Exploring the meaning of quality of life for assisted living residents: A photo-elicitation study

# Abstract

Assisted living is a popular alternative to residential care, promoting independence and enabling self-care through a supportive living environment. Practitioner understanding of quality of life (QoL) experiences are vital to facilitate good physical and mental health in assisted living. An idiographic case study approach explored resident experiences by combining photo-elicitation and interpretive phenomenological analysis. QoL was understood through three themes: facilitation of identity coherence and transition, the essential nature of socialising, and perceptions of a supportive environment. Assisted living has the potential to act as a bearer for cues of identity continuity with nostalgic devices facilitating environment transition and limiting biographical disruption. Furthermore, opportunities for social contact offer a protective function for residents adapting to negative life challenges such as bereavement. To foster health and QoL in withdrawn residents’ facilities should develop peer support programmes with benefits for both mentor and mentee.

**Key Words:** Ageing; Assisted Living; Phenomenology; Qualitative Research; Quality-of-Life

Exploring the meaning of quality of life for assisted living residents: A photo-elicitation study

With increasing worldwide life-expectancy (1,2), and limited improvements in later-life health (3), demands are being placed on health services. One key target of the European Commission’s Active and Healthy Ageing Innovation Partnership is to achieve a two year increase in healthy life expectancy by 2020 (4) and therefore ways to enable this need to be identified. Quality of life (QoL) is a key predictor of health and mortality in later-life (5) and must be understood and facilitated in order to meet this goal.

A key contributor to QoL is housing, with older adults at greater risk than any other age group of living in poor housing lacking in facilities (6). Assisted living is the fastest growing form of housing care for older adults, aiming to maximise function and QoL within a home-like atmosphere, while avoiding the appearance of an institution or medical facility (7). Residential design and services vary but can include domiciliary care, health and social support, and social activities (8). Transition to assisted living has been linked to significant improvements in physical and mental health including: depression, perceived health and cognitive functioning (9), a reduction in falls when compared to community controls (10) and improved QoL (11).

A concrete definition of QoL is challenging, however the majority of definitions agree that the concept incorporates aspects of physical, material, social and emotional well-being which can impact health outcomes (12). Essential policy requirements for well-being in older adults include supporting resilience, independence, having a role, income, health, citizenship, intelligence and mainstreaming older persons’ issues (13). Mitchell and Kemp’s (11) study of residents within an assisted living facility reported social climate to be the biggest contributor to life satisfaction and depression, arguing that these factors are indicative of QoL. However, while the use of existing definitions and quantitative measures of QoL can provide an overview of issues within assisted living populations there are a number of limitations to this approach.

Measures of QoL in older adults are typically developed for particular subgroups or age-associated illnesses (6,7,8) and definitions have been restricted by pre-determined assessment tools targeting function and underplaying the importance of psychosocial factors, such as life context and individual preference (15). A recent review of QoL measures used in care home settings (16) reported that while thirteen instruments had been employed, only three considered psychological, social and physical wellbeing. Critically, people may value different aspects of their life to different extents and these values may change with age (17,18). Traditional tools fail to capture this subjective experience and meaningful assessments must take into account the individual to whom it is being applied (19) in order to enhance understanding of the potential for positive evaluations of QoL in spite of ill health or disability (20).

Interpretive Phenomenological Analysis (IPA) is a well-suited strategy for this endeavour, as it focuses on how individuals make sense of particular phenomena (21). IPA begins with general areas of interest rather than specific hypothesis (22) ensuring understandings of QoL are grounded in issues important to the participants themselves (23). Qualitative work of this type can inform practice and create an evidence base for service development (24) and has been used to explore assisted living, health and QoL in previous research.

Shaw et al (25) employed IPA to examine older adults’ experiences of transition to an assisted living environment against an existential-phenomenological theory of wellbeing, highlighting that an authentic later-life was possible, but required emotional and social support to live through transitions and challenges of becoming aged. Similarly, Minney, Hons and Ranzijn’s (26) IPA study reported that participants in residential care’s perception of a good life was centred on the service provider’s ability to enhance physical, social and psychological well-being, while allowing a maintained sense of identity.

Past IPA work has employed semi-structured interviews to collect data. While this approach allows more flexibility than self-report questionnaires, there is an inevitable power imbalance in the researcher-researched relationship with researchers setting the agenda for discussion (27). The need to understand individuals’ meaning-making processes is vital as experience is situated in personal and social relationships and the physical world (28). From this standpoint, a more participant-driven approach is desirable to facilitate participant-led understandings of QoL. The use of photography as a research tool to explore the lives of older adults represents an effective approach for meeting this goal (29).

Photo-elicitation (30,31) allows participants to take control of the research agenda through the collection of photographs reflecting real-life experiences to be used as prompts for discussion during research interviews (31). Encouraging participants to take and select photographs for discussion regarding research topics, rather than using researcher-defined questionnaires or interview schedules, empowers older adults to share what is meaningful and important to them and provides a creative ‘lens’ through which feelings, emotions, and life challenges can be illustrated (29). Photography within research interviews elicits greater meaning than using simple verbal transactions (30), and helps to tap into latent memory to stimulate and produce emotional statements (31). Crucially, when used in combination with IPA photo-elicitation has been shown to be an effective tool for collating detailed, reflective participant-led accounts of QoL (32).

The aim of this study was therefore to explore individuals day-to-day experiences of QoL within an assisted living environment through the combined methodology of photo-elicitation (30,31) and interpretative phenomenological analysis (IPA) (33).

# Methods

## Design

A qualitative design was employed. IPA (33) was used, combining in-depth individual interviews with photo-elicitation techniques (30,31).

## Participants

The assisted living facility was based in a residential area of a city in the West Midlands of the United Kingdom. It comprised of 112 apartments with 87 rented and 25 leasehold, making it one of the larger schemes in the area. The apartments were situated in two buildings with a range of communal areas. A 24-hour care support team was based on–site offering services to people with care needs and providing an emergency response service if required. Regular care was provided based on a care assessment carried out by the local council’s adult social care team.

In line with the recommendation that four to ten participants is an appropriate sample size for IPA (33), seven adults were recruited through advertisements in newsletters, posters, a recruitment stall and word-of-mouth. Participants self-selected by volunteering for the research and were white British, English-speaking and aged between 64-82 years (Participant characteristics are detailed in table 1). Participants needing external support with decision-making or unable to carry out most day-to-day activities without assistance were excluded from the study.

\*\*\*INSERT TABLE 1 ABOUT HERE\*\*\*

## Procedure

During a sign-up meeting informed consent and descriptive characteristics were obtained. Participants were asked to spend two weeks collecting photographs of things they perceived to impact on their QoL and select six photographs they felt significantly represented their experiences. This replicates the method used in previous research (32). The provision of cameras and training was available for participants but was not required as participants chose to use their own cameras or camera phones.

Semi-structured photo-elicitation interviews were conducted with individual participants in their apartments or a private meeting room at the facility. An interview schedule prompt sheet was employed as a guide. Interviews began by exploring generic perceptions of QoL and experiences (*‘if I asked you what a good quality of life meant to you, how would you describe it?’, ‘what factors in your life do you think contribute to or hinder your QoL’, ‘Do you think the type of care you receive at an extra-care facility helps or stops you from achieving a good QoL?’* ). The participant and interviewer then looked at the photographs together and participants chose the order in which the photographs should be discussed. Sequential photograph discussion then took place using prompt questions from the interview schedule (*‘tell me why you chose this picture?’ ‘in terms of your quality of life, what do you think this photograph represents?’, ‘how did you feel taking the photograph/looking back at it now?’, ‘What makes this photograph important?’*). During the discussions the interviewer asked all of the questions on the interview schedule, however this was used flexibly and responsive active listening techniques (e.g. nodding, vocalising, asking questions such as *‘can you tell me more about that’*?) were employed to probe for additional detail. Audio-recorded interviews lasted between 45-60 minutes and were transcribed verbatim.

## Analytic Strategy

Interpretative Phenomenological Analysis (IPA) was conducted in an iterative and inductive cycle (33). Findings in IPA represent a double hermeneutic in which the themes developed are the analysts interpretation of the participants interpretations of their experiences and the approach is therefore subjective by nature (33). However, the use of a clear step-by-step analysis process facilitates researchers to ensure that themes are grounded in the accounts of their participants.

The step-by-step analysis process was conducted by the first author. In line with guidance for the conduct of IPA (33), an idiographic case-study approach was used, attending to each participant in turn. The first transcript was read by the first author for familiarisation and line-by-line coding was used to identify descriptive (things which matter in the participants lifeworld including events, objects and experiences), linguistic (e.g. pronoun use, pauses, laughter, repetition, fluency, tone, metaphor use), and conceptual (researcher interrogation, questioning and reflection on the data) features (33).

Following this, initial coding was developed into emergent themes using key words from the first reading of the text. These emergent themes were then clustered to develop a master theme list. Clustering was achieved by searching for connections by employing abstraction (putting like with like), subsumption (absorbing one theme into another), polarisation (examining oppositional relationships), contextualisation (looking at temporal, cultural or narrative features of the account), and function (the impact of how the participant is positioned by their account) (33).

The remaining cases were attended to using the pre-existing master list of themes to identify more instances within the new cases, while also identifying new themes and adding to the master list. Finally, a table containing all themes and supporting data extracts was compiled to facilitate comparison across cases and the production of the final superordinate themes. This theme table was employed by both authors to produce the narrative account of the results presented in this paper.

Consistent with Yardley’s recommendations for quality in qualitative research (34) theme development was discussed during regular meetings between the authors to ensure commitment, rigour, transparency and coherence. These discussions enabled themes to be interrogated to ensure they were grounded in the accounts of the participants, during these meetings theme titles, definitions and content were discussed and amended to ensure they captured the participants experiences. Impact and importance (34) was facilitated through discussion of the findings with the manager of the assisted living facility and production of a research report for the local housing group.

# Findings

Three superordinate themes were yielded: facilitation of identity coherence and transition, the essential nature of socialising, and perceptions of a supportive environment. A list of themes and descriptions of associated photographs can be found in table 2.

\*\*\*INSERT TABLE 2 ABOUT HERE\*\*\*

## Facilitation of identity coherence and transition

Participants discussed how establishing biographically coherent identities enabled them to maintain QoL. This included both continuation of pre-assisted living identity and transitioning into a collective assisted living identity.

### Continuation of pre-assisted living identity

Many photographs triggered a process of reflection on the link between pre-assisted living and present activities. For example, MK discussed her life-long hobby of collecting doll’s houses:

There was this gorgeous dolls house shop, which I fell in love with;[…] every time we went through [town name], we used to stop while I dragged [my husband] into this dolls house shop […] I loved them, you know, really, really loved them[…] [my husband] helped me a lot with it, he was very good, he was, to help me do the outside and help me to decorate it.’

MK’s doll’s houses offered an opportunity for identity continuity, representing a long-standing personal interest and providing opportunities for reminiscence on past experiences with her husband. The transition to assisted living facilitated re-purposing and sharing of this passion with others by hosting ‘open-days’ in her apartment:

everybody who comes they say, “I’ve heard about your doll’s houses can I go and have a look at them?”…So now, I have to have open days and I have to put a sign up and say the doll’s house lights will be on such-a-day. It’s just a lovely thing to do really.

This continuity of identity was perceived as of central importance for maintaining MK’s QoL. Similarly, KH photographed a hand-made flower arrangement and expressed her enjoyment of developing her passion by attending workshops. This hobby resonated with her previous role as a nursery nurse which involved engagement with crafts, as well as her established interest in flowers:

I love flowers, I absolutely love flowers. I’ve always sort of, fiddled about and tried to arrange them, but we’ve had about four [classes] now, or even five, and I’ve been to all of them and I absolutely love it

KH was enthusiastic about how the assisted living environment provided new opportunities to foster interests and to develop new skills. Although not explicitly stated, these activities could compensate for the lost ownership of the ‘beautiful’ garden at her previous home:

It’s nice to just look out on the garden, you know, because we haven’t got a garden and eventually, I want some plants along here [pointing to balcony]

Whilst KH appreciated the ability to observe the communal garden from her apartment, she did not feel ownership of it. Developing a new skill in flower arranging contributed to QoL in a way that compensated for lost opportunities to tend her own garden.

An ability to enact activities central to identity within the assisted living environment facilitated a sense of continuity following transition. However, an ability to live autonomously outside the assisted living environment was also important for some:

PB: A good quality of life to me is being able to do your own thing, but also to join in with others… […] It’s important that you still keep in touch with outside life – that sounds as if we’re inmates! [laughs]

Int: Is this a prison to you? [laughs]

PB: Definitely not! [laughs][…] It makes you realise that there is still life outside it, of the village, and you’re keeping up with it because people are coming in and they’re having a coffee, talking to you. So, it makes it that you realise, well, we’re still in touch.

The ability to continue past activities provided a sense of freedom that may otherwise be lost. PB’s experience of QoL appears as a balance between integration within assisted living and keeping ‘in touch’ with wider society and past life.

### Transition to a collective identity

Parallel to retaining a sense of one’s personal identity, all participants expressed a sense of becoming part of a close-knit community. This collective identity appeared to instil feelings of social belonging and provided a stable foundation to nurture social relationships important for perceptions of good QoL. One representation of collective identity was described by SC when discussing creating a ‘residents association’:

We’ve set one up here…residents associations are full circle, nobody’s higher than anybody, if any decisions have got to be made we all make it. […] It’s worked well, people are coming forward and telling you things and it’s brought more of the residents together

Following discussion of a photo illustrating the value of regular quizzes with friends, SC shared how residents created a committee of equality where collective decisions about facility issues were made. As a founding member and acting ‘secretary’, enabling equal discussion between community members was very important to SC, and appeared to facilitate a sense of community by bringing people together over a joint interest for the community’s shared well-being.

Negative aspects of identifying as a community member were also highlighted. When asked about the barriers to QoL, KH described negative community dynamics:

A little bit of bickering downstairs with some people, some people to be quite honest I don’t know what they want, but they’ll find faults with little things. But I think the secret is to just say, “hello, good morning, how are you?” and you don’t sort of listen, and if you don’t get involved then, on the whole, everybody else is really friendly […] I don’t like confrontation, I don’t like falling out.

KH avoided confrontations by using her ‘secret’ coping mechanism of universal politeness, demonstrating a resilience to the impact of negative behaviours by enacting optimism and evading personal involvement in altercations. However, this example highlighted the potential for other less resilient residents to be impacted by negative social relationships.

Another adverse aspect involved the changing age composition of residents. Newer residents were perceived to be older and frailer due to criteria set by the local council, who part-fund the facility, to take a percentage of residents requiring care packages. AW highlighted several concerns:

it’s changing a little bit […] They’re bringing in a lot more elderly and people who are restricted to their apartments, which unfortunately it isn’t the right place for them because they’re getting no quality of life, but also they can’t come and join in with things downstairs. And as we that are living here are getting older, you really need to be bringing in a younger layer – say 55 to 65 or 60 to 70 rather than 90, you know.

AW proposed that assisted living is inappropriate for older adults who cannot ‘join in’. She identified potential restrictions in the future and saw a need for a ‘younger layer’ to undertake active roles to support those who are ageing but feared there would be no ‘younger layer’ when she became older herself. This perceived imbalance appeared as a threat to the established collective identity and for AW’s future QoL for fear of being unable to ‘join in’ due to lack of resident support.

## The essential nature of socialising

Social participation and engagement

The opportunity to socialise with others infiltrated the accounts, with social events presenting a focus for many of the photographs representing good QoL. In line with the discussion around the threat of an imbalance of older and younger residents, many highlighted the value of intergenerational activities. In response to a photograph of a grandchild KH explained how social activities provided opportunities for intergenerational engagement in addition to mixing with other residents to develop a busy social life:

KH: everybody looks after everybody else’s children as well, you know, you keep an eye on them and you get so much pleasure out of the other grandchildren as you do your own sometimes. Like I say, you’re watching them grow up, so yeah. […]

I: So in terms of your quality of life then what does this picture represent?

KH: Everything

AW collected three photographs representing ‘the social life of the village’, consisting of a movie night poster, quiz poster and the residents at a music event, underlining the heavy influence socialisation had on her QoL experience. AW was often involved in social events including the role of quizmaster and running movie night:

Monday night is film night, that’s one of the things I do, we have a big screen with a projector and I-, people donate films to me or suggest films and then I put the film on every night at 7pm; we all sit and have a bowl of sweeties on the table and it’s a really, really, pleasant evening, you know, people really enjoy it.

AW willingly devoted her time to the organisation of social events and experienced a sense of vicarious gratification by contributing to the community. The magnitude of her appreciation for social opportunities is captured by the stark comparison between her past and present social life, with her current lifestyle reducing monotony and providing more freedom to socialise:

In our old home, we’d just be sitting in every evening…every night would be sitting in front of the television, so now we’ve got at least four nights out and more if we wanted.

New meaningful relationships.

Many participants described how assisted living helped to create and maintain meaningful relationships. MK and JP, both explained how they developed new friendships by taking on a peer mentor role. On discussion of a photograph of the communal garden, JP mentioned a friend who at first was very reluctant to leave his flat but had been supported to become more engaged by JP:

It’s took four years to get him out of his flat and I got him out…I’ve got him to come down and play dominoes […] He was a bit embarrassed because he couldn’t walk. I said, “look at life, there’s always people worse than yourself”, I says, “there’s people here worse than yourself”, I says, “but you’ve got to learn to live with it and to survive”. One day he came up and even one of the main officers asked, “how did you manage that?”, I said “I kept on at him”…you treat him as a person and they come out of their shells.

The surprise reported from staff members suggests achievements like this may hinge on the determined input of resident’s themselves, expending time and effort to empower fellow residents and encourage involvement. In the case of JP, this peer supportive role evoked vicarious enjoyment through the development of a novel relationship and instilled a sense of pride.

Similarly, MK discussed a photograph of her and her friend at Halloween, detailing how by offering her services as a ‘buddy’ to attend events with they became ‘such good mates’:

I didn’t know her at all and I found her downstairs one day and she said, “I don’t do anything-, I don’t come in-“ and I said, “oh, you can come in with me, why don’t you come in-”, so I said “look, I’ll wait for you”- I don’t remember this but she tells me this – I said to her “I’ll wait for you, I’ll sit here and when I go in, you can come in with me to one of the do’s or something”…She always said that it’s me that-, that made her do things, and now she can do anything.

JP and MK’s accounts are suggestive towards peer relationships being a critical source of support to help less confident residents avoid social isolation, whilst simultaneously providing the opportunity to develop long-standing friendships. Assisted living offered the opportunity for a supportive social environment, enabling new relationships to be established and maintained, which may be less available in wider community living. These relationships were an essential resource when coping with common later-life transitions discussed in the following theme.

## Perceptions of a supportive environment

The environment as a protector

The protective role of the environment was present in many accounts, with participants associatingtheir current physical environment with feelings of safety. For PB, the importance of feeling safe was emphasised by her recall of an experience of a potential intruder in her previous home:

Where we lived before we’d had somebody try to knock the door in when we were in, which was very, very scary. So I rung the police, you know…it was worrying, it was worrying, but [husband] just shouted “you don’t live here, you’ve got the wrong house, go home!” [laughs].

Despite moments of laughter in PB’s account, the fear instilled by this experience acted as a reminder of the importance of feeling safe for QoL. PB detailed how her husband had offered an additional layer of protection, however following her husband’s recent death, PB’s reliance on the physical environment for security could be heightened and explain why security measures were so important.

Participants also expressed vulnerability of ageing as motivating the need for additional security. For example, JP explained the inability of defend himself in old age:

*it’s a lot at our age, you know, we can’t defend ourselves […] the security is worth 100%*

While AW compared the assisted living security to living in the community:

When you live in a house and we had all fields behind us, so you were obviously-, as you were getting older, you feel more vulnerable. When you hear about people’s houses being broken into, you get extra locks on your windows and burglar alarms, you know – now we just relax.

The perceived inability to protect themselves triggered increased need for security as an extra line of defence, with the move into assisted living acting as a protective strategy against heightened threats in older age.

An alternate form of protection provided by the physical environment was buffering against social isolation. This was exemplified by KH in her discussion of a photograph depicting her view from her apartment:

Since [husband] died, you may think I’m a bit strange, but I never draw these curtains since he’s died because I don’t feel on my own, because I know that [friend] lives in that flat and [friend] lives in that flat, so I don’t feel that I’m on my own […]it sort of helps that I can see other flats and know that there are other people around me.

KH appeared to link her sensory experience of being surrounded by flats to the feeling of company and emotional support, suggesting the significant role of assisted living design in protecting residents against the threat of social isolation and traumatic loss. Elsewhere in the interview KH explained how the opportunities for social engagement motivated her to keep active at a time when things were difficult:

I think [social activities] gives you something to get up for in the morning, doesn’t it? Because you know, I’ve often thought when I’m feeling really down in myself, if I was on my own I think I wouldn’t bother to get up and get dressed even. It’s awful to feel like that. Because you want to go downstairs, you do, you get up, you make the effort, you get yourself ready and you go out.

She openly expressed her beliefs that without these social opportunities available to her she would live an alternate life experience, an experience embodied in depressive symptomology. The disturbing contrast between her perceived experiences with and without socialisation highlights the powerful, motivating role of social opportunities in retaining a sense of purpose, and distraction from immersive negative thoughts and feelings, acting as a form of psychological protection.

### The environment as a facilitator

For several participants, the physical environment appeared to facilitate the process of coping through common later-life transitions and access to onsite facilities played an important role in reducing burdens. For instance, TD valued the ‘convenience’ provided by the onsite restaurant where she eats seven days a week:

It’s here and we’re here, you don’t have to go to Sainsbury’s and buy your vegetables and bring ‘em back, and prepare them, and cook ‘em…[it’s] magic really isn’t it? Just magic.

TD emphasises the proximity of the onsite facilities and contrasts the convenience to the lengthy process usually involved in meal preparation, highlighting the significant difference the restaurant makes in activities of daily living.

For JP immediate environment was central to his QoL as all his photographs focussed on practical design. Two were taken inside his apartment, which appeared to lessen the burden caused by his current health status:

The flats were basically built for disabled people in mind or elderly people. The set-out is phenomenal to be honest with you, you can walk around here, you’ve got a suite kitchen…it’s so compact but it’s comfortable…years ago my mum used to live in flats and they’d not got nothing like this, you know, if she’d been here now it’d be like Buckingham Palace.

JP perceived the design as tailored to suit his personal needs, easing his ability to function effectively within the ‘compact’ yet ‘comfortable’ setting despite his age and mobility problems. JP also valued staff support, as they worked to build his confidence in areas important to him including learning to read and spell:

The reason I think the world of the place is that there’s someone there to give you help. I said, “I can’t read and write”, so therefore the actual workforce have done wonders for me. I can’t fault ‘em…I’ve learnt a lot in here because I went a reading class in here, a spelling class-,… I can read the buses where they’re going, like reading the weather on tele, I can pick places out, where at one time I couldn’t do that.

Staff appeared to empower JP and encouraged him to achieve things he had never achieved before. This accomplishment could have re-constructed self-perceptions of his own capabilities, which in turn could have been a leading factor into his extremely positive account of his QoL experience; ‘it turned my life around’. Combined with his use of a mobility scooter, the support from staff gave JP a sense of freedom he would not have achieved living in the community:

When I first moved into here, my sister used to take me shopping, but now I don’t need her I can just get on that and go myself…with my reading and writing I was a bit dubious and I went a couple of times with my sister. Once I knew what I wanted-, there was one day she couldn’t make it and I thought, well, I’ll give it a whirl on my own and I went on my own around Iceland and I was dead chuffed. I come out of Iceland and went “YES!”, to achieve something that you’ve never done through your reading and writing aspect, it’s a big lift, a big buzz’.

Not only did assisted living provide opportunities to improve his physical freedom, but also to overcome psychological fears. Through accessibility provided by his scooter and the confidence built through his new-found identity as a free agent, he described the day he was brave enough to shop on his own without reliance on his sister and his experience of a ‘buzzing’ success.

### Access to services

The assisted living environment appeared to provide opportunities for residents to access a variety of services, including domiciliary assistance, gardeners and financial support. The prospect of accessing 24 hour on-site care services was mentioned in several accounts as a vital part of offering a sense of freedom and providing reassurance for the future. PB reported the reassurance on-site care provided for her own sense of well-being:

Now, I chose this because [friend] is, I think she’s now 94-95, and she needs care. And this is an example of the carer bringing her down to join in and that is why I took the carer as well as Molly…when the time comes, I will be able to have the same treatment. If I ever need it, I know I’m gonna be cared for.’

On discussion of a photograph of her friend and carer, PB considered the benefits on-site care brought to her friend’s social involvement, with carers supporting her to get to the communal areas and enabling participation. By observing how care could improve outcomes for other residents, PB reflected on her own expectations of care needs in the future and expressed reassurance of knowing that she will be able to access the same supportive care; enabling her to preserve a sense of social involvement.

Alongside reflecting on how others with more severe care needs were supported by the service, PB went on to discuss her current access to care services:

It’s nice to know that these girls, they’re here. And it’s also, you know, if you have a fall or anything, you’ve got a lifeline in your apartment that you can press and they’ll come see to you…If you’re at home, you could be lying there, you’d had a fall, and you could be lying there…’

Although PB was not reliant on carers in her daily life, she described the reassurance offered by lifeline access in her apartment. This piece of equipment appeared to comfort PB, reassuring her that in a time of need she can alert staff and they will respond quickly as they are ‘here’ on-site. This comfort is starkly contrasted to the perceived consequences of a similar incident outside the facility, with upsetting imagery of someone helpless and alone where the aid response is delayed.

# Discussion

This research has illustrated the QoL experiences of older adults living within an assisted living facility. QoL was experienced within three interconnected themes: facilitation of identity coherence and transition, the essential nature of socialising, and perceptions of a supportive environment. Overall, QoL centred on the assisted living environment optimising opportunities for enhancing personal development, socialisation, protection and service provision, whilst enabling residents to retain a sense of identity and autonomy.

These findings illustrate that biographical and identity continuity are priorities for ensuring wellbeing in older adults transitioning to a new living environment. Facilitation of continuity can help to maintain QoL and provide opportunities for growth through the redirection of interests to activities possible within an assisted living setting. Assisted living therefore facilitated biographical continuity at a time when changes in circumstances could become a form of ‘biographical disruption’ (35). For these participants transition to assisted living appeared to cause minimal disruption to biographical conceptions, suggesting a re-established sense of place attachment after relocation (36). This successful transition could be understood through the concepts of Identity Process Theory (IPT) (37): assimilation (the absorption of new information into the pre-existing identity structure); and accommodation (adjustment of the identity structure to include this new information). If a threat to identity occurs, such as a change in living environment, behavioural or cognitive processes adjust to maintain the individual’s sense of distinctiveness, self-esteem, self-efficacy or continuity (38).

The importance of continuity within assisted living is consistent with previous studies and reflects the importance of maintaining connections to past roles and relationships (26,39). However, these findings extended the role of assisted living as being a bearer for cues of continuity (40). MK exemplified this on retaining ownership of her dollhouses; by fixing memory aids within the physical environment, MK was able to reflect and have a concrete background to compare herself across different times, creating coherence and continuity in her self-conceptions (40). Service providers should consider the impact of enabling residents to retain possessions significant to their self-construal and the importance of nostalgic devices when transitioning into a new environment to support biographical continuity and positive mental health.

The assisted living environment fostered personal growth by providing resources to develop capability and self-worth. These findings offer an alternative explanation to arguments that personal growth and purpose in life decline with age (Ryff and Singer, 2000). This decline reflects a lack of opportunity rather than an intrinsic lack of desire for growth, in line with positive psychological theories that argue for the importance of eudaimonic well-being in old age (42). It is the role of the practitioner in this context to assess the priorities of the patient, the vulnerabilities associated with their health conditions, and provide pathways to moving towards existential goals and possibilities. JP’s account of learning new literacy skills and developing autonomy and independence through supportive relationships with staff is a clear example of this process in practice.

The life-span theory of selective optimisation and compensation (SOC; Baltes and Baltes, 1990) proposes that individuals can successfully adapt to age-related health and environmental changes by using personal strategies: selection, optimisation and compensation. In this manner, individuals’ select life domains most important to them, optimize resources available that facilitate success and compensate for losses in these domains to adapt to change. SOC strategies become increasingly difficult to engage in due to reduced availability of resources in later life, with strategy use postulated to decline around 67 to 70 years of age (41). These findings advocate the potential for assisted living to prolong the availability of external resources as internal resources may deteriorate. For example, KH (76 years) appeared to compensate for the loss of her previously owned garden by participating in flower arranging activities to achieve the equivalent goal of retaining creative ownership. As has been found in other research of this type this was a strategic process only made apparent through reflecting and engaging in conscious meaning-making (45).

In line with the findings of Mitchell and Kemp (11), social climate was important to the participants’ QoL. Meaningful relationships were an important resource within assisted living. Transition prior to partner loss allowed participants to build friendships and ensure a reliable support system was in place before the anticipated loss occurred. This proactive preparation for support may have lowered the impact of bereavement stress on physical and psychological health (46). Social support through meaningful relationships was an important resource for coping with the stress of bereavement, with several participants discussing the benefits of developing a close social network. One participant described how physical environment was a facilitating resource to compensate for her feelings of loneliness following her husband’s death, as she linked the sensory experience of seeing apartments to the feeling of company. Although previous quantitative research found a link between assisted living design and QoL (47) these findings present an interesting avenue for further research as it would be noteworthy to explore how individuals make sense of this environment-emotion connection.

Whilst previous research has highlighted the value of peer support for wellbeing (48), these findings present a potential process of developing meaningful peer mentor relationships and illustrate the vicarious benefits experienced by the mentor as a critical factor in their QoL experience. Participants were not coerced into developing these relationships, but rather driven by intrinsic motivation suggesting an underlying desire to find out more about another individual in order to embody a successful peer mentor and foster a quality peer-mentor relationship. The process advocated a ‘buddy system’, with residents acting as anchoring points offering a sense of security and familiarity for their mentee when braving the unknown. The ‘buddy’ role appeared to involve aspects of practical support to overcome physical barriers and psychological support to overcome cognitive obstructions. Assisted living providers may want to consider ‘buddy system’ processes to engage withdrawn residents and increase their psychological well-being and health.

Socialisation for QoL was prioritised supporting previous research into the psychological well-being of older adults (49). Although socialisation appeared to foster belonging and collective identity, participants did hint at negative community dynamics, such as gossiping and arguments, which could have negative consequences for the experience of QoL. Rates of personal negative experiences were unexpectedly low in our sample in comparison to previous research (25), with participants appearing to place themselves on the outside of negativity looking in and potentially explaining why their experience of QoL was understood in such a positive light. This may reflect sample bias or social desirability to portray oneself as dissociated from such adverse interactions, or it could reveal the role of effective defensive personality traits such as resilience. Further research is needed to explore the role of personality traits in coping with negative community dynamics, as well as research to understand experiences of those who directly experience negative dynamics.

The findings of this research highlight the potential value of delivering lifeworld-led care (50) within assisted living facilities. This supports, and adds to, the work of Shaw et al (25) who advocate for lifeworld-led care at the point of transition to assisted living. This approach goes further than traditional patient-led care models in which the meanings of health, illness, suffering and wellbeing are taken for granted and patients can be conceptualised as ‘consumers’ or ‘citizens’ who should be given ‘more voice’ (51). Rather, throughout a patient’s residency practitioners must acknowledge the freedoms and vulnerabilities of living with health-related conditions and work to facilitate existential horizons and possibilities (for a detailed account of the philosophy underpinning lifeworld-led care see (51)). From a practical perspective, practitioners need to be open to individuals’ lifeworlds, listen to their stories, and gain a complete understanding of their experiences. This approach to understanding resident QoL should be the starting point for individually tailored interventions to improve wellbeing.

In particular, this research has illustrated the value of creative expression for enabling older adults to articulate their QoL experiences. Employing these techniques within care consultations can facilitate better understandings of patient priorities in order to deliver lifeworld-led care interventions. There are well reported therapeutic benefits of the use of participant photography to elicit experiential accounts within a research context (29,52), but while this type of therapeutic photography has been shown to be successful in psychotherapy, it has been rarely used in nursing practice (53). Photography within health care consultations therefore represents a valuable tool for improving patient-practitioner communication and understanding in a variety of settings and has been shown through this research to be an acceptable and feasible tool for older adults.

## Limitations

Limitations of this study include a potential for bias towards individuals experiencing a positive QoL experience due to their voluntary participation. The participants recruited were motivated to share their experience and enjoyed being socially involved, which as a result may have increased reports of a good QoL. Further research must be conducted to access more withdrawn residents and understand their experiences of QoL.

The research approach employed also has limitations, volunteers for the study may have had a particular interest in photography given that they all used their own cameras during the process. This may mean that photo-elicitation is less suited to those for whom photography does not hold the same appeal. In addition, this research only recruited participants with full cognitive capacity and therefore does not represent the experiences of those with restricted cognitive ability. However, the use of photography in research interviews is less reliant on cognitive ability than alternative approaches such as surveys, diaries or questionnaires (54) and therefore represents a valuable avenue for exploring QoL experiences in this group in future research.

## Conclusions

Facilitating QoL is essential for the prevention of poor physical and mental health in later life. Assisted living has potential to act as a proactive coping strategy for foreseen age-related health, social and environmental stressors. A good QoL appeared to be one where assisted living was used as an ‘optimizing strategy’ and a facilitative environment enabled a stable sense of self, social belonging and a feeling of safety. These findings provide insight into the process of potential peer support roles within assisted living, the opportunity for personal growth, and the importance of social opportunities for enhancing health and wellbeing.

# References

1. Christensen K, Doblhammer G, Rau R, Vaupel JW. Ageing populations: the challenges ahead. Lancet [Internet]. 2009;374(9696):1196–208.

2. Kontis V, Bennett JE, Mathers CD, Li G, Foreman K, Ezzati M. Future life expectancy in 35 industrialised countries: projections with a Bayesian model ensemble. Lancet [Internet]. 2017;389(10076):1323–35.

3. Reinhardt U. Does the aging of the population really drive the demand for health care? Health Aff. 2003;22(6):27–39.

4. Lagiewka K. European innovation partnership on active and healthy ageing: triggers of setting the headline target of 2 additional healthy life years at birth at EU average by 2020. Arch public Heal. 2012;70(1):23.

5. Dominick KL, Ahern FM, Gold CH, Heller DA. Relationship of health-related quality of life to health care utilization and mortality among older adults. Aging Clin Exp Res. 2002 Dec;14(6):499–508.

6. Handler S. A Research & Evaluation Framework for Age-friendly Cities A Research & Evaluation Framework for Age-friendly Cities. Manchester; 2014.

7. Resnick B, Mitty E. Assisted living nursing: a manual for management and practice. New York: Spring Publications; US; 2009.

8. Croucher K, Hicks L, Jackson K. Housing with Care for Later Life: A literature review. York: Joseph Rowntree Foundation; 2006.

9. Holland C, Boukouvalas A, Wallis S, Clarkesmith D, Cooke R, Liddell L, et al. Transition from community dwelling to retirement village in older adults: cognitive functioning and psychological health outcomes. Ageing Soc [Internet]. 2017 Aug 26;37(07):1499–526.

10. Kneale D. Establishing the extra in Extra Care. London: International Longevity Centre - UK; 2011.

11. Mitchell JM, Kemp BJ. Quality of life in assisted living homes: a multidimensional analysis. J Gerontol B Psychol Sci Soc Sci. 2000 Mar;55(2):P117-27.

12. Felce D, Perry J. Quality of life: its definition and measurement. Res Dev Disabil. 1995;16(1):51–74.

13. McCormick J, Clifton J, Sachrajda A, Chart M, McDowell E. Getting On: Well-being in later life. London: IPPR; 2009.

14. McKee KJ, Houston DM, Barnes S. Methods for Assessing Quality of Life and Well-Being in Frail Older People. Psychol Health [Internet]. 2002 Jan;17(6):737–51. A

15. Bowling A. Measuring disease. A review of disease-specific quality of life measurement scales. Buckingham: Open University Press; 2001. 390 p.

16. Aspden T, Bradshaw SA, Playford ED, Riazi A. Quality-of-life measures for use within care homes: A systematic review of their measurement properties. Age Ageing. 2014;43(5):596–603.

17. Hendry F, McVittie C. Is Quality of Life a Healthy Concept? Measuring and Understanding Life Experiences of Older People. Qual Health Res [Internet]. 2004 Sep;14(7):961–75.

18. Evans S, Vallelly S. Promoting social well-being in extra care housing. Hous Care Support Putt Good Ideas Into Pract [Internet]. 2007;10(4)(4):14–9.

19. Carr AJ, Higginson IJ. Are quality of life measures patient centred? BMJ. 2001;322(7298):1357–60.

20. Bowling A, Dieppe P. What is successful ageing and who should define it? BMJ. 2005;331(7531):1548–51.

21. Smith JA, Osborn M. Interpretative phenomenological analysis. In: Smith JA, editor. Qualitative Psychology: A Practical Guide to Research Methods. 2nd ed. London: Sage; 2008.

22. Langdridge D. Phenomenological psychology: Theory, research and method. Harlow: Prentice Hall; 2007.

23. Burton AEE, Shaw RLL, Gibson JMM. Living together with age-related macular degeneration: An interpretative phenomenological analysis of sense-making within a dyadic relationship. J Health Psychol [Internet]. 2015;20(10):1285–95.

24. Godfrey M. Qualitative research in age and ageing: enhancing understanding of ageing, health and illness. Age Ageing. 2015;44(5):726–7.

25. Shaw RL, West K, Hagger B, Holland CA. Living well to the end: A phenomenological analysis of life in extra care housing. Int J Qual Stud Health Well-being. 2016;11:1–12.

26. Minney MJ, Ranzijn R. “We Had a Beautiful Home ... But I Think I’m Happier Here”: A Good or Better Life in Residential Aged Care. Gerontologist [Internet]. 2016 Oct;56(5):919–27.

27. Potter J, Hepburn A. Qualitative interviews in psychology : problems and possibilities. Qual Res Psychol. 2005;2(4):281–307.

28. Larkin M, Eatough V, Osborn M. Interpretative phenomenological analysis and embodied, active, situated cognition. Theory Psychol [Internet]. 2011 Jun 11;21(3):318–37.

29. Mysyuk Y, Huisman M. Photovoice method with older persons: A review. Ageing Soc. 2019;(May):1–29.

30. Harper D. Talking about pictures: A case for photo elicitation. Vis Stud. 2002;17(1):13–26.

31. Collier J. Photography in Anthropology: A Report on Two Experiments. Am Anthropol. 1957;59:843–59.

32. Burton A, Hughes M, Dempsey RC. Quality of life research: a case for combining photo-elicitation with interpretative phenomenological analysis. Qual Res Psychol. 2017;14(4).

33. Smith JA, Flowers P, Larkin M. Interpretative Phenomenological Analysis: Theory, Method and Research. London: SAGE Publications; 2009.

34. Yarley L, Yardley L. Dilemmas in qualitative health research. Psychol Health [Internet]. 2000 Mar 19;15(2):215–28.

35. Bury M. Chronic illness as biographical disruption. Sociol Heal Illn [Internet]. 1982;4(2):167–82.

36. Rowles GD, Watkins JF. History, habit, heart and hearth: On making spaces into places. Aging Indep Living Arrange Mobil. 2003;77–96.

37. Breakwell GM. Social representation and social identity. Pap Soc Represent. 1993;2(3):1–20.

38. Breakwell GM. Coping with threatened identities. London: Routledge; 2015.

39. Bowers H, Crosby G, Easterbrook L, Macadam A, Macdonald R, Macfarlane A, et al. Older people’s vision for long-term care. York: Joseph Rowntree Foundation; 2009.

40. Korpela KM. Place-identity as a product of environmental self-regulation. J Environ Psychol [Internet]. 1989 Sep;9(3):241–56.

41. Ryff CD, Singer B. Interpersonal Flourishing: A Positive Health Agenda for the New Millennium. Personal Soc Psychol Rev. 2000;4(1):30–44.

42. Seligman M. Flourish. North Sydney: Australia: William Heinemann; 2011.

43. Baltes PB, Baltes MM. Successful aging: Perspectives from the behavioural sciences. In: Baltes PB, Baltes MM, editors. Cambridge: Cambridge University Press; 1990.

44. Freund AM, Baltes PB. Life-management strategies of selection, optimization, and compensation: measurement by self-report and construct validity. J Pers Soc Psychol. 2002 Apr;82(4):642–62.

45. Eatough V, Smith JA, Shaw R. Women, anger, and aggression: an interpretative phenomenological analysis. J Interpers Violence [Internet]. 2008 Dec 4;23(12):1767–99.

46. Ouwehand C, de Ridder DTD, Bensing JM. A review of successful aging models: Proposing proactive coping as an important additional strategy. Clin Psychol Rev. 2007;27(8):873–84.

47. Orrell A, McKee K, Torrington J, Barnes S, Darton R, Netten A, et al. The relationship between building design and residents’ quality of life in extra care housing schemes. Heal Place. 2013;21:52–64.

48. Biggs S, Bernard M, Kingston P, Nettleton H. Lifestyles of belief: Narrative and culture in a retirement community. Ageing Soc. 2000;20(6):649–72.

49. Huxhold O, Fiori KL, Windsor TD. The dynamic interplay of social network characteristics, subjective well-being, and health: The costs and benefits of socio-emotional selectivity. Psychol Aging [Internet]. 2013 ;28(1):3–16.

50. Galvin K, Todres L. Kinds of well-being: A conceptual framework that provides direction for caring. Int J Qual Stud Health Well-being [Internet]. 2011 Jan 9;6(4):10362.

51. Dahlberg K, Todres L, Galvin K. Lifeworld-led healthcare is more than patient-led care: An existential view of well-being. Med Heal Care Philos. 2009;12(3):265–71.

52. Hughes M, Burton AE, Dempsey RC. ‘I am free in my wheelchair but pain does have a say in it though’: The meaning and experience of quality of life when living with paraplegia and chronic pain. J Health Psychol [Internet]. 2017;135910531775025.

53. Riley RG, Manias E. The uses of photography in clinical nursing practice and research: A literature review. J Adv Nurs. 2004;48(4):397–405.

54. Tishelman C, Lindqvist O, Hajdarevic S, Rasmussen BH, Goliath I. Beyond the visual and verbal: using participant-produced photographs in research on the surroundings for care at the end-of-life. Soc Sci Med. 2016;168:120–9.

Table 1: Case Study Descriptive Characteristics

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pseudonym | Age | Gender | Years in Residency | Health Conditions |
| TD | 82 | Female | 1- 5  | None |
| PB | 73 | Female | > 5  | Osteoarthritis; Angina; Cellulitis |
| KH | 76 | Female | 1- 5  | None |
| MK | 78 | Female | > 5 | None |
| JP | 64 | Male | > 5 | None |
| AW | n/r | Female | 1- 5 | None |
| SC | 64 | Female | 1- 5 | Ischemic heart disease; under-active thyroid; depression; arthritis |

Note: Health conditions were self-reported. n/r = not reported

Table 2: Participant photograph descriptions and associated themes

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Pseudonym** | **TD** | **PB** |  | **KH** |  | **MK** |  |
| Theme | Subtheme | Restaurant facilities | Cake from restaurant | Burns night poster | Music event poster | Exercise class poster | Animals visiting event | **Theme not linked to a photograph** | Friends at ‘horse racing’ event | Live music event | On-site healthcare staff with her friend | Friend in wheelchair | Friends at café | Birthday cake (representing husband) | **Theme not linked to a photograph** | Husband and friends (now bereaved) | Friends on a group outing to the zoo | Visit from grandchildren | View from flat window | Flower arrangement | Grandchild | **Theme not linked to a photograph** | Photographs of grandchildren | Dolls houses | Self with handmade windmill at event | Self and friends at a wildlife event at ECH | Group of friends at ECH | Best new friend made at ECH | **Theme not linked to a photograph** |
| Identity | pre-ECH |  |  |  | x | x |  | x |  | x |  |  |  |  | x |  |  | x | x | x | x |  | x | x |  |  | x |  | x |
| Collective |  |  | x | x |  |  | x | x | x | x |  | x |  | x |  |  | x | x |  | x | x |  |  | x | x |  |  | x |
| Socialising | Participation |  | x | x | x | x | x |  | x | x | x | x | x |  | x |  | x | x |  | x | x | x | x | x | x | x | x | x | x |
| New relationships |  |  |  |  |  |  |  |  |  |  | x |  | x | x | x |  |  | x |  |  |  |  |  |  |  | x | x | x |
| Environment | Protector |  |  |  |  |  |  | x |  |  | x |  |  | x | x | x |  |  | x | x |  | x |  |  |  |  |  |  | x |
| Facilitator | x | x | x | x | x | x |  | x | x | x | x | x | x | x | x | x | x |  | x | x | x | x | x |  | x | x |  | x |
| Services | x |  |  |  | x |  | x |  | x | x | x | x |  | x |  | x |  |  |  |  | x |  |  | x |  |  |  | x |

Table 2 (cont.): Participant photograph descriptions and associated themes

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Pseudonym** | JP |  | AW |  | SC |  |
| Theme | Subtheme | Restaurant facilities | On-site shop | ECH Garden | Mobility scooter | Flat layout/facilities | Flat kitchen facilities | **Theme not linked to a photograph** | Cinema event poster | Quiz event poster | Flat and husband and pet dog | Pet dog | ECH garden | Friends at social event | **Theme not linked to a photograph** | View from flat window | Flower arranging | Grandchild at ‘horse racing’ event | Husband | Quiz event question sheet | Friend washing dishes in kitchen | **Theme not linked to a photograph** |
| Identity | pre-ECH |  |  | x | x |  | x |  |  |  |  | x |  |  |  | x | x |  | x |  |  | x |
| Collective | x | x | x |  |  | x |  | x | x |  |  | x | x | x | x |  | x |  | x | x | x |
| Socialising | Participation |  | x |  |  |  |  | x | x | x |  |  |  | x | x |  | x | x |  | x |  | x |
| New relationships |  |  | x |  |  |  |  |  |  |  |  |  |  |  |  |  | x |  | x | x | x |
| Environment | Protector | x |  |  |  | x |  |  |  |  |  |  |  |  | x |  |  | x |  |  |  |  |
| Facilitator | x | x | x | x | x | x | x | x | x | x | x | x | x | x |  | x | x |  |  | x | x |
| Services | x | x | x | x |  | x | x |  |  |  |  | x |  |  |  | x |  |  |  |  |  |