusses Implications for Professional Practice and Conclusion

CHAPTER FIVE: Implications for Professional Practice and Conclusion

The goal and expectancy of all professional staff in a LTC facility is to provide the best care for residents under often-chaotic conditions. Each professional group working with a given resident has a different role or perspective on what care should look like. Therefore, I focused my thoughts and observations on practice implications for social work within LTC, using social work values and ethics as a guide.

The amount of support and advocacy social workers do to ensure residents are well cared for and given what they need exceeded my expectation. Social workers engage in a range of activities from advocacy to charting any changes to alert other staff on important aspects of a resident's care. Although advocacy is already part of the social work job description, some residents and family that I spoke with needed some form of advocacy in order to have good QOL. Social workers practising in LTC facilities must continue to lobby, work with other professionals, and advocate for policy change to provide inclusiveness to those in LTC.

The core values of social work must be displayed at all times and residents' QOL must be the main focus at all times. Social workers have an important role in supporting residents facing life-changing or challenging situations and working with residents whose rights may be undermined through abuse and neglect. I encourage social workers participating in multi-disciplinary team meetings to continue to contribute from a holistic view, with a perspective of the whole person, rather than to focus only on symptoms, situation, or circumstances. Social workers should put residents first, ensuring that their needs are met in ways and situations residents choose, and not according to how professionals believe things should be achieved, because social workers are in good position to support better resident's endings and QOL.

One of the current roles for social workers is also to help residents find resources and identify areas of main concern. Social workers need to manage resources well and efficiently in such a way that will sustain or maintain a focus on achieving the chosen outcome of residents using or accessing these resources. When resources are made available, residents will have the guarantee and be assured that they can exercise choice and control over the way that services are provided.

Residents who are in LTC facilities who use social care and support services recognize the limits and boundaries social workers can face when working within the controlled rules and resources of an organizations (Beresford, 2004). Most times organizational and budget issues have a strong impact on a resident's relationship with social workers. It is important that policy makers are open and transparent about changeable decisions, putting older adults into consideration.

Strategies for Change

Develop Infrastructure

New infrastructures must be encouraged including changing policies, professional roles, organizational boundaries, and funding to increase staff levels (i.e., more nurses, care aides, and social workers). Change is also needed in relation to how government can best exercise their roles: paying for care for older adults with low incomes, and defining the nature of care through licensing rules. If policies, training, and care are changed from the policy makers or governing body, we will reach a point when the controversies and questions surrounding QOL in LTC will be minimized and possibly be a thing of the past.

Develop Feedback Forms for Families

Feedback and information is needed at the macro level to describe the work of provider organizations as well as at the micro level of the resident in LTC. Providers also need to learn and train their staff on how to improve QOL, discuss concerns with residents and their family, and use that information to improve services that are been rendered to residents and their family. Feedback collected across different facilities can be used to measure and compare progress in QOL either within nursing homes or across other LTC settings.

Create More Supportive Environments

What is needed is better access to specialized equipment such as eating systems, hands free drinking equipment, slip resistant tray liners,. Supportive environments also include wheel chair accessible walkways, rails and entries for residents, and maximizing the sense of privacy that many older adults see as a big part of a good QOL.

Take Back the System

LTC for older adults needs to be viewed in new and different ways. consideration and focus should be on the hopes and fears of all older adults and include the perspectives of family members as well as service personnel (e.g., social workers, nurses, aides, doctors), and policy makers.. Consideration and discussion is needed about the conditions under which older people could better be treated and given choices, security, privacy, relationships, and meaningful activity. All individuals involved in these discussions and decisions should keep in mind the overall goal of a good QOL for older people and, in particular, for people with dementia. LTC providers should begin their discussions by considering how residents with physical and cognitive disability would want to live in their old age. In all ways, we must

keep our focus on QOL and how we can better improve the lives of older adults living in LTC.

Conclusion

QOL in LTC facility is an important topic that is enhanced by the seniors' independence, choice, individuality, and autonomy. Promoting the QOL of seniors requires multi-disciplinary input and effort to promote the general model of LTC delivery. An actual model would target promoting independence, choice making and privacy in individual care and living environment reducing power struggle relationship between residents and formal caregivers, enabling participation in decision making, and improving family involvement and interaction.

It is important for LTC facility managers to develop methods to reassure social relationships, such as cultural, outdoor and leisure activities, as well as physical exercise, among the LTC residents, Beresford (2004) supports the thought that social separation is connected to aggravate mental and physical health. Loneliness may be identified among LTC residents and those living in the community, subject to the living conditions they are in. It is also known that group activities greatly contribute to residents' independence. There is also need for proper training of those involved with residents in LTC, so that staff may develop strategies significant in providing support, reassurance and encouragement in the adaptation, adjustment and maintenance of QOL to residents (Gerritsen et al., 2004).

The practicum placement at SFL was a valuable learning experience giving the opportunity to develop strong social work skills for use in a residential care facility and caring for older adults in general. The focus on older adults is timely and relevant because of

the increasing challenges of delivering health care services to clients and an aging population

in a climate of financial limitations and controls.

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Appendix: Learning Goals and Activities

For this practicum my focus will be on gaining comprehensive knowledge and performing social work duties within a residential care facility setting. In discussion with the proposed practicum supervisor, the practicum will include activities such as:

1. Shadowing and working with an experienced social worker in several departments and progressively taking on more responsibilities

2. Actively participating in multi- disciplinary team meetings

3. Grief and loss work with clients and families

4. Assessments

5. Psychoeducational and education work with clients and families

6. Discharge planning and referral

7. Developing familiarity with dementia and the associated challenges.

Time will also be set out in my schedule to allow for documentation and journaling at the end of each working day. Personal observation and reflections will be written as part of my learning, but information that could identify clients or workers will not be included to protect the identity of those in SFL. This is an effective method for documenting practicum experiences and reflecting on practicum learning (Bhandari, 2011). Observation will be the primary focus of information gathering, and any questions I have will be written down and discussed with my supervisor. My main purpose and focus will be on developing my understanding and skills to execute the responsibilities of health care social workers.

In close consultation with my practicum supervisor, and under the general direction of my academic supervisor my specific goals will be:

Specific Goals

1. To develop an increased knowledge and understanding of a range of SFL policies, procedures, services, and programs and the health professionals employed within the facility.

   Activities

   - Read and become familiar with the use of pertinent policies and procedures

   - Attend multi- team meetings

   - Arrange to meet with representatives of as many of the following programs/ services as available: physiotherapy, occupational therapy; nutrition; mental health services; home and community care services; elderly services.

2. Develop knowledge and use of community resources

   Activities

   - Meet with and become familiar with various community resources (e.g. Prince George Council of seniors, Hospice House, and Rainbow Adult day centre.

   - Independently assess community resources that are available to a client and refer effectively to ensure successful use of resources.

3. Increase my knowledge about adult guardianship and adult protection

   Activities

   - Review pertinent legislation and policies regarding adult protection and guardianship

   - Recognize and effectively manage issues related to guardianship and protection

   - Gain an understanding how continuity of care for a resident is maintained throughout the facility and how providers view care, work, and contribute to the quality of life of adults experiencing a range of disability issues living in their care.

4. Enhance my communication and intervention skills

Activities

- Shadow my supervisor for the first 2-3 weeks to learn skills specific to working with clients and their families

- Meet with clients either independently or with my supervisor to assess and establish what services are needed to make them have the type of quality of life they desire.

- Complete documentation as required on each client which will be reviewed and co-signed by my supervisor.

- Progressively take on more responsibility for managing case load independently throughout the practicum. This will be done with ongoing consultation and supervision from my supervisor.

5 Develop an increased knowledge of medical terminology used at SFL

Activities

- Become familiar with regularly used terms used by medical and systemic terminology encountered during the practicum, which will include an understanding of how to communicate these concepts to clients and families

- I will develop my understanding of how the medical model and social models of disability are understood and used in daily social work practice at SFL.

- To gain an understanding about dementia and the unique care requirements within SFL.

6 Develop knowledge about common social and medical issues faced by SFL social workers

Activities

- Attend workshops on dementia and palliative care

- Attend Alzheimer's society meetings and workshops

7   Gain an understanding of how the social model and medical models of disability are understood and used in daily social work practice.

8.   Become familiar with dementia and the associated challenges.

Activities

- Gain an understanding of sun downing

- Gain an understanding about the different stages of Dementia

- Gain an understanding in different behaviours associated with dementia

9   Engage client families in psychoeducational activities.

Activities

- Shadow my supervisor and develop my communicating skill on working with clients and families

- Provide information about community resources,

- Counselling interventions as needed that is proactive as well as crisis oriented, and conducting assessments.