Social Activity and Quality of Life of Older People Living in North Dublin:

The Care Worker's Perspective.

Conor O' Malley

Student Number: 1245020

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Supervisor: Bernadette Quinn

Head of Department: Bernadette Quinn

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Department of Social Science

DBS School of Arts

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Abstract

The proportion of older people in Ireland is set to increase dramatically in the future. This study investigated the role that social activity plays in the quality of life of older people from the perspective of health and social care workers. A qualitative thematic analysis was carried on the data gathered from tape recorded semi structured interviews of 6 HSE care workers. Among the themes highlighted in the results were Social Interaction, Isolation, Health, Access, Family and Community and Individual Needs. The results showed that social activity is central for older people's quality of life and that social isolation was damaging to it. Areas for improvement were discussed as well as limitations of the research. The research adds to the body of knowledge on older people's quality of life.

Social activity and quality of life of older people living in North Dublin: The care worker's perspective.

<u>Introduction</u>

Ireland is getting older. The proportion of the Irish population aged over 65 is on the increase, similar to most Western European nations. In fact, the European Commission has recently designated 2012 as the European Year of Active Ageing in an effort to promote healthy ageing. The policy makers of Ireland and Europe are faced with steadily ageing populations and their impact on public services and finances, most notably the cost of healthcare (European Commission, 2010).

According to CSO figures, 11% of the Irish population is over 65 years of age, this amounts to 467,900 persons (CSO, 2007). In the last decade, Ireland has seen an increase of 54,000 persons in this age bracket (CSO, 2007). According to future projections, in the next 40 years, the proportion of Irish people aged over 65 is set to double to 22% - a staggering 1.4 million people (McGill, 2010).

Older people represent an increasingly significant portion of the population and are identified in the National Development Plan as a group vulnerable to social exclusion. Loneliness and isolation are common for older people, many of whom are increasingly living alone or caring for an elderly partner (Treacy, Butler, Byrne et al, 2004).

Achieving a decent level of quality of life for older people is a desirable goal, and has been positively associated with their good health and well being (Borglin, Jakobsson, Edberg et al, 2005). Maintaining the well being of older people is important and as a group they should be assisted in living independently in the community for as long as they can. Society should aim to delay older peoples' move into long term residential care as much as possible.

As the proportion of older people in society increases, so too will the demand for the costly services to care for them. Promoting better quality of life for older people is becoming an ever more important issue and one that can be of benefit for society as a whole, both economically and socially. In Ireland, a greater level of research into this area could be of enormous value to better inform future policy making.

Health and social care workers operate first hand with older people already in need of care services. HSE primary care staff deal with older people living the community and they are ideally placed to give a picture of how their clients are living and coping. The care worker's perspective on their clients' quality of life could be crucial to the development of services that meet older people's needs more efficiently. Therefore, this study will explore from the care worker's perspective, how social activity can affect older people's quality of life.

Literature Review

Quality of Life

Interest in quality of life research has intensified internationally in recent decades. Confronting the challenge in terms of meeting the health and social care needs of older people has played a major role in this escalation (Smith, 2000). Quality of life as a concept is difficult to define and this has been a key problem facing those conducting enquiries into this area (Gabriel & Bowling, 2004) (Smith, 2000). Social science researchers cannot reach agreement on a generic definition or measure. However there is consensus on the sheer complexity of the concept and that continued research is required to add to our understanding (Smith, 2000).

Any investigation into quality of life, must firstly discuss what the term itself can actually refer to. Hughes (1993) recognises that there can be no fixed definition but describes quality of life as being a multi-dimensional concept. Bury and Holme (1993) refer to the dimensions of quality of life being a combination of objective conditions and subjective evaluations. Objective conditions can take account of general health, functional status and socio-economic status. Equally, subjective evaluations may encompass of a range of life experiences including; perceptions of well-being, levels of satisfaction and self esteem (Bury & Holme, 1993). So it could be said that quality of life as a concept, incorporates both the *conditions* of life and the *experience* of life (Hughes, 1993).

Research into the quality of life of older people in Britain was conducted by Gabriel and Bowling (2004). This research recognised that previous literature suggests that there are common core values within societies and that the presence or absence of these can affect overall quality of life. Previous approaches to examining quality of life have included needs based approaches derived from Maslow's hierarchy of human needs, to a recognition of the multi dimensional nature of quality of life. Gabriel and Bowling (2004) outlined how in Europe, a functionalist research stance has often led to a negative view of old age as a time of dependence and ill health. This stance underestimated the quality of life of older people and instead focused on their care needs rather than their own views and priorities. What Gabriel and Bowling (2004) set out to examine was quality of life from the perspective of the older person and in lay terms. Their aim was to add to the development of the concept and the body of knowledge on quality of life in later years based on older people's own views.

Gabriel and Bowling's (2004) published research focused on the data gathered from in-depth qualitative interviews with 80 participants in England and Scotland. From these interviews, several overall themes emerged from the older person's perspective on quality of life. These themes included; social relationships, home and neighbourhood, psychological well being and outlook, social activities and hobbies, health, financial circumstances and, finally, independence.

Gabriel and Bowling (2004) pointed out that these domains of quality of life are unique in that they are derived from the perspective of older people. They concluded that these

domains show an interlinking and interaction with each-other in people's lives and surrounding society. They also concluded that a better understanding of the quality of later life can be gained by moving beyond the proxy measure of health and functional status, towards a model based on concepts derived from older people themselves.

Gabriel and Bowling's (2004) work has been beneficial in that it sought out older people's own perspectives and attempted to break away from merely expanding on previously established dimensions of quality of life. Their work has helped shed light on what needs should be met in order to improve quality of life for older people and in turn, hopefully improve their general health and well being. This work can help to shape future policy related to older people. Work of this nature could be carried out in Ireland to identify what matters to older people here. Older Irish people already in need of care services could be used as a sample to find out what could help to improve their circumstances and quality of life.

Further research by Bowling attempted to identify older people's perceptions of active ageing and what may enhance later life (2008). According to Bowling, previous conceptions of ageing have been based on social functionalism which led to disengagement theory (2008). This theory suggests that the continual withdrawal from social interactions and activities is an inevitable part of later life. However this theory has more recently been replaced by continuity theory. Bowling outlined how continuity theory argues that the people who age successfully are "those who carry forward their values, lifestyles and relationships from middle to later life" (2008, p293). Bowling found

support in the previous research for the claim that aspects of active ageing (including social networks, support and participation) show an association with health, mortality and quality of life.

Bowling's research to identify older people's perceptions of active ageing involved computer-assisted personal interviewing of participants aged over 65 and living in Britain (2008). The most common responses mentioned at interview were; physical health and functioning (43%), leisure and social activities (34%), mental functioning and activity (18%) and social relationships and contacts (15%). Bowling (2008) found that these themes overlap with themes from previous studies on older people's perspectives of quality of life. The two concepts seem inter-related and ageing actively can help enhance quality of life. Bowling also suggested the need to develop a concept of active ageing which embraces frailer and less active older people (2008).

Bowling's examination of what the concept of active ageing means to older people expanded on previous work looking into older people's quality of life (2008). This research could be replicated with an Irish sample to find out what could improve opportunities for active ageing here. Bowling (2008) also highlighted the need to incorporate the needs of frailer and less active older people so as they would not be marginalised. Perhaps older people already in need of care services could be involved so as to shed light on what could enhance their experience of later life.

Older People Receiving Care

Murphy, Cooney, O Shea and Casey (2009) described how it is well established that the incidence of disability and illness increase with age. 23% of people aged over 65 have a disability but this rises to 65% in those over 80 (Murphy et al, 2009). Their research set out to identify what could be determinants of quality of life for older Irish people living with a disability in the community. The scope of disability of the participants included stroke, arthritis, depression, vision and hearing deficits, learning difficulty and dementia, as these were the conditions of highest incidence.

Following interviews with 122 participants, Murphy et al (2009) found that the topics that arose were similar to those in previous research on older people's quality of life. These included health, social connectedness and financial security. Murphy et all discussed how the issue of health and its impact on quality of life, depends much on the individual's ability to adapt and their response to deteriorating health. They also found that disability made active community participation difficult for their interviewees but social connectedness was still important to them. Murphy et al suggested that care workers (in this case nurses) can help to improve life quality for older disabled people living in the community by advocating for resources and ensuring that service provision responds to need (2009).

The research by Murphy et al. (2009) added to the body of knowledge surrounding the concept of quality of life of older people in an Irish context. Their focus on older people

with a disability living in the community allowed for another angle on the issue. This narrowing of focus gave an insight into the viewpoint from a significant proportion of the older population, one which may have been overlooked from the previous research.

A 2007 investigation by Murphy, O Shea and Cooney looked into quality of life for older people in long term residential care in Ireland. Murphy et al. outlined how the Irish population is ageing and assume that this in turn will lead to an increased demand for residential care in the future. Therefore, a study into quality of life for those in long term care was needed (2007). The research was carried out on site at 12 different long term care facilities. Perceptions of quality of life were collected by way of qualitative interviews with residents and staff.

Once again social connectedness (community and family) emerged from the data as one the main themes, along with care environment and ethos, personal identity, and activities and therapies (Murphy et al, 2007). Connectedness to family and community was found to be important in maintaining well being, again highlighting the social aspects that appear to be essential to a good quality of life. Murphy et al concluded that in residential care settings, quality of care takes prominence over quality of life considerations. Their study contended that quality of life of the residents should also be a major focus of this sector (2007).

The work of Murphy et al. (2007) differed from the previously reviewed research in that it included care managers and staff as participants, as well as the older people receiving

care. Similar work could be replicated in a community setting to get care workers''
perspectives on what could improve clients' quality of life, in addition to the opinion of
older people themselves.

Social Isolation and Health

York & Waite outlined how previous research shows that social isolation has a negative effect on both the physical and mental health of older adults. This negative effect has even been compared in significance to the harmful effects of smoking and other major health risks (2007). Their research built on the idea that the concept of social isolation could be thought of in two dimensions – objective isolation and subjective isolation. Objective social isolation was defined as physical separation from other people indicated by of lack of social ties and social activity. Subjective isolation referred to personal feelings of loneliness, emotional closeness and perceived social support

According to York & Waite (2007), being part of a social network plays a major role in a person's level of health. A lack of network ties and infrequent interaction with network members would be a sign of objective isolation. This type of network can have negative health consequences because social connection and interaction are essential for social support. Being embedded in a social network has been shown to be beneficial for health and this is particularly true among older adults (York & Waite, 2007). Among the benefits listed by York & Waite are; better immune system function and cardiovascular health, reduction in the effects of stress, better mental health and reduced depressive symptoms (2007). Participation in social activities outside of the home has also been emphasised as a factor preventing objective isolation. Being involved in activities such as; community groups, volunteering, and attending mass have shown positive physical

and mental health effects, as well allowing access to sources of social support and social capital (York & Waite, 2007).

York & Waite outline how features of subjective isolation have been found to be damaging to health, and a perceived lack of social support is among them (2007). Perceived social support is especially beneficial to mental health because its presence acts to diminish the effects of stress and stressful events. Perceived social support also promotes physical health and is linked with decreased rates of all cause mortality (York & Waite, 2007). Feelings of loneliness and a lack of closeness in relationships with family and friends are the other features of subjective social isolation that have shown to adversely affect health.

The research undertaken by York & Waite on the negative effects of social isolation on the health of older people in the United States added to the previous literature. Their work included a breakdown of the concept of social isolation into objective and subjective dimensions. York & Waite suggest that experience of objective isolation can lead to increased subjective isolation and in turn ill health - "the more objective isolation one experiences, the more that one perceives himself to be isolated, the greater his chances of having bad health" (p. 12, 2007). Their findings showed that both objective and subjective social isolation can have a damaging effect on the health of older people and that both dimensions interact with one another. This allowed for a better understanding of the factors involved in isolation and this in turn could help guide future policy and measures for prevention.

An investigation into social networks and loneliness and their relationship to the well being of older people in Dublin was conducted by Golden, Conroy, Bruce, Denihan, Greene, Kirby & Lawlor (2009). They described how deficits in social support have previously been linked to a range of adverse health outcomes for older people. Golden et al (2009) set out to highlight the role played by subjective and objective social isolation in levels of wellbeing, depression and hopelessness in community dwelling older people.

Golden et al. found a significant overlap between social isolation and loneliness. A quarter of men and 40% of women in their sample experienced loneliness (2009). Social isolation and loneliness were also found to overlap with feelings of hopelessness and depressed mood. Golden et al highlighted in the previous literature a link with "reported increased all-cause mortality" (p.699, 2009) in older people who are both lonely and depressed. The research by Golden et al (2009) helps to illustrate the connection between social isolation and its associated negative affect on the well being of older people in an Irish context.

A previous study, carried out on behalf of the National Council for Ageing and Older People, also explored the area of loneliness and social isolation for older Irish people (Treacy, Butler, Byrne, et al, 2004). This illustrated the importance of social networks in preventing social isolation. The study found that participation in social activities could result in significantly larger social networks and that older people themselves expressed socialising as being critical to their mental health (Treacy, Butler, Byrne, et al, 2004

p.170). Other benefits of social activity have been documented in the USA. Being socially active in later life has been associated with a positive affect on the rate of motor decline (Buchman, Boyle, Wilson et al, 2009).

<u>Aims of this Research</u>

We are part of an ageing society. In almost every country the proportion of people aged over 60 is the fastest growing age group (WHO, 2011). In Ireland the amount of people aged over 65 is set to double in the next 40 years (McGill, 2010). This demographic change presents us with the challenge to meet the increasing health and social care needs of our ageing population.

Decent quality of life is associated with good health and well being of older people. The previous literature has shown that social interaction and connectedness has emerged time and again as an important aspect of quality of life for older people. Social interaction can help to prevent isolation and its associated negative effects on health.

Previous research on quality of life informs us that it is a complex, multidimensional concept that is difficult to define and measure. There is consensus among the literature that increased research is needed to aid our understanding. The aim of this study is to explore the area of social activity and what part it plays in the quality of life of older people from the perspective of the care worker. Care workers who deal with older people as clients on a day to day basis have a unique insight into their daily lives and their perspective is valuable. Care workers are ideally positioned to observe the objective conditions of their clients' quality of life. From this position they can identify what gaps should be filled for better health and social care services in the future. This study hopes to

explore what care workers see as being important to enhancing older people's quality of life. This study hopes to extend on the previous research and in doing so, to add to the current body of knowledge and on quality of life for older people.

The general research question that this study seeks to answer is: How much does social activity and interaction impact on the quality of life of older people living in North Dublin. This enquiry will be taken from the perspective of care workers whose professional occupation involves caring for older people. The purpose of this research is to use thematic analysis to gain an understanding of what is central to quality of life for older people and how much being socially active can play a part in its enhancement.

Methodology

The proportion of older people in Ireland is growing. The demographic change is projected to increase dramatically over the next 40 years (McGill, 2010) and has serious ramifications for the future provision of health care services. This study aims to highlight that being socially active can improve older people's quality of life. The topic was explored from the perspective of care workers who deal with older people living in a community setting in North Dublin. This research was carried out using qualitative methods by way of a data led thematic analysis.

Part of the overall purpose of this study is to examine the themes, meanings and motivations that may emerge when discussing social activity and quality of life among older people. Therefore, a qualitative methodological research design was deemed the most appropriate for this study. This featured the thematic analysis of the data collected from face to face interviews. This thematic analysis approach is best suited to provide the most efficient means of getting rich and detailed information via personal accounts from individuals and their experience with this topic.

Apparatus

The most effective method of gathering the data from the interviews was by use of Dictaphone voice recorders. This recording allowed word for word capture of what was said and meant that the researcher had more than just memory and notes to rely on. Two

Dictaphones were used simultaneously, one as a back up to prevent the loss of data as result of malfunction, battery loss or lack of recording memory or tapes. Once transcribed, the raw data was analysed using Nvivo 9.0 software developed specifically for qualitative data analysis.

Olympus Digital Voice Recorder DS-150

Sony Clear Voice Plus Micro Casette Recorder M-560V

Nvivo 9.0 qualitative analysis software from QSR International

<u>Participants</u>

There were 6 participants used in this study. The participants were selected by contacting organisations that deal with the care of older people living in the community. Relevant organisations were researched on the Internet to get an idea of what they do and then contact was made. Those initially contacted included HSE organisations and staff, as well as private and voluntary organisations. Communication was made via email, telephone and informal contact. Participants were sent an outline of the study with an introduction letter from the college.

Private and voluntary organisations were unable to take part in the study so HSE staff made up the entire sample. It was decided to select staff with different occupations in the care sector, so as to give a more broad range of participant. Of the 6 HSE staff, 2 were Primary Care Social Workers, 2 were Public Health Nurses, 1 was a Clinical Nurse Manager in charge of a day care centre and the final participant was a day care centre co-ordinater. The HSE Primary Care Team for Dublin North East provided 4 participants – 2 social workers and 2 public health nurses. The Primary Pare Team specialises in providing health and social care for people in the community. All staff confirmed before the research began that a large proportion or, in some cases, all of their clients were older people and that they would be happy to take part in any research that may add to the body of knowledge in the research area.

The age range of the participants was well distributed and ranged from mid-twenties to mid-fifties. All participants were female as the health and caring sector is over-represented with female staff. A male perspective may have been of benefit but the results of the research should not be affected by any gender bias as gender was not a focus of the study.

Procedure

The primary source of data for this study was face to face in-depth interviews. The interviews were conducted in March 2011 by one research interviewer and lasted from 45 minutes to 1 hour. Prior to the interview date, the researcher spoke to all participants by phone to briefly outline the research topic and what participation would entail. Before the interview began all participants were again shown a letter of introduction from the college research supervisor. Participants were also presented with a consent form to sign which informed them that the data would be kept strictly confidential. All interviews were conducted at the participant's work place in a private room. The researcher informed participants that the interview could be stopped at any time for a break or if they no longer wished to continue.

Semi-structured interviews were chosen as the interview format. Semi-structured interviews provide greater freedom for both the researcher and the respondent. This fluid format provides flexibility in the phrasing, content and sequence of questioning. For

example, the interviewer may insert a supplementary question or a prompt if the respondent has not provided the information required by the research objectives. The advantage for the respondent of the semi-structured interview is that questions are generally open-ended and allow for greater freedom to articulate their viewpoint (Creswell, 2009) (Denscombe, 2003). The interview questions were based around the dimensions of quality of life that been encountered in the previous literature. All participants were asked the same set of basic 20 questions and additional prompts were used when necessary to revert participants back to the relevant question or to illicit a more detailed answer. Once the interviews had ended, the researcher thanked the participants for their time and contribution.

<u>Data analysis</u>

Upon completion of all 6 interviews the next step was the verbatim transcription of the recorded conversation. This provided the raw data to be analysed. To maintain confidentiality, all names were omitted from the transcription and the participants were assigned names ranging from P1 to P6. The Public Health Nurses were assigned P1 and P2, the social workers were assigned P3 & P4, and finally the day care centre staff were assigned P5 & P6. The transcription process helps illuminate the research and enables the researcher to get and in-depth understanding of the material.

The completed transcript was read and re-read several times to enable the researcher to gain total familiarisation with the data. The data was then further analysed to unearth and code recurring topics that were relevant to the research. These codes were then sorted and grouped into categories and themes. This analysis allowed the researcher to identify the main themes in the material that were of significance to the general research question. The following results section describes the findings.

Results

The participants in this study were care workers who provide health and social care services to older people. They were interviewed in depth regarding the quality of life of their clients and about what sort of role they perceived social activity to play in life quality. The main themes and sub themes listed below emerged from the interviews and these will now be discussed.

Social Interaction

Social Isolation

Health

Access

Family

Community

Individual Needs

Ideas for Improvements

Social Interaction

A major theme that became apparent from the research data was that of Social Interaction. This was really one of the first issues that came to the fore as being important from the perspective of the care workers. The interview participants were keen to stress social interaction as being a major factor in their clients' quality of life.

Basic human contact was felt to be of the utmost importance for older people and that it was a basic need of life.

> "Human contact. That's the number one thing that's important for them and if they have that, you know if they have that they will fall into a more positive frame of mind and gain access to more services you know and they'd be *living* life."

A basic level of human contact was also seen as being important to clients at the day care centres. The care worker here described how many of the older people attending the centres were lacking in this type of contact and how they very much looked forward to getting it.

"When they get out of the taxi, I say hello and give them a hug. And they absolutely *love* that hug, I mean they mightn't get a hug from one end of the week to the other. One lady going home in the evening time would stand there waiting for her hug….it's just contact you know."

As well as this basic level of contact, more in-depth social interaction was seen to be a great bonus for those who attend the day centres. The clients seem to very much enjoy having the centre as an outlet where they can meet others and socialise.

"Talking and contact. Everyone comes in here and they're happy and talking. They love the contact. Social contact, human contact you know they love socialising."

The participants reported that there was a keenly felt need for social interaction among their clients. The older people they work with seem to relish any opportunity to socialise. The chance to get out into the community or to socialise with others in any way came across as being what they want most from day to day life. This need to socialise would be more acutely felt by those older people who had little family support or interaction at home.

"that's mainly what they want, they want company… again it's getting them out of the house, a change of scenery you know."

A participant who works as day care centre coordinator referred to the fact that for one of her clients in particular, the chance to socialise with others was the highlight of her week;

"She'd say…*'this is my day out I look forward to this every single week, I can't wait for the next week'*, so they do look forward to the one day a week, people who haven't got families around them and that."

The day care centres cropped up a lot around the issue of social interaction. The HSE primary care staff interviewed (social workers & public health nurses) indicated that the day care centres provided a crucial element of social interaction for their clients and in some cases it was the only one. Even for older people who are living happily with family, the chance to socialise with peers was something that was very important. Participant 1 described one disabled client who goes to great lengths to attend the day care centre and that she gets great benefit from it;

"Cos I have a lady who's really immobile, she's got MS and basically she can't get out of bed at all, she needs 2 carers, a hoist to do all her personal care, everything you know. But she goes out to (name of day care centre) on a Wednesday and she goes somewhere else on a Thursday and I swear it's absolutely what keeps her going…it's her own thing, it's her own independence"

The day care centres also appeared to be essential sites for people who had no other social outlet. The care workers all described having clients that would have no opportunity for social interaction at all apart from their time at the centres. It was especially of benefit to older people who spent a lot of time alone in their homes. Attending the day centre offered these people a place to regularly meet friends and to spend the day in the company of other people.

"It's a full day being with other people. The dinner is a big thing, it's a good social end of it too. Because an awful lot of them would be eating on their own at home but here there's 5 or 6 around the table so they love that. It's a great social aspect because they're on their own aren't they"

"…a good lot of them live on their own in you know these complexes and they absolutely love coming in, they call it a club rather than a day centre because they're friends are here. They have built up a friendship with people who have come and new people that are coming they build up a friendship as well"

Social Isolation

The staff working in the day care centres reported that some clients had absolutely no social interaction apart from their time in the centre. Many of them would be widows or widowers now living alone after the loss of their partners and perhaps their children had grown up and moved away. These older people could be described as experiencing social isolation.

"…some of them only have their day out to the day centre, that would be their one day a week. When they get out of the taxi they'll say they haven't seen anyone since last week."

"We have some people who are completely on their own, no family, it's very sad and this would be their only outlet."

Social Isolation also became evident as a problem that the social workers were very concerned about. Their older clients were often referred to them in the first place because of social isolation. The social workers looked at isolation as having a negative impact on their clients in terms of mood, outlook and mental health. They also perceived social isolation as damaging to their clients overall health and quality of life. It was a concern that they actively sought to address in their work so as to improve the situation of their clients.

"For my older clients, isolation is a big issue. If that can be addressed, generally, across the board their quality of life will improve. Isolation is one big, big, big issue, if that can be improved, their quality of life will certainly be improved"

Health

The subject of social isolation also brought the theme of health into play, especially mental health. Again the social workers found that their clients could be in a depressed or negative frame of mind as a result of their isolation. This negative outlook also had the knock on effect of making their clients reluctant to become active in improving their quality of life. Social isolation created a downward spiral that could prove difficult to break and it often impeded their attempts to help the person in difficulty.

"It's more their actual mental health that's often the difficulty because they're so isolated. And they're very much lacking in motivation then to do much with their lives and there's no one to kind of motivate them to do that"

"Depression. If you're depressed you don't want to leave the house even though it's a dual…it's kind of a benefit to go. So it can be a barrier you know to participation."

The participants generally perceived that health played a major role the quality of their clients' lives. Older age often means that clients have health problems that make them less mobile and able to get around. This could mean that they would have to get home help for assistance with the tasks of day to day life. It also meant that some clients were completely housebound. They would be unable to attend day centres or interact in their own community. However there was the perception that some older people felt their health problems were part and parcel of being older. Many clients with health problems still enjoyed a good quality of life and it's possible that a positive outlook helped them to do this.

Access

A major theme that came to light in the data analysis was that of access. This was mentioned by all participants in reference to transport and also regarding barriers to gaining access to community services.

Transport, however, was the main focus in theme of access. The care workers felt that the lack of decent transport options to cater for older people severely impacted on their clients' quality of life. Their clients were living at home and in the main were happy

with this but they often had to rely on others to carry out basic everyday tasks. Ordinary things like shopping and errands, going to day care centres or a GP visit could be made impossible if there was no bus route or family member to drive them. Many of their clients no longer drove themselves anymore so they were not really able to get out and about unless they had help. This had a negative impact on their sense of independence and severely restricted them in their daily lives.

"…if a person is maybe dependent on transport, or depending how mobile a client was I mean that makes it very difficult to go to these things even though they'd love to"

"if family don't have transport to bring them often there's none available. "

Lack of transport was also seen as one of the main obstacles to a fulfilling social life for older people. It was clear from the participants that there was often the situation where an older person would be trying to lead a more active and independent life, to be regularly involved in the community and parish centres but they were prevented from doing so because the transport just wasn't available.

"…they can go to bingo, they can go to church and they can go shopping, Legion of Mary maybe, bridge club. But you have to get out to those things or they only happen whenever, you have to have someone to get you in and out"

Some participants felt that the services available were not being taken up by the people who would benefit most from them due to poor transport. For example, one participant spoke of a community social group that was set up and was targeted at isolated and lonely older people. This group was an ongoing success and it greatly improved the social life of those who attended. The problem was that some of the most lonely people were so isolated because they had no transport and could not attend the group even though they very much wanted to. The centre was used by many people who already benefited from a healthy social life. Poor transport service reduced the impact that such community initiatives could make.

"I don't know how we can make it better in the community other than to have better transport so if you're going to open a club to have some sort of minibus that can go around and collect everyone. It has to be - otherwise you're only helping the fit, well off people who can go down to the shops anyway that's why you'll find that you get the same group that go to absolutely everything, because they're able and then you look at the ones who actually don't get out of the house at all"

Inadequate transport was seen by both social workers and day care workers alike as a source of frustration. It meant they often could not provide a service to someone who needed it. For instance where some intervention was needed to lessen the effects of social isolation or depression on an older person, this could be hindered by access being

impossible. The social worker could set the person up with a place in a day care centre but they might not be able to physically get there despite wanting to. Feelings of subjective social isolation could be exacerbated by this type of situation.

"Unless we can get someone out of the house it's very hard to cheer someone up who has been looking at the same 4 walls 24/7, it's getting someone in and out of the house. Accessibility in and out of things is the main reason I can't do things I'd like to do. Yeah transport is a huge barrier."

The cost of transport was also seen by the participants to be a prohibitive factor to older people's quality of life. Due to lack of affordable local buses or inadequate bus routes, older people would have to rely on taxis. The bus would be the preferred option as it's a free service for over 65's but many of the older clients could not manage the walk to a bus stop that was far away or the route the bus took through their locality was not near their house. For those who are not well off and just relying on their pension, taxis are an expense they can ill afford.

"So it impacts greatly on their quality of life, especially around transport if they want to get taxis. Like some of them there mightn't be near a local bus service and they'd have to pay for a taxi to go the GP so they may go to the GP less than they should because they've to pay for taxis and things because they're isolated"

Another aspect on the subject of access that came to light was the lack of resources available to older people. While participants felt the available services were good and effective, there was simply not enough to meet the demand in the community. For example, the capacity of the day care centres was too low. The centres were constantly full and there were long waiting list to get a place. Consequently, people in dire need of access to such a service were being lost in the gaps in the system. Even in the case of older people lucky enough to have a place in a day centre, the participants strongly emphasised how one day a week of being socially active was simply not enough to meet their needs. The participants were concerned about the impact this lack of access had to the quality of life of their clients.

"Apart from like the people that really enjoy the day centres. I mean that is they'd love to go to the day centres a couple of days a week but they can only fit them in one day a week. This is such a huge area that they just don't have room for, which is an awful pity"

"They'd definitely go, yeah at least 2-3 times a week. It used to be that some people could go 2 times a week but now it's just so difficult to even get a day and you could be waiting months to even get a day"

<u>Family</u>

What was found in respect of the issue of family was that it played an enormous role in the quality of older people's lives. All of the participants called attention to the benefits of having a strong family network to support their older clients. This was mentioned in reference to subjective elements of life such meeting the social interaction needs of people and feelings belonging. Family support also helped to meet the objective life needs of older people by providing practical help in their day to day lives. A good family network meant that older people were being well looked after and their emotional needs were also satisfied. Older people with no family support would be a concern for the care workers. They were in danger of social isolation and its negative effects and also they would be seen to be struggling to get by in terms of everyday life tasks.

"…having a good family network you know that they can rely on and it's good having grandchildren and that. If they have good support from family and so on. Yeah I think they are all contributory factors to having a good quality of life."

"family support goes a long way in life. You know in terms of enhancing the service, I mean the quality of care that we deliver in terms of when we're not there…I mean family support helps…and there's nothing as good as having your own family with you"

A number of participants also felt that those without family support were basically on their own. The nursing staff mentioned the very old perhaps living on their own with no children and perhaps their husband of wife had previously passed away. These older people may have no relationships or interaction with anyone outside of the services they were receiving from the HSE or voluntary groups. This was seen as greatly diminishing the quality of their lives.

"It's huge. Like if you've got a good family support, you've got a good family network it makes a huge difference to the client. Em I suppose, elderly people get lonely and if they don't have family coming and helping and checking in, you know they might have home help and so on but if they don't have family there, they get down you know and I mean eh it's crucial like that family play a part"

<u>Community</u>

Following on from the subject of family is that of community. The participants viewed the community as being an important aspect of their clients' lives. It was discussed as being of great importance in terms of social interaction and also a major element of quality of life. A good community spirit meant that even the older person living on their own with no family would have social contact and relationships with the people living around them whom they had known for years.

"I do think older areas like maybe this area within (name of suburb), there's a lot of generations within these roads, and they've lived here and they're still living here, their daughters and their families are still living here and it's a real sense of community around here. Whereas I don't think in some areas it's quite as good."

"Some people have good neighbourhoods and they're close to their neighbours. They call in to them and you know, they give assistance to one another and that is so important in their life."

Several participants referred to the enormous social changes that have taken place in Ireland recent decades. The property boom resulted in badly planned new housing estates sprouting up and that there was often little sense of community here. A mix of new people and unfamiliar nationalities combined with poor infrastructure led to a

perception that community spirit had been somewhat eroded during the Celtic Tiger years. Older people who ended up in the newer estates for whatever reason were seen to be suffering as a result of this loss of community.

"I think what the problem is with the change in society you often have an older person who is living being quite isolated surrounded by new people who've moved in, who don't know their neighbours, so they've lost community."

"they are used to living in a community type setting where they know all their neighbours, whereas here it's a very transient type of community so people are in and out all of the time so they don't know anyone, don't really trust people in the area and there's no infrastructure."

Individual Needs

Another theme that arose from the interview data was that of the individual needs of older people. A number of participants felt that some of the services on offer were too generic and did not take into account the particular needs of older people. In the case of the day care centres it would be as a result of providing a service to a group of people, so meeting distinctive personal needs was a difficulty.

"I mean a lot of the clients we would encourage to go to like a day centre, there's 2 or 3 day centres just within this area, now some people absolutely love it and you mention it to other people and they're like 'Oh no, no way'…"

While the clients who attended day centres were very happy to do so, there were many people for whom these centres had no appeal. This would certainly be the case for people who were at the younger end of the "older age" spectrum even though they were isolated and in need of a social outlet. They would feel that they were too young to be involved in a day care centre.

"I'd suggest the day care centre for meeting people but *'No No they're all very old there'* that's what he said to me so his perception's there that he's a spring chicken you know that he's not one of them"

"Some people don't like the idea of a day centre because it's either a nursing home or has a nursing home feel about it"

Both of the social workers lamented the lack of recognition of people's individual needs. They felt that there was a gap between retirement and very old age where people were left with little resources and services. These people were very prone to isolation and there was often no appropriate service on offer to suit them.

"I have one retired lady but there seems to be nothing to cater for her. She'd like to do a lot more with people like herself and I know there are people like her out there. I've been racking my brains for people like her you know she's willing to join to a group but there's nothing. She is lonely and getting depressed as a result"

The lack of services to suit a variety of needs was considered to be an aspect of service provision in need of drastic improvement. The current state of things meant that people were being pigeon holed into categories that weren't appropriate to their circumstances. There was a feeling among participants that the services provided to older people took a very simplistic view of their needs. There seemed to be no recognition of older people as a mixed group with varied priorities and requirements. This is apparent in what another social worker stated;

"having to all enjoy the same activities because everybody is equal and individual and I think that if there was a service that could actually you know get to know the needs of the individual and find, find those, find what their needs are within the community rather than having to fit them into what's there already"

<u>Ideas for Improvements</u>

In the course of the interviews, areas where improvements could be made were outlined. The participants felt they were in a position to recognise where the conditions of older people's lives could be improved. The most basic area of society that was viewed as needing improvement was in community and neighbourhood involvement. The participants' clients were all living in a community setting but they could often be forgotten about and overlooked by the other people living in their neighbourhood. It was felt that society in general should be more attentive to the needs of the older people who live in our midst.

"I think what's missing is a social awareness of the older person in our community and that that would be something that we need to regain in our areas."

The idea of voluntary neighbourhood schemes was seen as something that would make a huge difference to older people in terms of social interaction and life quality. The care workers perceived that their clients put greater value on interaction with volunteers and everyday people because they were not being paid, it was something they wanted to do. Voluntary groups were mentioned as being potentially able to fill gaps where state and private agencies were either inadequate or entirely absent.

"I think what's missing in a lot of ways are kind of neighbourly people popping in and out like for a chat, who aren't there to be paid but are there on a voluntary basis. And I think we've lost that voluntary sector in our society"

"I think volunteers, if they could have transport and maybe be able to actually bring people out and live a normal…like go and have a coffee, do what other people are doing, not associate things with day centres. A lot of people just want to live like the way other people do"

Again the topic of better access to facilities and services in the community was emphasised. All participants felt that there was a severe lack of options for older people living in the community. This was especially true for older people who had mobility problems and could not attend or get a place in day care centres. These people however would benefit greatly from a less formal set up in the community.

"More clubs then I suppose. Things that would be easier accessible that you could just drop in and you might not have to go every week. Like a little kind of community centre that you could just drop into for a cup of tea"

The participants from each occupation did point out that the improvements they would like to see were quite unlikely to happen due to the current economic difficulties the state is in. Several participants voiced a hope that the charities and voluntary groups involved with older people would get more funding in future. They saw these

organisations as providing essential accompaniment to their own HSE services. Without the voluntary sector filling the gap, the quality of life for their clients could be a lot worse.

Discussion

It is common knowledge that Ireland is an ageing society and this trend is set continue more rapidly in the future. The resulting demographic change will have major implications for the provision of health and social care services to an ever larger proportion of older people.

Quality of life has been linked to affecting the general health and well being of older people. This study sought to focus on older people who were already in receipt of community care services and this was done by exploring the subject from the perspective of the care worker. Professionals employed in caring services for older people are well placed to inform on what can enhance the quality of their clients' lives. This qualitative thematic analysis aimed to investigate the area of social activity and how it could have a bearing on older people's quality of life from the care worker's perspective.

Several themes and related sub themes emerged from the interview data. Social Interaction was the first issue that came into focus as a being very significant factor in older people's quality of life. Care workers reported social interaction as being a basic requirement of life and something that was imperative for their clients. This finding has parallels with previous literature which showed that social relationships featured heavily as a dimension of older people's quality of life (Gabriel & Bowling, 2004) (Bowling, 2008).

Social Isolation presented itself as a theme of the research. Care workers described how this was quite prevalent among their clients who lived in a community setting. The care workers were concerned with the damaging effects to health and life quality that the experience of social isolation could bring about. Particular mention was made to mental health. Previous literature has already highlighted the link between social isolation and health (Yorke & Waite, 2007) (Golden et al, 2009).

The theme of Access was another major topic that was underscored in the research findings. This was manifested both in terms of poor infrastructure, and also the inadequate resources and services that were available to older people living in the community. Poor infrastructure was found to be an impediment to independence – which has been described as crucial dimension of quality of life for older people (Gabriel & Bowling, 2004). Insufficient resources such as; low capacity in day care centres and a scarcity of community groups were outlined by the care workers as inhibiting the social outlets available to their clients. Poor levels of access were blamed for impairing the social lives of older people and this resulted in diminished quality of life.

Family and Community also emerged from the research as areas that were central to the social activity and quality of life for older people. Having good family support and a sense of belonging to a community was seen by the participants as a key aspect of having a good quality of life. It was noted that where family and community links were lacking, people were starved of social interaction and this in turn could lead to social isolation. The importance of being part of a social network was highlighted in the

previous research by York & Waite (2007) and also by Treacy, Butler, Byrne, Drennan, Fealy, Frazer & Irving (2004).

The area of Individual Needs of older people came across from the research data. Day care centres had limited resources to cater to individual needs and were also aimed at quite elderly people. Care workers found that many of their more able bodied clients complained of having little social resources and this impacted on their quality of life. Participants bemoaned the fact that an over simplistic view of older people's needs had lead to people at the younger end of the 'elderly spectrum' being overlooked in the provision of social outlets. This finding was somewhat at odds with Bowling who found that more frail elderly were the ones being overlooked (2004).

Ideas for Improvements was a final theme that emerged. Care workers identified community awareness of older people as an area where there was room for improvement. Voluntary community and neighbourhood groups were seen as something that should be emphasised as they can provide vital social outlets for older people.

This research has helped to illuminate how social activity and interaction are important factors of older people's quality of life. Care workers dealing with older people everyday indicated that a satisfying social life can be of great benefit to older people and their life quality. Attention was also drawn to the fact that a lack of social activity can be damaging to health and quality of life. The study identified the need for more social facilities and poor access to the existing ones as issues that should be addressed.

There were some limitations to the research. The first being that only care workers employed by the HSE were interviewed. Because many welfare services for older people are provided by voluntary and private organisations, it would have been beneficial to include the viewpoint from these sectors also. The research was conducted on a small scale and as a result was quite narrow in scope. The study focused one area of Dublin and therefore the issues that came to light were representative of this geographical area only. The perspective of care workers is valuable and the research was of their point of view. This position does not take into account the direct perspective of the older people themselves and this was also a limitation.

Future research into this area would very much benefit from conducting enquiries directly with older people. Collecting information first hand might help to give a more complete picture of quality of life of older people and how social activity plays a part in it. The input of voluntary and private company care workers may also prove of value. Future research could also be larger in scale and geographical scope to gain a greater representation of older people's circumstances and needs.

While social interaction proved significant to older people, other dimensions of quality of life could also be explored in the future. The area of voluntary community and neighbourhood groups was mentioned as an area where improvement could be made so a more in depth investigation here may be useful. More research on older people's quality

of life is needed to help in the development of a conceptual model. A greater understanding of the concept will help in developing ways to enhance it.

This research has helped to demonstrate how social interaction is central to older people's quality of life. The themes that emerged from the data have highlighted other aspects that can influence the life quality of older people living in the community. The research has added to the body of knowledge regarding the concept of quality of life of older people.

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Appendix

Interview Schedule

REC & SOCIAL ACTIVITIES AND THEIR EFFECT ON QUALITY OF LIFE FOR OLDER PEOPLE FROM CARE WORKERS' PERSPECTIVE

Opening Questions

1. What is your role in the primary care team?

2. Would a great deal of your time be spent with older people?

3. Are much of your team's overall resources and time spent working with older people?

4. How would you be put in contact with them? Refferals?

5. What would be the most common problems, why would they need your help?
   Prompts:
   - range of health conditions, problems with mobility?

Relationship between care worker and older persons

6. Your time spent with older people – is this mostly in visits to their home or would it be in residential care setting?

7. How do older people you work with receive you?

   Prompts:
   - Do they see your visits as encroaching on their independence?
   - Or see it as positively contributing to their QoL in assisting them to live at home etc?

Family Circumstances

8. How much does family support play a role in their quality of life?

Prompts:
 - Would they spend much time/majority of time alone?
 - Any social network other than family?

Financial situation

9. How would you describe their financial situation – dependent or financially secure?

Prompts:
How does this impact on their Quality of Life?
Any difference in the more financially secure clients – do they seem happy or less happy compared to less well off?

Day to day life

10. How dependent on others are your clients, in order to remain living at home?

Prompts:
Does being dependent affect their Quality of life, self esteem, being a burden,feeling helpless, etc.
-A source of depression?
-Loneliness?

Recreation and Social Activities

11. Social activities and the opportunity to engage in them, how much do you think this is a priority for your clients?

12. Of those who are relatively active - what sort of activities do they engage in?

Prompts:
Members of social clubs, formal groups with regular, organised activity?
Day care centres? – what sort of activities would be available there?
Or would many of them just have hobbies?

13. Of those that are quite inactive / immobile – how often would they socialise, get visitors etc.

Prompt:
What do housebound do for fun enjoyment? -What do they do to keep occupied?

14. Are there any activities/programs you're aware of that are having a positive effect for people?

Prompts:
 What do they really enjoy?
  Why? - any social aspect?

15. What do you perceive to be barriers to participation for older people?

Prompt:
Do you feel that lack of transport is a barrier to social acitivities?
Would you say that your clients are satisfied with their access to activities?

Environment

16. How happy would you say your clients are with the place in which they live?

Prompts:
Is it a pleasant place to live, a nice environment?
How safe would they feel in their own neighbourhood?
Would they be fearful of crime, burglaries, etc?

Round Up

17. From your perspective would your clients report a good level of quality of life?

Prompt:
Do women or men seem to have better quality of life?

18. What in your opinion is especially important for your clients' QoL?

19. What could be done – anything you'd like to see introduced?

20. Anything you feel I have left out that you would like to highlight?

Thanks very much for your time and help, etc.

Consent Form

To Whom It May Concern:

This research study is to be used for educational purposes only. All interviews will be safe-guarded by the researcher and will be correctly disposed of after use.

All participants will be given complete confidentiality and their place of work will also remain unnamed in this study.

If you are satisfied with all confidentiality issues, please sign and date.

Signed: _____

Date: _____