ORIGINAL ARTICLE

Social inclusion of older adults in care: Is it just a question of providing activities?

TESS KNIGHT & DAVID MELLOR

School of Psychology, Deakin University, Melbourne, Australia

Abstract

We investigated the experiences of older adults in residential care in relation to social activity and inclusion. We also examined the explored phenomenon of resident’s social inclusion from the perspective of those providing care for the residents. Our participants were 25 care providers and 25 residents drawn from five low-level-care residential facilities in metropolitan Melbourne, Australia. We used one-to-one in-depth interviews which were aimed at tapping into themes related to social inclusion. Of special interest to us was residents’ lived experience of social inclusion within the context of their lives in residential care. We found that although participation in activities emerged in our study as being valued and encouraged by care providers, residents were left feeling isolated, compromised, and as though they were not “at home”. We concluded that the difference between caregivers’ understanding and residents’ experiences of social inclusion highlights the need to shift the focus from the provision of activities as an indicator of social inclusion to gaining a deeper understanding of the lived experiences of those in care. We suggest that such a focus would assist in the care of the growing number of older adults who face the transition from their own homes to a residential care facility, and guide us toward a more meaningful understanding of “well-being” in this context.

Key words: Social inclusion, well-being, quality of life, successful ageing

Introduction

With life expectancy in Western society having increased substantially over the past five decades (Hoyert, Kochanek & Murphy, 1999), much attention in gerontology has been turned to positive or successful ageing in an attempt to identify ways of enhancing the quality of life of older adults (e.g. Baltes & Baltes, 1990; Knight & Ricciardelli, 2003; Ryff, 1989; Torres, 1999). However, the dearth of research on successful ageing is limiting our understanding of the construct, particularly in relation to the “oldest-old”, many of whom are in full time care. Without an informed understanding of issues related to the quality of life of these older adults, programs implemented to improve quality of life will be only partially relevant.

It has been argued that quality of life can be broadly considered in two ways (Cummins, 2000). First, measures such as income, housing, and health status can be used to evaluate an individual’s quality of life. Such an approach is useful for the purposes of service and care providers in planning what is nominated to provide the basis for an individual’s well-being. Second, measures of how a person feels about his/her life can be used to understand that individual’s quality of life. The benefits of this approach are numerous and well documented (e.g. Diener, Tamir & Scollon, 2006; Landau & Litwin, 2001; Stathi, Fox & McKenna, 2002). For example, the more a person “feels” satisfied with life and enjoys a sense of well-being, the more likely he/she will be to partake in social activities, develop friendships, explore interests, and enhance his/her quality of life and life expectancy (Barkay & Tabak, 2002; Pitts, Krieger & Nussbaum, 2005). Given older adults’ changing circumstances when they enter an aged-care facility, it is important to understand their experiences in order to get a sense of what it is like to be in their shoes, as such an understanding shifts the focus of care quality from the domains of structure.
and process to the domains of individual needs and quality of life (Lowe, Lucas, Robinson & Crystal, 2004).

Chou, Boldy and Lee (2003) have provided a conceptual framework for understanding the satisfaction of residents in aged care facilities. The framework includes facility factors (size, location, age, and ownership) and resident factors (level of dependency, age, and sex), both of which inform staff factors (staff satisfaction, professional development, care hours/staffing level, and work experience). All three of these factors contribute to resident satisfaction, which is operationalized in terms of,

- their accommodation (room size, storage, etc.);
- the facility (design, accessibility, outdoor areas, etc.);
- social interaction (level of activity, social life, contact with outside world etc.);
- meals (amount of food, temperature of food etc.);
- staff care (staff attitude, respect for privacy, promptness in responding to requests etc.); and
- resident involvement (level of input to decision-making in the facility).

Perhaps the most intangible of the factors in this model is social interaction. Social interaction is a well-known indicator of well-being (Antonucci & Akiyama, 1991; Pitts et al., 2005), yet elderly people in residential care are highly susceptible to social exclusion. Although many residential care facilities have a strong focus on activities, this does not necessarily translate into the social inclusion of residents, especially the frail who are particularly marginalized.

In this study, we investigated the meaning of social inclusion of older adults in one type of Australian aged care facility, hostels. Hostels are typically for those aged people who require low-level care. Residents are usually frail but independent in that, although they may have meals and some housekeeping and other support services provided, they do not require nursing care (Chou et al., 2003).

Our primary aim was to understand the experiences of social inclusion of older adults living in residential care. We also aimed to understand caregivers’ experiences in the provision of socially inclusive activities for residents and their personal experiences of social interaction in the context of their care giving. Exploring the themes that emerge from the dual perspectives of both those who provide care for the residents and the residents themselves, would assist us to understand the relevance of activities that are presumed to facilitate social interaction, and their impact on residents’ experiences of social inclusion or exclusion. By entering into the social world of older adults in hostels, we also aimed to determine some of the reasons that loneliness and isolation are prevalent within a health care system that promotes inclusive practices, and to propose strategies to overcome barriers to socially inclusive activity in the aged care context.

**Methodological approach**

We undertook this research from a broadly phenomenological perspective in order to come to understand the experiences of social inclusion of older adults in low-level-care residential facilities, and the meanings of these experiences, in relation to their well-being. We also sought to gain an understanding of their carers’ views on social inclusion and related themes. Congruent with Monti and Tingen (1999), the ontological and epistemological assumptions underlying our phenomenological approach are that reality is complex, holistic, and context dependent. We chose to focus on human experience to explore satisfaction and well-being, as described earlier. Our approach valued multiple ways of knowing and allowed us to uncover the knowledge embedded in the experience of both residents and carers. We sought to come to an understanding of essential meanings and, following Merleau-Ponty (1962), to describe these meanings, as they exist in their lifeworld. Our method involved empathic contact with participants, and engagement of the researchers in all stages of the research process. Given that such immersion could “blind” researchers to nuances of meaning, we independently analysed the data and negotiated the outcomes. We also presented our findings for discussion with both carers and residents of one of our participating hostels and engaged an independent aged person to verify the themes we drew from the data.

**Participants**

Participants were drawn from four hostels from various suburbs in metropolitan Melbourne, and one in a regional centre, in Australia. These facilities were purposively sampled to represent a range of socio-economic, religious, and cultural backgrounds. Facilities differed in size from 34 to 76 residents, and there was considerable variation in fees, admission criteria, staff-to-resident ratios, activities and amenities available, and in the quality of the physical environment. This variation is typical of the diversity in Australian aged care facilities. Participants totalled 50 in number: 25 care providers (including diversional therapists, personal care workers,
personal care coordinators, nurses, and activities officers) and 25 residents (five from each facility).

Procedure

Approval to conduct this study was obtained from Deakin University Human Research Ethics Committee and the Boards of Management of the participating facilities. Facility managers provided lists of residents and assisted the researchers to exclude those residents considered ineligible for participation in the study due to the following exclusion criteria: moderate or severe cognitive impairment; diagnosis of a mental illness, including dementia; acute illness; inability to communicate in English; age less than 65 years; or the presence of an intellectual disability.

The study was set in each residency. One-to-one in-depth interviews lasting between 30 to 60 minutes were the means of data collection. The interviews took place at a time that was deemed convenient for both the participants and the researchers. The questions were aimed to provide an understanding of the experience of social inclusion and activities which are organized within the establishment. They tapped into level of participation in these activities, encouragement to participate, and participants' perspectives of the value of participation in their specific contexts. Examples of the questions asked included “Tell me about your social life here”, “How important is social activity in your establishment?” and “How satisfied are you with the social activity in your establishment?” The interviews were later transcribed for coding and analysis of the text.

Data analysis

Following the process of interrogating phenomenological data to draw out themes outlined by Colaizzi (1978), we initially read the transcripts to become familiar with them. From each transcript, extracts of text that related to the broader phenomena of social activity, social inclusion and well-being in the context of aged-care were given meanings. These meanings were then organised into clusters of themes and sub-themes for the carers, as summarized in Table I, and for the residents, as summarised in Table II. We engaged with the data again, comparing the themes with the transcripts in order to ensure that our interpretation was true to the participants’ stories, and, as described above checked our themes and interpretations with both groups of participants, and an independent aged person.

Table I. Themes emerging from the analysis: Carers.

| Theme                                                                 |
|----------------------------------------------------------------------|
| Care quality has primacy                                             |
| (a) Activity equates with social inclusion and sense of belonging    |
| Organised activity results in social inclusion                       |
| Ownership of the activities leads to a sense of control and increases interaction |
| Activities can facilitate contact between residents and their families |
| (b) The withdrawn and isolated residents pose a challenge            |
| (c) Filling the void: Beyond the call of duty                        |
| The needs of isolated residents are recognised                      |
| Opportunity to respond is limited                                    |
| (d) Volunteers are important contributors to the social environment  |
| (e) There are barriers to social inclusion                            |
| Resources                                                            |
| Time                                                                |
| Routines                                                             |

Findings

We present our findings by way of extracts of data from interviews with carers followed by extracts of data from interviews with residents. These extracts are indicative of the perspectives of each group that was interviewed. Recognising that the researcher’s interpretations play a part in the analysis of phenomenological data, Wertz (1983) points out the importance of the communication of these interpretations to the reader. Keeping this in mind, we present our comprehensive understanding at the conclusion of our findings.

An overarching theme that emerged as we engaged with the carers’ data was care quality. The carers seemed genuinely concerned for the well-being and happiness of the residents and, although at times constrained by limited budgets and limited time, they constantly looked for, and took the opportunity to do that little bit extra to “make someone’s day”. Evidenced in the discourse of the residents was their gratitude for the good care that they received but just as evident was their sense of loss—loss of control, loss of once-loved activities such as gardening, loss of friendships, and most of all, loss of the feeling of being “at home”.

Table II. Themes emerging from the analysis: Residents.

| Theme                                                                 |
|----------------------------------------------------------------------|
| Life in hostels is “Good enough”, but not the life of choice         |
| Staff and the care provided are appreciated                          |
| 2. Despite the care offered by staff, well-being is impaired by      |
| (a) Loneliness amid company                                          |
| (b) Loss of autonomy, privacy and independence                       |
| (c) Feelings of vulnerability                                        |
| (d) Not feeling at home                                              |
| (e) The need to comply to survive                                    |
There was some variability in the responses of carers, often due to the differences in the facilities in which they worked. For example, in some hostels residents who were cognitively intact were mixed with residents who were suffering from dementia. This limited the nature of activities offered and the freedom of residents to interact with others. In other hostels, these groups were separated, enabling more homogenous groupings to be made.

While some hostels were relatively new and had been designed to enhance the possibilities for interaction between residents to promote inclusion, others lacked space and facilities. The feeling amongst carers in facilities that were more pressed for space was one of forced limitation, of making do with “one’s lot”:

That room down the end is . . . it’s really only a small lounge area. . . . There is nowhere that I could screen a film. We use the bathroom for hairdressing. . . . I would love to have an indoor bowl set up . . . that sort of thing but there is not the space or room for it.

Some hostels seemed to have a culture of socialising, whereby residents enjoyed each others’ company, while in others there was little interaction. For example, in one hostel, the interviewer noticed that at meal times there was no conversation and enquired about this. The response from the caregiver was:

They like it being quiet. If anyone makes too much noise they complain. I don’t know if that is a learned thing because they are living in a place where there is a large number of people. They do their own thing and keep to themselves.

Although the respondent stated that the residents “like it” that way and would otherwise “complain”, the feeling that emerged was one of loneliness and isolation in the company of strangers for the residents. What emerges on the part of the carers is “leaving well-enough alone”, with the justification for this being “they like it that way”.

In another facility, the picture was quite different: “In the house, there is only 12. They know each other, and they sit at the same tables. They really socialize between themselves”. Despite these differences, a number of themes related to social activity emerged from the data, including some commonalities, which are described in the following text.

**Activity equals social inclusion.** The first commonality was the range of activities that were offered in the hostels. Typically, activities such as singing/music, bingo, exercises, quizzes, craft, and outings were run on a regular basis. There was an equating of group activity with social connectivity.

Some things that involve group activity are really important because it gives everybody a chance to communicate and, as you can imagine, not every person gets on with every other person . . . we all have our little idiosyncrasies, but I find that when you do bring people together that they can put aside those issues and just enjoy it as a community.

It was felt that the social nature of these activities and the importance of gaining control through residents “owning” the activities enhanced social interaction.

When they do go out they talk on the bus. In craft there is a lot of chatter and they do talk quite a lot. [It is the] same with the bowls or other functions. . . . Bingo is another one . . . they are very proud because they run it themselves.

Further in this vein, some hostels made efforts to include family and friends in activities and social events, as a means of increasing the level of contact between residents and their loved ones.

Most residents always come to the social events we have here at the lodge. . . . We invite families and friends and all, and I would say . . . we would get most residents to all of those.

Generally, the carers described these organized activities as “popular”. However, the engagement of residents in them was variable, with some choosing to be involved and others not. In-house activities were seen as equitable in their availability, in that it was felt that all those wishing to participate could. Alternatively, involvement in outings was restricted by factors such as the size of the bus available, the physical mobility of the residents, and in some cases the cost of the outing. The experience of some carers was that the forum for social interaction was well provided during such outings, yet from the perspective of others, outings provided an escape:

We do a lot of trips as well, which brings a sense of belonging and social interaction. There are some residents that probably don’t go out as much, and it is an opportunity for them to come out.
I tend to find that that [craft] is more stimulating than just your bus outing, because they can sit in a bus and just look out the window.

The dialogue here seems more to do with what “should” bring a sense of belonging rather than understanding what does.

The challenge of withdrawn and isolated residents. Staff in all hostels were aware that some residents choose not to participate in the available activities. They referred to these people as being “loners” or “withdrawn”, and in some cases “depressed” and felt they could not intervene. “Some people are very isolated because they choose to be. We can’t do anything”. Others were isolated because they had no family or their family did not maintain regular contact and for these, carers felt they could fill the void, to some extent. “There are some that haven’t got family and they need our support”.

Filling the void: Beyond the call of duty. In this void, and with perceptions that more activities were required, the carers saw providing social contact to be their duty. They reported making conscious efforts to engage with those residents perceived to be isolated and viewed this as an important (implicit) part of the job from which they also derived satisfaction:

There is one lady who doesn’t do anything with us … but every morning staff go there and talk to her for 10 or 15 minutes … everybody likes her, so for the staff it is easy to go and talk to her. I go and I do her nails, and she loves it.

They indicated that if time permitted, they would like to engage with residents further and do things such as sit down and watch the news with them. However, all that can be afforded is a short occasional visit.

We try and spend a bit of time with them each day but because of our workload it is just really hard to be able to sit and have a one on one conversation with them. I try at least once a day to sit and have five minutes with someone, and make it someone different each day.

Often the carers found different ways to do more for the residents by creating opportunities. These included doing their paper work in the community room in order to have a presence there and to give residents the opportunity to “have a chat if they feel bored”. However, this extra effort was perceived to be at a personal cost as management’s views regard-

Volunteers are important. Volunteers played an important role in most facilities, and often filled the social gap for residents who avoided taking part in organised activities and who were more withdrawn and isolated than others. The benefits of this social contact were reciprocal. “We’ve got a [volunteer] lady who runs the kiosk and her husband [who was residing here] passed away … the residents come and sit and chat to her, and for her it’s good”.

Barriers to social inclusion. The major barriers to encouraging further social activity reported by carers were time and money. The recurring theme in comments made by carers was that they had too much to do by way of prescribed duties to spend more time with the residents, to “spend that gentle time with them”, perhaps “going through a book”.

We have so many things we have to do; we are cleaners, we are carers. We are basically everything, but we would like to be able to sit down there to paint their nails and things like that.

It shouldn’t just be all work and you don’t have time to sit down and have a chat…. These residents like you to sit down and have a little chat with them, and tell you about their life.

The situation that has arisen from such a lack of resources is being exacerbated as more demands are made on staff. “We are getting residents in who are needing more and more support … and it is getting more difficult.” As such, medical and personal aspects of care receive the attention even though it is “becoming more apparent that the lifestyle and recreation side of care is an important factor”. Other barriers to social interaction included the highly structured routines governing the facilities. “We tried to set them up to have a DVD on Saturday night, but that didn’t work because they want to hit the sack at 7.30”.

Finally, some carers saw social and recreational activities being reduced. For example, a men’s group that had been functioning well could no longer be sustained to the same extent; barbeques aimed at gathering residents socially were limited due to lack of time; gardening, a hobby that many residents loved, was difficult to organise given the lack of resources; bowls was restricted in terms of the numbers that could be managed, and wood-working relied on resources that were not always available.
Summary. On the surface, carers indicated that there were many opportunities for social activity for residents. In each hostel, there was a range of regular activities that provided evidence of the opportunity for residents to come together and interact around the structured activities. However, in recognising the implicit importance of social interactions for the well-being of residents, carers took it upon themselves to ensure that every effort was made to provide further social activity. This often meant going beyond the scope of their jobs, in terms of both time and effort. Carers demonstrated an awareness of the needs of individual residents, some of whom required a little more coaxing than others to socialise. Other residents benefited from one-to-one activities with carers who made the time for such activities. Of concern was the lack of resources needed to allow carers to provide the social activities that they perceived to be necessary for the well-being of the residents. Staff and, sometimes, physical resources such as appropriate space to conduct activities were lacking.

Residents’ experience of social activities and social inclusion

Although our interviews placed a great emphasis on the social inclusion of residents through activities, residents’ conversations were about feeling distant, not feeling at home, and having to comply with hostel programmes and staff. This is not to say that residents did not recognise the effort made by the staff to involve everyone by providing a wide range of activities, but rather, this recognition often led to compliance as residents felt they should acknowledge such effort by participating in the activities provided. Further to this, residents, even those who took part in a number of activities designed to encourage social involvement, often felt isolated, mainly because life in an institution was not the same as life at home. There was no sense of being “at home” and even those who reported being happy or feeling good spoke of being “happy enough” or feeling as “good as can be expected”.

‘Good enough’ talk. Being “happy enough” was indicative of residents’ recognition that staff worked hard and were generally very good to them, providing them with social events through a number of organised activities and outings. They considered the housing, meals, and care they received to be appropriate and adequate. All things considered, there was not much to complain about—but there was not much to be happy about either. As one resident explained, “I am reasonably content most of the time”. Even those residents who claimed to be “very happy” in the hostel were not unreserved in their claims. For example, “now I am perfectly happy and contented. I know that there is no other place that I can go, so I make the best of a bad lot”. Similarly, “Oh I just feel that I am happy enough I think, under the circumstances”.

The “circumstances” referred mainly to having to be in an institution. The need to be in an institution was often the perception of others such as a doctor or a family member (generally a child). Residents recognised that these significant others were worried that they were unable to care for themselves properly and were concerned for their welfare.

The doctor didn’t want me to stay at home on my own and it was worrying my family . . . I thought I may as well come in here [the hostel] and give my family peace of mind—they know that I am well looked after and they don’t have to worry.

However, residents also seemed a little concerned for their own welfare. For example, they were often very ready to “go along” with the move to a hostel they had yet not seen, having had little or no input into how and when the move should take place.

I used to think many times “I am sure I could manage if I was home”, but then I stop and think of all the things I couldn’t do. So I had to make myself think of those things and realize that I am being looked after here.

Despite this, the relief of being well cared for did not alleviate the disappointment associated with living in an institution. “I never realized what it would be like until I came here—I thought it would be better”. It was not, they felt, that their expectations were too high. In fact, many residents tried to prepare themselves for the shift but they were not prepared for what they met.

Here is not a very enlightening, uplifting place . . . . We have a lot of dementia people and that gets you down. . . . I didn’t expect to find as many as that. I knew that people wouldn’t be well, I had no illusions about that sort of thing. I thought they would be able to converse . . . but you find the ones that can have a conversation stay in their rooms.

Loneliness amid company. Of real concern to the residents was the loneliness and isolation associated with being in the company of people with whom they had very little in common.
There is very few here that want activity—the great number are quite content to sit on their bums and watch a bit of TV.

I am friendly with them but they are—I suppose we haven’t got the same interest or something.

In these circumstances, some residents spoke of having to rely on family members for social contact in spite of living in a community setting. Others made efforts to create opportunities for social interaction as a means of avoiding facing up to their unhappy situation. For example, one participant visited another resident on the basis that:

[she] loves me to go down to see her—it all fills in your life. You know? It fills in your time. I think when people don’t do anything they get sorry for themselves.

Loss of autonomy. Loss of independence was a theme that underpinned much of the residents’ discourse. Residents indicated that they had been given little choice about moving to a hostel, that they had no choice with whom they lived, that they had little or no privacy, and that now there was no way out. In fact, loss of independence was described as “the saddest part of living here”. “Living here” did not give the sense of belonging. Many residents said they had little or no choice about moving to a hostel, that they had no privacy that seems inevitable in a hostel situation. A staff member entering a resident’s room during the interview sparked the following comment that was filled with regret and despair that life is not how it should be. “See what I mean, you have got no privacy . . . Frankly, deep down I hate the place . . . I haven’t got what I would like as I am dying”.

Associated with loss of independence was the lack of privacy that seems inevitable in a hostel situation. A staff member entering a resident’s room during the interview sparked the following comment that was filled with regret and despair that life is not how it should be. “See what I mean, you have got no privacy . . . Frankly, deep down I hate the place . . . I haven’t got what I would like as I am dying”.

The loss of independence impacted negatively upon close relationships whereby couples could no longer live together. Sometimes this was due to the lack of double rooms, but more often, the reason was that only one of the couple required full care which meant shifting to another facility. There seemed to be no exceptions to this rule. “My husband and I are separated because of his health—he had to go into a nursing home. That makes me sad at times”.

Independence was all that some residents wanted. It was not that they were treated poorly—they were dependent and could never regain independence. “They are very good to you here but being independent was all that I wanted . . . I realise that it can never be any different now”.

Feeling vulnerable. Residents were also grieving for what will come—seeing others doing so poorly is a reminder of where one is heading, a thought many would rather avoid as “it is a bit distressing that people you know are going ‘gaga’”. “You are surrounded by people who are confused. . . . Some days I can take that, and other days I think ‘I can’t stand that today’ . . . it’s a reminder of how frail we all are”. The thought of having to go to a nursing home (high-care facility) was frightening for residents and some said that they would rather die first.

Residents’ perceptions were that decline was all around them and that there was no escape except through death. “I have got to live here for the rest of my life”. One woman spoke as though she had died as she described the way her home had been sold and her furniture “disposed of around the family” after she had suffered a stroke and was relocated to a hostel.

However, many of the residents recognized that they needed to be cared for, and to make the most of the situation they were in, despite their longing to be elsewhere. “I think I would be better off not here but I try to enjoy it—try to join in the many activities that we have”. Others were resigned to living one day at a time, as “there is nothing left in my future now”. They took refuge in the simple things in life that occur daily “I am looking forward to watching Denton [a television show] and I have my cup of tea”; or things that many of us might call “mundane”—“My favourite thing is waiting for lunch to come along”.

Happiness is being at home. Happiness was not evident in residents’ discourse. The reason for this was that life in the hostel was a compromise—“good enough” considering what they really wanted did not seem possible to attain. “I am not happy [at the hostel]—there is nothing better than your own home . . . some days I like it—I don’t love it that’s for sure—I will tolerate it”. Living in a hostel situation was so unlike being at home that one resident used jail as an analogy:
I don’t mind doing that—going out—yes, we call into shopping town and that . . . it’s good because it really is to get away from the four walls—to get outside. You feel like you are in jail at times.

Others tried to create a homely environment: “The staff tell me this room is real homeland. Well, you have to make it home after all”. Some of the feelings residents had of not being at home were associated with activities that were common at home that were either not available in the hostel or were just ‘not the same’. The loss associated with these activities was a loss of control:

I miss the garden. . . . All my married life we had fruit trees and [a] vegetable garden and a dog . . . I wouldn’t be able to look after a garden now, so I realised that I have limitations.

That was one of the joys of my life; oh dear, to get out in the garden . . . . There is sort of a garden out through the dining room but it’s very overgrown and we’ve been battling to get something done.

Complying. While residents felt that there were many things missing in their lives now, they still had to be satisfied with what was available. For some residents this was indicative of a forced acceptance of the situation without question. “I do miss things that I used to do such as knitting and gardening . . . but I have to be satisfied with that”. Compliance was, in a sense, also used as self-preservation. Others felt as though they could not speak up about things that bothered them about life in the hostel, as they preferred not to stand out by “rocking the boat”. As one resident pointed out, “making comments about food here or whatever . . . you don’t want to do it too often because I don’t think they will be too pleased”.

Residents also recognised that they had to fit in with others, and that this was often at the expense of their own needs and desires.

I used to be a great bowler and a swimmer, but you can’t always do the things that you want to do—now the swimming is curtailed a bit because of no transport . . . there was only a couple of us that went swimming so of course they can’t justify running it for two . . . they used to take us a couple of times—in the water you don’t get any pain [from arthritis].

Many residents attended activities that were organised by the care providers and were happy enough to do so. Yet even this was often a compliance response. “You feel that you should go because these girls [the activities organisers] are putting themselves out”.

Summary. Residents felt as though they were in a situation that was not ideal but was good enough considering their circumstances. This acceptance of one’s lot meant that residents were neither happy nor unhappy, satisfied nor dissatisfied. They were grateful for the effort staff put in to caring for them and tried to show that appreciation by taking part in the activities offered. Compliance also led to taking up residency in the hostels, as often residents had done so for their families who were concerned about them living alone. All this seemed to leave the residents feeling compromised, dependent, isolated, and very much not at home. Whilst they may participate in social activities, such participation does not equate with the experience of social inclusion. Their social needs remain unmet, despite their presentation of being generally satisfied.

Comprehensive understanding

What has become evident to us is that the meaning of social inclusion to residents is quite removed from the meaning their carers are willing to focus on. We say “willing to focus on” because evidenced in the carers’ discourse was the recognition of how limited they are within the context of their work role to do the things they know would enhance the quality of life of those in their care. Their time was devoted to managing the housekeeping and meeting the physical needs of residents (e.g. dressing, showering, managing meal routines, etc.), and while in all hostels there were programmed activities delivered by a range of people (including volunteers), many residents did not fully engage in these activities. Carers observed this, but noted that there was little time in the daily routines of hostels to do more of the personally engaging things, like spending time talking with residents, doing their nails, laughing and joking with them, and making them feel more at home. Despite this awareness of the mismatch between activities and residents’ needs, we perceived a sense of self-preservation in the carers’ attitudes such that they did not have to dwell on the loneliness that the residents were experiencing because they have neither the resources to help alleviate this, nor the capacity to change the routines of the hostels. One carer suggested, “some people are very isolated because they choose to be”. Such a contrarian hyperbole as ‘choosing isolation’ highlights an avoidance of confronting the issue of isolation that pervades our aged care health system. In sum, the most significant meaning derived from the carers
reports is that in their demand-filled work and the daily routines of life in hostels, the availability of activates allowed facilities to meet their obligations related to the well-being of residents in a superficial way, but not to meet the needs of the residents.

To residents, however, social inclusion was not about joining in the various activities that were provided. It was about feeling socially connected. At the heart of such connectedness is feeling at home, at one with those around them (regardless of how many or how few), of having control of their lives, of having privacy, and of being able to make a contribution to those with whom they feel connected. This is a far cry from an afternoon of bingo or a bus trip to the local shops.

The residents’ experience of “not feeling at home” is related strongly to their low sense of belonging, unfulfilling social activities and somewhat superficial interactions with people with whom they are unfamiliar and with whom they do not share interests and backgrounds. Without relationships with these qualities, residents cannot experience nearness, warmth, and other social qualities that would contribute to feeling “at home”. Whilst carers showed some awareness of this as described above, they had neither the time, nor the responsibility to fill the void. A review of the number of carers on staff, and a reconceptualisation of the types of relationships they have with residents, and the range of activities offered is required if the current aged care system is to better meet the social needs of residents.

Whilst our study has highlighted the sense of not feeling at home as a central phenomenon in the well-being of older adults in care, related phenomena that emerged were continuity of a “normal” life, familiarity with daily life, living a meaningful life, and being comfortable in the context of life. A number of existential themes need to be interrogated further to come to a better understanding of the lived experiences of those in care. These themes include loss of autonomy, vulnerability, lack of privacy, loneliness amid company, feeling invisible, unappreciated, always being the recipient, of life only being “good enough”, and forced compliance.

**Discussion**

In this study, we aimed to examine the experiences of social inclusion of older adults in residential aged-care facilities and the importance residents and their carers placed on social activity. Social interaction is an important factor in the well-being of older adults and we recognized that many in aged care facilities, especially the frail, might face a number of barriers to inclusion in such activities.

From the point of view of the carers, they did what they could with the limited equipment, time, and resources available to them to make sure that there were a number of activities available to suit different needs, and that everyone was afforded the opportunity for activity designed for social interaction. In order to do this, the carers encouraged participation, even in cases where the residents tended toward isolating themselves, because they perceived such interaction to be very important for the residents’ well-being.

Close reading of transcripts of residents’ interviews gave rise to an overwhelming sense that the dimensions of social inclusion which we aimed to explore were of little consequence to those living in aged care facilities. From the residents’ point of view, they would rather not have been living in a hostel. The content of their discourse reflected compliance, politeness, and at times an indifference about social interaction. They were considerate of the time and effort that the carers were willing to put in, and showed appreciation of this by politely complying. However, meaningful personal relationships, happiness, and a sense of control, which have all been associated with quality of life, emotional well-being and positive ageing (e.g. Bramston & Tomasevic, 2001; Knight & Ricciardelli, 2003; Ryff, 1989) were not evident. Simply put, the hostel was not their home and never could be. The acceptance they spoke of was not an acceptance that life is how it should be, which is evidenced in the successful achievement of Erikson’s (1982) final developmental crisis of integrity versus despair. According to Erikson’s Theory of Psychosocial Development, if a person approaches the end of life with feelings of regret for how his/her life has unfolded, then despair is the resulting emotion. Such despair is often exemplified in the high rates of depression among our aged populations (Davison et al., 2007; Teresi, Abrams, Holmes, Ramirez, & Eimicke, 2001). Nor was the acceptance they spoke of one that reflected adaptation, which is deemed necessary to achieve a good quality of life (Baltes & Baltes, 1990), maturity (Vaillant, 2000), and fulfilment (Maslow, 1968). Rather, the acceptance they spoke of was an enforced acceptance of their circumstances which compromised their sense of autonomy and life satisfaction.

Our study uncovered discontent and a rather apathetic state in residents that needs to be further explored. Many seemed depressed and even those who were “happy enough” were not ageing positively in that their lives were not fulfilling. This brings into question the usefulness of the aged care facilities’ model of care. Although activities in the hostels might have provided the opportunity for social
interaction and by their availability provided the opportunity for social inclusion, they were not meeting the needs of the residents. The model does not allow for giving our older population meaning in life, which is an important facet of successful ageing. Our findings therefore pose a challenge. This challenge is to remove the blinkers with which we view aged-care and to put ourselves in the shoes of those who must give up their home and its social context. Policy in health care must be informed of the needs of older adults and act from an understanding of the struggles of adjustment that those in aged-care facilities must face.

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