SENIORS' EXPERIENCES IN ASSISTED LIVING FACILITIES: A STUDY EXPLORING QUALITY OF LIFE

ELHAM AL-OMARI
Bachelor of Nursing, Jordan University Of Science and Technology, 2003

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfillment of the Requirements for the Degree

MASTER OF SCIENCE (NURSING)

Faculty of Health Sciences
University of Lethbridge
LETHBRIDGE, ALBERTA, CANADA

Abstract

Seniors are a diverse population who go through many physical and mental changes as they age. During the last decade, Assisted Living Facilities (ALFs) have dramatically increased in numbers to provide care and living services in a home-like environment. Assisted living Facilities have a continuous interest in enhancing the quality of their programs and services. The purpose of this descriptive exploratory study was to explore the quality of life as perceived by seniors who reside in ALFs. Interviews with 17 residents of two ALFs shared their perspectives on quality of their life while living in an ALF. Three major themes surfaced from residents' descriptions: 'physical environment', 'social environment', 'home-like atmosphere'. Quality of life in ALFs remained predominantly an outcome of exchange between the personal capability of residents to adapt to changes and the capacity of the facility to meet residents' diverse needs.

Acknowledgments

I would like to express my deep gratitude to my family for their great support and patience. I would like to acknowledge the support of the University of Lethbridge, and its staff, particularly the School of Graduate Studies and the Faculty of Health Sciences for their financial support. I would also like to acknowledge the financial support of Covenant Health Research Centre. This work would not have been possible without the assistance of my principal supervisor, Dr. Claudia Steinke; her patience, understanding and remarkable support is highly appreciated. Also, the ongoing guidance and support of my other committee supervisors, Dr. David Gregory, Dr. Shannon Spenceley, and Dr. Pam Loewen, have been very beneficial. Thank you so much for sharing time, knowledge and inspiration. I wish to express my deep gratitude and appreciation to all the participants who took part in this study. I am grateful to my friend Victoria Holec for her invaluable assistance in editing my work. I am also most thankful to the valuable contribution of Linda Janz for her assistance and support of this work.

Contents

Abstract ... ii
Acknowledgments ... iii

Chapter 1. Introduction ... 1
- **Background of the Study** ... 1
- **Statement of the Problem** ... 3
- **Research Opportunity** ... 4
- **Purpose of the Study** ... 5
- **Significance of the Study** ... 6
- **Definition of Terms** ... 6
- **Research Questions** ... 8
- **Theoretical Perspective: Lawton's Model of Quality of Life** ... 8

Chapter 2. Review of the Literature ... 10
- **Quality of Life** ... 10
- **Quality of Life among Seniors** ... 12
- **Quality of Service Delivery** ... 12
- **Living Options for Seniors** ... 13
- **Assisted Living Facilities (ALFs)** ... 15
- **The Concept of Aging in Place** ... 16
- **Informal Care Giving** ... 18

Chapter 3. Methodology ... 20
- **Research Design** ... 20
- **Philosophical Stance** ... 21
- **Phases** ... 22
  - Phase I – pilot study. ... 23
  - Phase II – naturalistic inquiry. ... 24
- **Setting** ... 24
  - Site one. ... 24
  - Site two. ... 28
- **Data Collection** ... 31
  - Sample. ... 31
  - Recruitment. ... 31
  - Interviews. ... 32
- **Data Analysis** ... 33
- **Scientific Rigor** ... 35
  - Credibility. ... 35
  - Transferability. ... 36
  - Dependability. ... 37
  - Confirmability. ... 37
- **Ethical Considerations** ... 38
- **Dissemination** ... 41

Chapter 4. Findings ... 42
- **Description of Participants** ... 42
- **Themes and Categories** ... 43
- **Theme #1: The Physical Environment** ... 44
  - Physical space. ... 45
  - Design and accessibility. ... 47

Proximity to neighbourhood attractions. 50
Proximity to family. 52
Personal possessions. 52
Views and outdoor spaces. 53
Summary of Theme #1: The Physical Environment **55**
Theme #2: The Social Environment **56**
Relationships with residents. 57
Relationship with former friends. 59
Relationship with family. 60
Relationship with staff. 62
Community integration and activities. 64
Summary of Theme #2: The Social Environment **67**
Theme #3: Home-Like Atmosphere **68**
The meaning of home. 68
Food and dining. 70
Autonomy. 74
Privacy. 77
Independence. 80
Summary of Theme #3: Home-like Atmosphere **82**
Summary **83**

Chapter 5. Discussion 84
Demographics **84**
Physical Environment **85**
Social Environment **86**
Engagement in Social Activities **88**
Food and Dining **89**
Autonomy, Independence, and Privacy **90**
Lawton's Model of Quality of Life **91**

Chapter 6. Conclusion 94
Implications for Research **96**
Implications for Practice **97**
Theoretical Contribution **97**
Limitations of the Study **98**
Reflection and Reflexivity **99**

References 103
Appendix A: Invitation Poster **121**
Appendix B Invitation Letter **122**
Appendix C: Informed Consent **123**
Appendix D: Resident Interview Protocol **126**
Appendix E: Oath of Confidentiality **130**
Appendix F: Tea Party Invitation **131**

List of Tables

Table 1. Demographic Data Descriptions (n = 17) 43
Table 2. Themes and Dimensions 44

List of Figures

Figure 1. First facility design footprint (ALF-1).. 48
Figure 2. Second facility design blueprint (ALF-2).. 49

Chapter 1. Introduction

Background of the Study

The aging population has become a global phenomenon and a major social concern for seniors and their family members. Over the last few decades, many of the world's nations experienced significant decrease in fertility rates and consequently aging of their populations. In addition, life expectancy in many countries has increased significantly as a result of improvement in healthcare and declining fertility rates. Between the years 2000 and 2050, the number of people aged 60 years and over is expected to increase from 605 million to two billion (WHO, 2012). This means more and more people are living longer and entering an age where they may need additional supports.

In Canada, the senior population is the fastest-growing segment of Canadian society (Statistics Canada, 2010). The senior population (age 65 years and older) currently represents 14% of the Canadian population and is projected to increase from 4.2 million to 9.8 million between 2005 and 2036 (Turcotte & Schellenberg, 2007). By the year 2056, seniors could account for more than one-fourth of the Canadian population (Statistics Canada, 2010). According to a report focusing on seniors and aging released by the Canadian Institute for Health Information (CIHI, 2011), while Canada's seniors are living longer and are healthier than ever, they are frequent users of the health system, costing more than any other segment of the population. This is because seniors' conditions are usually more complex, presenting to the system with higher levels of acuity and a number of co-morbidities. Seniors use 40% of hospital services in Canada and account for about 45% of all provincial and territorial government health spending.

Within Alberta, the province’s population is rapidly growing and aging as are the populations of other Canadian provinces. The number of seniors in the province has tripled from 130,045 in 1974 to 385,241 in 2009. Between 2011 and 2021, the percentage of Albertans aged 65 and older will increase from the current 11% to 15% of the total population (Government of Alberta, 2010).

The fact that people are generally living longer has significant implications for the healthcare system. With aging, people generally experience an increased prevalence of chronic disease and physical and cognitive impairments that affect the ability to live independently (Golant, 2001; Inzitari et al., 2007; Li & Conwell 2009). According to the 2009 Canadian Community Health Survey (CCHS), 24% of seniors reported three or more chronic conditions, and 25% of those who are 85 and older reported a moderate to severe limitation in their functional capacity (Canadian Institute of Health Information, 2011). Seniors who have more chronic illnesses and disabilities become frequent users of the healthcare system, and are costing the healthcare system more than any other segment within the Canadian population (CIHI, 2011; Terner et al., 2011). As a result of the changes faced by aging, a greater need for assistance with daily activities and personal care is often needed. Consequently, more supportive living options for seniors are required (Ramage-Morin, 2005; Sands et al., 2006).

The term supportive living refers to accommodation in a home-like setting, where people live as independently as possible, and at the same time have access to supportive services that meet their dynamic needs (Alberta Health, 2012). Residents in a supportive living setting can range from seniors who require support services because of age and reduced ability to care for their day-to-day needs, to young adults with mental health or physical disabilities (Alberta Health, 2012). Approximately 85% of all supportive living care clients are age 65 years or older, and 35% are age 85 years and older (CIHI, 2011). In the year 2010, there were 4,633 residential care facilities in Canada serving a population of 247,270 residents (Statistics Canada, 2013).

Within the province of Alberta, supportive living is regulated by Alberta Health. Designated Supportive Living (DSL) facilities are contracted by Alberta Health Services (AHS). According to this contract, AHS controls access to a specific number of spaces within the facility based on an agreement with the operator (Alberta Health, 2013). There are diverse approaches to providing DSL facilities within the province which range from enhanced lodges to nursing homes, group homes, ALFs, adult family living spaces, and family care homes (Centre for Health Services and Policy Research [CHSPR], 2012). Assisted Living Facilities, which are the focus of this study, are community-based living options where 24-hour on-site personal care and support care services are provided by a combination of licensed practical nurses (LPNs) and healthcare aides (HCAs) (Alberta Health, 2012). Currently, there are 25,000 residents living in more than 700 licensed supportive living settings in the province of Alberta (Alberta Health, 2012). However, it is difficult to estimate the exact number of DSL facilities in Canada given the lack of the national standards for supporting living settings across the country (Golant, 2001; Hirdes et al., 2011).

Statement of the Problem

Over the past few decades, gerontologists, policy makers, seniors' advocates, and health professionals have been searching for the *optimal residential care model.* Practitioners and academics have worked continuously to develop effective regulations for residential care settings. Yet, at both provincial and federal levels, residents and their families, employees, and government officials continue to express indecision and dissatisfaction with the varying levels of quality. This is largely the result of inconsistent or ineffective regulation as a means to standardize the quality of the product and services provided within residential care settings (Eckert et al., 2009; Zimmerman et al., 2003). Learning about the seniors' care models led me to acquire an interest in exploring seniors' perceptions of quality of life in residential care settings such as ALFs.

Research Opportunity

During the summer of 2012, I had the opportunity to join a team of researchers from the Health Services Quality Institute (HSQI) at the University of Lethbridge. The team was involved with a quality assurance project of a local ALF. The goal of the project was to assess whether the new facility met its intended objectives, which involved improving outcomes for individuals (i.e., residents) and the organization.

The project is ongoing, however during the first phase I accompanied the research team in a tour visit to an ALF (one of the host facilities). I was also involved in the interviewing of a subset of champions and directors of the ALF. The interviews provided invaluable data about the facility and enlightened my perspective about the proposed research topic. Through my involvement in the project with the HSQI team, I became interested in assessing seniors' perceptions of quality of life while living in such facilities.

I felt this was a favourable research opportunity, and a concept that needed to be explored further. I wanted to find out what quality of life meant to different people, and how it was measured and understood. From here, I decided to frame this as the topic for my Master's thesis and contribute my findings to the larger HSQI project. Fortunately, the host organization agreed to provide access to their clients. The results of my study serve to inform the larger project. The results from the larger project will provide evidence to assist in decision making efforts to improve quality in ALFs.

A second reason why I viewed this opportunity favourably is because the majority of research that assesses quality of life appears to measure more along the lines of satisfaction with life. In addition, much of the research takes place in hospital settings rather than residential care settings (Jeon, Fethney, Ludford, 2012). Research is scarce when looking for evidence that assesses quality of life among people who live in ALFs and who suffer from illnesses and disabilities (Karlawish et al., 2008).

More importantly, this was a favourable research opportunity given my upbringing and work experience as a registered nurse. Growing up and spending a considerable amount of time working in the Middle East exposed me to an environment rich with diversity and multiculturalism. Through this experience, I have been fortunate to develop a strong sense of what it means to provide cross-cultural and appropriate care. Moreover, I have learned a great deal about quality assurance within the international healthcare arena. However, as a recent immigrant to Canada, I have yet to have the opportunity to work as a registered nurse here in Canada and I feel there is much to learn about quality within the Canadian context. While I may feel culturally aware when providing healthcare in my home country, the situation is different here and I do not feel as informed as I should or would like to be. I think that my experience working with researchers from the HSQI at the University of Lethbridge and also the experience of conducting this study helped me tremendously in acquiring a better understanding of the Canadian healthcare system and also what the concept of quality of life means to Canadians; particularly those Canadian seniors living in ALFs.

Purpose of the Study

The purpose of this study was to explore and understand the concept of *quality of life* among seniors living in ALFs. Most of the existing quality assessment studies examined the assisted living quality from the perspectives of owners, administrators, and healthcare providers and focused on organizational and structural components of the ALFs (Frankowski, 2011; Zimmerman et al., 2003). Therefore, in this study I examined the quality of life in ALFs from the viewpoints of residents who are considered to be the main consumer of care and services.

Significance of the Study

Despite of the growth of seniors' supportive living options, most of the research conducted on such facilities focuses on organizational and structural components of supportive living communities. Comparatively little research has been done to understand residents' perceptions on quality of life in these facilities, and to study factors associated with their physical and psychological well-being (Burdick et al., 2005; Hawes, Rose, & Phillips, 2000; Hawes et al., 2003; Philips, Hawes, Spry, & Rose, 2000; Zimmerman et al., 2003). This lack of research is troubling, because in Canada alone, there is a wide variation within and across provinces and facilities in the types of residents they serve and in the way they approach care and housing options for seniors. In addition, the word quality is broad and subjective, and opinions about quality vary widely among different consumers and/or client groups. It is important to learn what the concept of quality of life means to the residents of ALFs and contribute this knowledge to improvements of research and practice.

Definition of Terms

The terms defined below are used frequently throughout the thesis. Definitions of these terms are necessary for clear understanding:

Aging in place. Traditionally, the concept of aging in place refers to seniors who remain in their own home throughout their senior years. Within the context of ALF, aging in place means to continue living in the facility with the highest level of independence and not to be discharged to a higher level of care (Burdick et al., 2005; Rosenblatt et al., 2004).

Assisted living facility. Assisted Living Facility is a term used to describe a community-based living options designed to accommodate the needs of frail individuals or seniors through design features, housing management, and access to healthcare services (Health Canada, 2005).

Assisted living resident. An assisted living resident is defined in the study as a senior who is cognitively intact and who has lived in the facility for at least six month.

Informal caregivers. Informal caregivers refer to family and friends who provide unpaid assistance with tasks such as personal care to help seniors remain in their homes, transportation, and companionship, thereby reducing demands on the healthcare system (CIHI, 2010).

Quality of life. Definitions of quality of life are numerous and inconsistent because of the multiple perspectives and methods of assessing it. The individualistic, subjective, and multidimensional nature of the concept of quality of life makes it difficult to define. Different terms are used to describe quality of life such as ‘well-being’, ‘life satisfaction’, and ‘health status’. Quality of life among seniors is determined by their lived experience within a certain life context, including the economic, cultural, and political influences of the society, it is also determined by the seniors’ expectations, attitudes and values within that context (Bond, 2004).

Senior population. Canadian definition of senior population refers to people aged 65 years and older (Statistics Canada, 2010).

Supportive living. The term supportive living refers to accommodation in a home-like setting, where people live as independently as possible, and at the same time have access to supportive services that meet their dynamic needs (Alberta Health, 2012).

Research Questions

This research explored the following questions:

1. What are the experiences of life in ALFs as perceived by seniors themselves?
2. How do seniors residing in ALFs perceive their quality of life?
3. What does quality of life mean to seniors residing in ALFs?

Theoretical Perspective: Lawton's Model of Quality of Life

This research does not test theory but rather builds on theory within the domain of seniors' health and supportive living. In this study, I applied Lawton's (1991) Model of Quality of Life to serve as the underlying theoretical framework. The framework helped to not only inform and assist me in better understanding the concept of quality of life, but importantly, the framework served to guide the process of framing of the interview questions and data collection.

Lawton's (1991) Model of Quality of Life provides both a way of organizing assessment and a way of identifying needs to be assessed. Lawton's perception of "the good life" represents an attempt to define quality of life in a comprehensive model. Four sectors are included in the model: behavioural competence, objective environment, perceived quality of life, and psychological well-being. Behavioural competence is the evaluated quality of behaviour in domains that by normative social judgment are thought to be necessary for adaptation to the external world (Lawton, Moss, Fulcomer, & Kleban, 1982). Objective environment is measured quality by physical, social normative or consensual standards which all lie outside the person (Wahl & Oswald, 2010; Wahl, 2001). Psychological well-being is the subjective evaluation of the total quality of the self and the overall way the self relates to the world. Perceived quality of life is the person's subjective evaluation of the adequacy of the separate domains of life and roles in life. Behavioural competence and objective environment are directly observable by others and therefore capable of being evaluated by social normative or physical criteria in the absence of any evaluation by the subject. In contrast, perceived quality of life and psychological well-being are intrinsically subjective judgments of the person being evaluated. Both subjective and objective perspectives are necessary in the model because they complement each other.

A complete picture for quality of life can be determined only if both objective and subjective criteria are used in the total assessment process. However, in this research, I focused solely on the subjective elements of understanding quality where quality of life has no meaning apart from what an individual personally touches, and people may experience and interpret the same circumstances differently. I therefore realize the study does not paint a complete picture of quality of life. The subjective focus of this study will help to understand some components of Lawton's Model of Quality of Life, but will not assess all components of the model.

Chapter 2. Review of the Literature

In the following section, I present a review of the existing literature deemed as important to a better understand quality of life among seniors. This review provides an overview of the literature on quality of life and quality of life among seniors. I then discuss living options for seniors with a focus on ALFs and also the concepts of aging in place and informal caregiving.

Quality of Life

Quality of life is considered to be one of the most desirable outcomes in all domains of healthcare. How to best support quality of life among seniors has become a growing health and social policy concern. As stated earlier, definitions of quality of life are numerous and inconsistent because of the multiple perspectives and methods of assessing it. The individualistic, subjective, and multidimensional nature of the concept of quality of life makes it difficult to assess and measure (Beerens et al., 2013; Borglin, Jakobsson, Edberg, & Hallberg, 2005). There is also disagreement about the meaning of quality of life in the literature; different terms are used such as ‘well-being’, ‘life satisfaction’, and ‘health status.’ These various terms serve to highlight the lack of agreement in the literature (Bowling et al., 2002; Howell & Cleary, 2007; Phillips, 2012). The Center of Health Promotion at University of Toronto has developed a definition of quality of life that is applicable to all individuals from different age groups. According to this centre, quality of life refers to the degree to which an individual enjoys the important possibilities of his or her life. These possibilities reflect an interaction between personal and environmental interaction (Raphael, 2010).

In some definitions quality of life has been embraced as a way of summarizing an array of qualitative indicators that go far beyond the traditional clinical approach that strives for the cure or the relief of disease (Parmenter, 1994; Sheck, 2011). Verdugo et al. (2012) included many elements that are beyond the traditional medical model, they suggest that quality of life concept reflects the following four concepts: a) quality of life consist of the same factors and relationships for all people; b) quality of life is experienced when an individual's needs are met and when the individual has the chance to pursue life enhancement in major life activities; c) quality of life has both subjective and objective components; and d) quality of life is a multidimensional concept, influenced by individual and environmental factors.

The literature identifies physical activity as an essential attribute contributing to the concept of quality of life. Physical activity is considered a vital way to enhance physical, emotional, and social well-being, and therefore enhances quality of life (Jill et al., 2013; Segar, Eccles, & Richardson, 2011). Haas (1999) defined quality of life as a multidimensional evaluation of an individual's current life circumstances in the cultural context in which people live and the values they hold. Haas' definition recognised quality of life as a subjective sense of well-being embracing physical, psychological, social, and spiritual dimensions. In some circumstances, objective indicators may serve as an alternative assessment of quality of life (Haas, 1999). According to Noro and Aro (1996), the term quality of life expresses "a broad range of dimensions of human experience ranging from those associated with necessities of life, such as food and shelter, to those connected with achieving sense of fulfillment and happiness" (p. 355). The authors further claim that "quality of life can also be seen as a dynamic interaction between the external conditions of an individual's life and the internal perceptions of those conditions" (p. 355). Hence, quality of life is a dynamic and multifaceted concept because it constitutes various elements among different people and the expectations for quality of life vary across different environments.

Quality of Life among Seniors

In the existing literature, the description of quality of life among seniors remains confined and mostly centres on successful aging (Howell & Cleary, 2007). Successful aging is a combination of three factors: a) a low probability of contracting disease or disability; b) good physical and cognitive function; and c) participation in life activities (Howell & Cleary, 2007). Most researchers describe quality of life as related to a lack of physical and cognitive impairment, or decreased level of activities of daily living. Few researchers have defined quality of life from the perspective of the seniors themselves (Bowling et al., 2002; Howell & Cleary, 2007; Farquhar, 1995). The self-rating of health and well-being is repeatedly reported as more powerful than objective socio-demographic and economic indicators in justifying the variance in quality of life ratings (Bowling et al., 2002).

Quality of Service Delivery

Despite the extensive research on defining quality, less attention has been given to the consumers' view of quality (Oermann, Dillon, & Templin, 2011). With the rapid growth of seniors, owners and operators of ALFs are being urged to focus on consumer satisfaction and service delivery as a way of distinguishing themselves in terms of quality. Consequently, sustained efforts are directed toward developing measuring tools that capture the complexity of quality in a careful and meaningful manner (Sutherland, Leatherman, Law, Verma, & Petersen, 2012). To set appropriate measures for quality of life, a shared understanding of the concept quality of life is needed; a common understanding of this concept would also enable clarity for research within the field.

Quality assurance in ALFs refers to the implemented activities in which the quality and appropriateness of care are ensured by all members of professional groups. Quality assurance focuses on the efficacy and suitability of the treatment to the client, accessibility of care, and efficiency and continuity of care (Bilawka & Craig, 2003). Hawes and Phillips (2007) explained the reasons why a focus on quality assurance is required in ALFs. First, the ALFs serve an increasingly vulnerable population. Second, ALFs provide services without any federally developed standards for quality of care. Third, it is an industry beginning to acquire more public funds in payment for its services which create more pressure on consumers. These points create a direction towards the development of standards of care and quality indicators that consumers, institutions, and regulators can use for their benefit to differentiate among ALFs.

Living Options for Seniors

Living options for seniors requiring daily support vary widely across Canada. Governments, health professionals, managers, advocates, the public and the media use the term *assisted living* inconsistently. Inconsistent and confused product or service identities have made the decisions harder for consumers and their families to choose a facility that provides high-quality care and living options (Golant, 2001). In addition, Canada’s residential care is provided in a largely fragmented system which poses many barriers to efficiency and coverage, and there is divided responsibility of funding across government ministries (Hollander, 2012).

In Alberta, the continuing care system is made up of three streams: home care, supportive living, and long-term care. As seniors’ needs change, the range of services provided is adjusted accordingly. *Home care* is a program that supports the wellness of seniors, to assist them in remaining safe and independent in their home for as long as possible (Alberta Health Services, 2012). *Supportive living* is the choice of seniors who are unable to live at home safely and independently and require a higher level of support than can be provided through home care. Supportive living serves the needs of a wide range of individuals who require support services because of aging, chronic conditions, frailty, and to young adults with mental health or physical disabilities.

Supportive living has three levels: supportive living three (SL3), supportive living four (SL4) and supportive living four-dementia (SL4-D). Supportive living three is a level of care that provides residents with access to a Health Care Aide, 24 hours a day, for personal care and support as well as continued professional care through a local home care program. SL3 care can be provided in supportive living spaces such as lodges, supportive living facilities, or personal care homes. Within this, SL3 level residents may have also access to other health professionals, including physical therapists, occupational therapists, and social workers (Alberta Health Services, 2009). SL4 is a higher level of personal care and support for those who have complex medical needs that are predictable and safely managed with an on-site Licensed Practical Nurse, and the direction of a home care Registered Nurse. In addition, SL4 patients may require chronic disease management and higher levels of assistance in daily activities. SL4-dementia is a level of care for individuals with moderate to severe dementia. These individuals may have a high risk of wandering and unpredictable behaviours but are not a safety risk to themselves or others (Alberta Health Services, 2011).

Supportive living includes many different types of settings such as senior lodges, group homes and designated supportive living accommodations (Alberta Health Services, 2012; Government of Alberta, 2012). Assisted Living Facilities are known to as supportive living options that are preferred by seniors who can no longer live at home yet do not need the level of care provided in a nursing home (Mitchell & Kemp, 2000). *Long-term care* is another suitable option for seniors with complex healthcare needs and whose cannot be safely managed in their own home or in a supportive living facility. Long-term care is provided using a more hospital-like model. Under the direction of a family physician, an on-site Registered Nurse supervises client care with the support of Licensed Practical Nurses, Healthcare Aides and other healthcare providers as appropriate (Alberta Health Services, 2012).

Assisted Living Facilities (ALFs)

Assisted living is a term used to describe a range of living options designed to accommodate the needs of frail individuals or seniors through design features, housing management, and access to healthcare services (Health Canada, 2005). Assisted living is a new phenomenon in Canada; it first appeared in the Canadian context in the mid-1990s (Centre for Health Services and Policy Research, 2012). It is the most rapidly growing field in the care market since the mid-1990s; its popularity is demonstrated by the expanding numbers of residents and settings (CHSPR, 2012; Mollica & Johnson-Lamarche, 2005)

Assisted Living Facilities currently serve the largest percentage of seniors who are frail and require assistance with their activities of daily living but do not require the 24 hour medical care provided in a long term care setting. The province of Alberta defines ALFs as community-based living options where 24-hour on-site personal care and support services are provided by Healthcare Aides. In some ALFs, personal care and support services are provided by 24-hour on-site Licensed Practical Nurses and Health Care Aides. (Government of Alberta, 2011).

Seniors and their families prefer ALFs to other institutionalized care settings because they offer a greater choice, control, and dignity in a home-like atmosphere (Hawes & Kimbell, 2009; Mollica, Johnson-Lamarche, 2005). However, ALFs are multifaceted accommodations where people live and where political and economic factors, social and cultural beliefs, and conflicting expectations intersect (Eckert, Carder, Morgan, Frankowski, & Roth, 2009). Despite the offering of choice and control, discussions about moving into an ALF remain difficult conversations and transitions for seniors and their family members. A move to an ALF brings about many changes in terms of relationships, roles, responsibilities and activities. Furthermore, little research attention has focused on ALFs specifically, including its residents, the services provided, the involvement of family and friends, changes over time, and comparison with long-term settings (Strain, Maxwell, Wanless, & Gilbart, 2011*)*. An individual's adaptation and satisfaction with these changes may be nurtured or impeded by the operations of the facility and also the individual's perceived quality of life and support from family and friends and other people residing in the facility (Tompkins, Ihara, Cusick, & Park, 2012).

The development of ALFs represents a fundamental change in supportive living options. Advocates assert that ALFs "represent a promising new model of residential care, one that blurs the sharp and invidious distinction between receiving long-term care in one's own home and in an institution" (Hawes, Philips, & Rose, 2000, p.1). ALFs are thought to provide a range of services that make them an attractive but less institutional alternative to nursing homes (Zimmerman, 2001).

The Concept of Aging in Place

Traditionally, the concept of aging in place refers to seniors who remain in their own home throughout their senior years (Alberta Health Services, 2011). Within the context of assisted living, aging in place means to continue living in the facility with the highest level of independence and not to be referred to a higher level of care (Burdick et al., 2005; Rosenblatt et al., 2004). Recently, the concept has been expanded to ALFs, a type of supportive housing environment that is considered to be less restrictive and more home-like than the traditional nursing home (Ball, Whittington, Connell, Hollingsworth, King, & Combs, 2004). While the concept of aging in place seems favourable, there is research to suggest that seniors who age in a place, such as an ALF, are more likely to experience increased health problems over time and may also be at risk of reduced quality of life and lower facility satisfaction (Mitchell & Kemp, 2000). With greater dependency on institutionalised care, the elderly person is at an even greater risk for the loss of functional abilities (Billson, Shaw, & Shaw, 2012). Researchers claim that many aged people in residential care suffer from depressive symptoms, which are often unrecognized or untreated and highly related to disability and mortality (Cummings, 2002). Moreover, multiple chronic conditions affect everyday living, including interactions with significant others and healthcare professionals (Bodenheimer & Berry-Millett, 2009). Aging in place in ALFs might expose seniors to the risk of becoming dependent on the institution and losing functional abilities. A study by Perkins, Whittington and Hollingsworth (2012) revealed that although most residents showed a desire to age in place in ALFs, many key aspects that residents linked with home were missing, such as maintenance of residents' self-concepts, personal autonomy, and cultural values.

The quality of services delivered in ALFs, where many residents are aging in place, remains an ongoing concern for clients, their families, healthcare professionals and policy makers. Researchers have suggested that gaining a comprehensive understanding of residents’ behaviours, and subjective experiences is influential to establishing services and designing interventions that are successful and accepted by residents (Perkins et al., 2012).

Informal Care Giving

As Canadians age, informal caregiving becomes increasingly important to the well-being of seniors. Informal caregivers include family and friends who provide unpaid assistance with tasks such as personal care to help seniors remain in their homes, transportation, and companionship, thereby reducing demands on the healthcare system (CIHI, 2010). According to the 2008/2009 Canadian Community Health Survey (CCHS), about one-third of Canadians aged 45 years or older were providing care to a senior with short or long-term health conditions or limitations. Informal caregiving can be emotionally demanding and impede any sense of work-life balance, as informal caregivers often find less and less time for themselves and their life interests (Canada Statistics, 2012). While Canadians are willing to take care of their families and friends, caregiving duties impose challenges that may burden caregivers and impact their work, health, and family (Cranswick & Dosman, 2008).With the larger proportion of seniors in Canada, and lower fertility rates, there will be fewer and fewer adults to care for the elderly.

Results from the General Social Survey (2007) showed that Canadian seniors provide a significant proportion of care for other seniors (Cranswick & Dosman, 2008). In 2002, more than two million family and friend caregivers aged 45 years and older reported assisting a senior because of the senior's long-term health condition(s). In 2007, the number of caregivers aged 45 years and older increased by over 670,000 to 2.7 million caregivers; most of eldercare (75%) was provided by people between 45 and 65 years of age. It is important to note that those people providing eldercare were becoming seniors themselves (Cranswick & Dosman, 2008; Cranswick, 2003). These statistics possibly support the need for more supportive living options.

Unfortunately, only a small number of studies have been conducted on ALFs; instead, most of the research has been conducted within the nursing home setting (Hyde, Perez, & Forester, 2007). Perhaps this is because the assisted living concept is relatively new. Hyde et al. (2007) suggest that the inconsistency of approaches in ALFs offers a rich ground for researchers to compare the differing settings and different approaches to care. For example, little research has looked at outcome factors such as perceptions of quality, satisfaction, and well-being among ALFs residents. Research in these areas would be useful to stakeholders such as healthcare providers, policy makers, and more importantly the residents of such facilities.

Chapter 3. Methodology

Qualitative research is a means of understanding based on distinct methodological traditions of inquiry that explore a social or human problem (Creswell, 2009). Qualitative approaches investigate how people assign meanings to their experiences, social events and topics. The meaning that people assign to these things shapes their attitudes, experiences and social realities (Hesse-Biber & Leavy, 2010). Creswell (2012) argued there is no agreed-upon format to design a qualitative study. However, selection of an appropriate research design is driven by the specific research questions. To assure its relevance and reflexivity to the study, a chosen design should be presented clearly working through every stage of the research (Maxwell, 2012).

In this chapter, I describe the descriptive exploratory research design applied. I provide a thorough description of the facilities under study including history, design, structure, care and services. I also discuss the purposive accrual of 17 participants along with recruitment strategies. I present the means for data collection and analysis. I discuss aspects of trustworthiness; in addition, address ethical considerations. This section concludes with plans for dissemination of the findings.

Research Design

In this study, I employ exploratory descriptive qualitative design to understand the experiences of seniors who reside at ALFs. A descriptive approach is appropriate because it can best explore and describe the experience of seniors and allow for an in depth and accurate understanding of meanings. Qualitative descriptive inquiry is the method of choice when straight descriptions of phenomena are desired (Sandelowski, 2000). Sandelowski (2000) noted that researchers adopting descriptive qualitative design stay close to their data and to the described words and events. The main goal of descriptive qualitative inquiry as explained by Adams and Schvaneveldt (1985) “is to portray an accurate profile of persons, events or objects” (p. 106).

Descriptive methods typically answer the question of *‘what’* in research (Gillis & Jackson, 2002), and therefore, best suited to this study were the questions: *What are the experiences of life in ALFs as perceived by seniors themselves? What does quality of life mean to the seniors residing in ALFs?* Descriptive exploratory studies seek to investigate and richly describe an under-researched aspect of social life (Hesse-Biber & Leavy, 2010). A qualitative descriptive exploratory design captures all elements of experiences and uncovers the actual experience of each participant (Sandelowski, 2000). Using this qualitative approach, I seek to understand the residents’ perceptions of quality of life and the meaning they give to that concept while living in ALFs. The meaning that each participant gives to his or her own experience will help to determine their personal needs and the best way to meet those needs (Cohen, Kahn, & Steeves, 2000). To meet the individual needs of participants, it is important to first understand what those needs are, so that we can work together in trying to meet those needs.

Philosophical Stance

In qualitative inquiry, a study should be situated within a philosophical stance, which illustrates the researcher’s particular paradigm, philosophical views, and assumptions about reality and the type of relationship between the researcher and the researched (Burns & Grove, 2011). Philosophical stances inform researchers about what factors to consider in their inquiry and serve as a guide to answer their research questions (Speziale & Carpenter, 2007). Exploratory descriptive research adopts the ontology of interpretivism, based on the premise that social phenomenon can be understood through interpretations of individual’s subjective experiences. Like other qualitative research traditions, interpretivist research rejects the notion of positivism, which assumes an objective view of the world (Creswell, 2009). Interpretivist researchers embrace a reconstructed understanding of the social world, in which reality is viewed as subjective with emphasis on the holistic and dynamic aspects of human experiences (Guba & Lincoln, 1994).

As a general rule, qualitative methods attempt to capture the subjective meanings of human experiences in their entirety, from the context in which they occur. Researchers working in this tradition believe that knowledge about reality is socially constituted and historically embedded (Guba & Lincoln, 1994). This means that individuals' perceptions about reality are shaped by their social, cultural and other contextual experiences (Creswell, 2009). Therefore, different people may construct meaning in different ways, even in relation to the same phenomenon. One of the central characteristics of interpretivism is that the researcher is considered as the main instrument for the collection, analysis and interpretation of data (Denzin & Lincoln, 2005). Therefore, interpretivists perceive research as a subjective process of exploring, reflecting and explaining the phenomenon under investigation. The study will take place (i.e., data collection) in the natural setting of the participants' world. That is, the researcher will engage with the participants in their homes in order to understand their experiences, thoughts, and perceptions in relation to the study phenomena.

Phases

A two-phase approach will be applied. Phase I will involve a pilot study, followed by a naturalistic inquiry involving semi-structured interviews (Phase II).

Phase I – pilot study.

In preparation for the main study, a pilot study will be conducted. A pilot study is a feasibility study that represents a small-scale version of the planned study and is designed to inform the anticipated study and to guide the development of the research plan (Jairath, Hogerney, & Parsons, 2000; Kim, 2011)**.** The main benefit of conducting a pilot study is that it allows researchers to make adjustments and revisions to the overall research process including data collection process, data analysis, and more specifically the instrument (i.e. interview questions/ guidelines) as needed, prior to conducting the main study (Jairath, Hogerney, & Parsons, 2000; Kim, 2011; Sampson, 2004). Creswell (2012) recommends pilot testing in qualitative research to refine the interview questions. In addition, a pilot study can be especially useful to novice researchers when they assess and prepare their interview and observation techniques (Creswell, 2012; Sampson, 2004). As a practical recommendation, Creswell (2012) suggests that novice researchers should start with a pilot study and collect limited data, which might consist of one or two interviews, so as to estimate the time needed to collect data in the actual study.

In this study, I will conduct two semi-structured interviews (n=2) over a one-week period at one facility. The interviews will be conducted in the same manner as for the main study. I will analyze this data using thematic analysis, the same process that will be used in the main study. Data from this phase may be included in the main study. The purpose of this process will be to ensure the questions are relevant and understandable to the participants and the overall study process is appropriate. The pilot study will enable me to conduct an interview under realistic conditions, and help me to estimate the average time needed for the actual interview. It will also help me to create an atmosphere that encourages participants to speak and allows me to observe their reactions to my questions in the natural setting.

Phase II – naturalistic inquiry.

The main component of this study will involve semi-structured interviews that will take place in the natural setting of the participants. I will apply interview-based inquiry employing a small number of participants approximately 17 participants (n= 17). The in-depth and intensive nature of interview-based research will justify the small sample size (Crouch & McKenzie, 2006). I will interview participants until I reach data saturation. Data saturation will be achieved when no new themes are generated from the data (Creswell, 2012). The small sample size will facilitate the researcher's close connection with the participants and enhance the validity of rich, in-depth detail in naturalistic settings (Crouch & McKenzie, 2006). Furthermore, the small sample size will allow the researcher to explore the in-depth meaning and understanding of the interview questions (Hesse-Biber & Leavy, 2010).

Setting

The study will take place in two ALFs in Alberta; each facility operated by a different organization. All information included about the organizations will be provided by the organizations themselves and sites managers.

Site one.

The first site is an ALF that lies under the umbrella of a faith-based health organization. This organization is one of the largest health organizations in Alberta. It is also recognized as a leading provider of seniors care in Alberta, serving 12 communities across the province. The organization provides a range of healthcare services, including acute care, continuing care, assisted living, hospice, rehabilitation and respite care, and seniors' housing. This faith-based organization is committed to serving people of all faiths, cultures, and circumstances with compassion, respect, collaboration, social justice, integrity, and stewardship. Reaching the highest quality standard is the operational goal for all of the organization’s programs and services. Thus, this organization incorporates several essential features into its quality improvement efforts: planning, oversight and evaluation of initiatives; appropriate data collection and analysis; and collaboration, teamwork and communication among caregivers, administrators, and support staff.

The objectives of this facility are based on the philosophy of the organization, which are to provide residents with choices and the highest quality care that supports and promotes mental, physical, emotional, social, and spiritual health through the effective use of resources in a progressive, vibrant and welcoming environment.

According to the documents released by the organization, a Designated Assisted Living (DAL) model has been successfully implemented at the facility. The Designated Assisted Living model was positioned to provide a solution to meet the growing supportive living needs in the province. Within the DAL model, residents are supported in making informed choices that enable them to have as much freedom as possible. A collaborative team-based approach to care involves facility-based staff and community staff (home care, occupational therapy, physiotherapy, etc.) who are committed to meeting evolving needs of residents as they age in place. Supports from the community (e.g., community-based social work) are utilized as much as possible, and families are encouraged to participate in providing personal and community support, such as accompanying clients to medical appointments, shopping, etc.

Facility design. The facility comprises 200-suites facility that opened in April 2008. It claims to provide a cost effective alternative to facility-based long-term care for seniors, those with chronic disabilities, those with terminal illness, and those requiring rehabilitation. There are also areas within the facility that are specifically designed for residents diagnosed with dementia. The facility includes 124 private studio suites, 16 couple suites, and 60 secure dementia suites, each with a private bathroom and shower. Residents are encouraged to bring and use their own furnishings to promote a sense of home and familiarity. The facility has accommodated admissions from long term care facilities and very few residents have required admission to long term care from this facility. A local community pharmacy is contracted to provide services that include staff, resident and family education, and medication reconciliation to optimize medication use.

Accommodations. Residents have their own private room; there are also rooms designated for couples. The main physical features of regular suites are keyed access, sliding bathroom door, kitchenette area (small kitchen sink and space for a small fridge), locked medication drawer, independent thermostat control, vinyl flooring, barrier free washroom with walk-in shower, two closets, large window and window coverings, and conveniently located call bells. Call bell pendants and wrist straps are available to residents. Residents have access to common lounges, dining rooms, and activity spaces.

Resident care. Resident care includes medical and personal care, recreational therapy and spiritual care. Staff training programs have successfully met the staffing needs of the facility and special programs have been developed to improve the quality of care and potentially decrease the utilization of acute care services. Personal and nursing care is provided on a 24/7 basis by a team of Personal Care Attendants (PCAs) led by a Licensed Practical Nurse (LPN). While the staffing ratio for the regular assisted living residents averages 2.4 hours per resident day, dementia residents require a higher staff to resident ratio. Nursing care focuses on the promotion of health, maintenance of self-care activities, resident recovery from disease and injury, and the active compassionate care of dying persons and their families. Licenced Practical Nurses work to their full scope of practice including complex medication administration, care plan development and implementation. Personal Care Attendants (PCAs) are responsible for all personal and uncomplicated medical care.

Recreational care. Recreation programs range from physical activities (e.g., walking, swimming, cycling) to cognitive emotional and socially focused programs (e.g., field trips, picnics, group crafting, group singing, group games). Recreational activities are offered five days a week for regular assisted living residents and seven days a week for assisted living-dementia residents. Activity Assistants are responsible for organizing the program and leading recreational activities. Personal Care Attendants also play a major role in the delivery of the activities. Community volunteers are heavily recruited and are used primarily in assisting the residents with their recreation activities.

Spiritual care. The spiritual program is led by the chaplain and delivered by the chaplain, facility staff and members of religious organizations in the community. The chaplain offers a compassionate presence while providing emotional and spiritual care and counsel, promoting wholeness and well-being. The chaplain is available during regular hours and on-call to participate in individual or group sessions including bed side care, family case conferences, ethics consultation, and critical incident stress management. Additional spiritual programs are integrated into activity programs and delivered by affiliated religious community groups and organizations (e.g., spiritual & religious classes, group prayer, group meditation).

Hospitality services. Food and housekeeping services are provided on a contract basis by a qualified Hospitality Services Provider (HSP) that has specialized systems, processes and staff resources to deliver a high quality service at a reasonable cost. Residents receive three hot meals based on a four-week menu rotation and two snacks daily. Modifications to the menu based on resident needs are provided. Meals are prepared from scratch in the main kitchen and delivered in bulk to each dining room where PCAs plate and distribute the meals to the residents. Housekeepers provide a thorough cleaning of resident rooms once a week and are responsible for regular cleaning of all common areas. Personal Care Attendants perform daily light cleaning activities in resident rooms. Residents are encouraged to do their own laundry, but this service can also be provided by assisted living staff for an extra charge.

Site two.

The second site is an ALF operated by a private, for-profit organization. This organization was established by a group of doctors who had previously developed the aging in place model in England. They introduced the model to Canada in 1998. Their corporate mission is to develop and manage innovative supportive housing and long-term care communities in Alberta, and to provide the best quality of life experience for all residents. All communities are operated on the principle of providing seniors with quality personal care in a home-like surrounding. The company has developed many supportive living communities across Alberta. The ALF included in this study is the second assisted living community established by this company; it was founded in the early years of the organization.

Facility design. This is a 112 suite facility that opened its doors in 2002. Residents may choose from studio or one-bedroom suites. The building design and living environment support principles of independence, individuality, dignity and choice, and facilitate flexible service delivery to clients. Residents of this facility are also encouraged to bring and use their own furnishings to promote a sense of home and familiarity.

The facility is designed to create an environment that considers both the need for a home-like environment and service delivery efficiency. This facility is known for its unique design, location, and welcoming atmosphere. Conveniently located on west side of the city, across from a public park and on the city bus route, the facility is exclusively designed with a small grouping of suites that face 14 decorated leisure areas surrounded by soaring, elegant atriums. The dining rooms located in the middle of the atriums, the atriums are surrounded by fireplaces which add warmth and community feeling to the dining rooms. This feature is especially nice during evening meals when residents experience this restful and pleasing ambience.

Accommodations. Residents have their own private room; there are also suites designated for couples. The suites are designed to maximise living and storage areas. Each suite has a spacious bathroom with large vanities, support bars, and easily accessible call bells. It contains a kitchenette with refrigerator, microwave, sink, and ample cabinetry. An air conditioner installed in each suite enables personal climate control. For safety, each suite has a fire alarm, sprinklers and 24 hour emergency call system.

Resident care. This facility also provides medical and personal care, recreational therapy, and spiritual care. Alberta Health Services (AHS) determines the care requirements of the residents through the AHS community program. This assessment is completed by an AHS Home Care staff member, with input from the resident, their family members, and facility employees to identify those services required to meeting the each resident's care needs. The assessment covers activities of daily living care such as bathing, dressing, meal time support, medication, mobility, and other care services. These services are provided by AHS to residents who are assessed and qualify for the home care program. The facility may provide these services, in part or in total, at no cost to the resident, depending on an individual care-needs assessment. However, the facility offers personal care services to those who may not qualify for the AHS program but wish to purchase the service on a fee-for services basis. Personal and nursing care is provided on a 24/7 basis; the facility provides 11 (PCAs) scheduled to work each 24-hour period. Personal Care Attendants are available for immediate care, assistance, and advice. Rather than having 24-hour on site LPNs, Home Care Nurses (HCNs) visit residents based on need. Other optional services may be purchased at additional cost including medication assistance program, laundry, and TV cable.

Recreational care. The facility offers various recreation and wellness programs (e.g., art & crafts, fitness) in addition to a variety of entertaining social gatherings. Transportation via a community van is offered by the facility. The van is available for several community and field trips; residents may catch a ride to a shopping mall, theatre, or bowling alley. Inside the facility there is a billiard and games area, an exercise room, a hair salon, a tuck shop, and an arts and crafts centre for residents' enjoyment and convenience. All residents have access to these recreational amenities.

Spiritual care. Spiritual programs are integrated into activity programs and delivered by affiliated religious community groups and organizations. The facility holds spiritual services frequently for all the residents, and host a variety of denominations including, United, Catholic, interdenominational and Mormon. Bible study is being trialed upon request of the residents.

Hospitality services. Food and housekeeping services are included in a monthly accommodation package. The suite is cleaned on a weekly basis by housekeeping staff. A maintenance team regularly checks the facility to ensure that the interior and exterior of the premises are properly and safely maintained. Restaurant-style dining with choice of menu featuring a primary choice and alternate at all meals is provided. Helpful dining staff will serve residents three nutritious meals a day. Complementary snacks and refreshments are always available.

Data Collection

Sample.

Participant will be recruited to the study based on convenience and purposive sampling. Convenience sampling involves drawing participants who are both easily accessible and willing to participate in a study (Creswell, 2009; Morse, 1994). Purposive sampling is a type of sampling in which particular settings, persons, or events are intentionally selected for the importance and richness of the information they can provide (Maxwell, 2005). The main criteria for inclusion in the study will be: participant must be a senior citizen (65 years and older), a resident of the ALF facility for a minimum of six months, cognitively capable (e.g., ability to communicate verbally, ability to understand and comprehend the questions asked), and willing to participate in the study. Demographic information to be collected will include: age, gender, level of education, marital status, occupation, and location of primary residence prior to residing at the ALF. I plan to conduct single interviews with approximately 17 (n=17) participants.

Recruitment.

In site one I will work to recruit participants by placing invitation posters throughout the facility that include study details and my contact information (see Appendix A). Three weeks later I will follow up with a tea party that will be organized in collaboration with the site manager. This social event will provide me an opportunity to connect with the residents in a relaxed setting and inform them about my study. I will invite participants to attend the tea by distributing invitation cards to residents (see Appendix F). During the social, I will introduce myself as the principal researcher and provided residents with information about the study. This social will allow the residents to meet me, learn about the study, and express interest in becoming involved in the study as a participant. At this time, I will also distribute an invitation letter with further details about this study and my contact information (see Appendix B). This process at site one generated nine participants (n=9).

At site two, the manager will personally speak with residents to assess interest and then provide me with a list of the potential participants and their contact information. I will then meet with participants, introduce myself and explain the study to them and work to arrange a mutually agreed upon time to conduct the interviews. This process at site one generated eight participants (n=8).

Interviews.

Each participant will be interviewed separately. The semi-structured interview will take approximately 45 minutes in duration and will be audio recorded upon participant consent to ensure accuracy in data collected and transcribed. At the start of the interview, the participant will be provided with a copy of the informed consent (see Appendix C), which will be reviewed and signed prior to proceeding. Once this is completed, the interview will proceed. An interview protocol (see Appendix D) will be used to guide the semi-structured interviews and elucidate the meaning of six broad domains: a) experience of living in ALF, b) values, c) meanings, d) quality, e) autonomy, and f) changes. Before starting the interviews, I will obtain some demographic information (see Appendix D) and reassure the participant that they can withdraw from or discontinue the study at any time during without consequence.

In order to check my understandings of the interview and to determine accuracy of the work, the responses will be verified by confirming the statements with the participants. Each interview will be transcribed verbatim with the assistance of a transcriptionist, who will sign an oath of confidentiality. I will also review the transcript along with the recorded interview. After transcribing the interviews, I will provide a copy of the transcribed interview to those participants who had asked to review a copy before their data being included in the analysis. The purpose of this review is to ensure that the transcribed data is correct and no changes need to be made.

Data Analysis

Data analysis will be commenced upon completion of the first interview and this process will continue until saturation is reached and no new themes emerge (Corbin & Strauss, 2008; Creswell, 2012). In qualitative inquiry, with the exception of saturation, there are no criteria for determining adequate sample size (Creswell, 2008, 2009, 2012; Mason, 2010; Thorne, 2008).

In this research, thematic analysis will be used which is considered to be a foundational type of qualitative analysis (Braun & Clarke, 2006; Limputtong, 2009). Braun and Clarke (2006) recommended this method for novice researchers, since it provides core skills that will be useful for conducting other methods of qualitative analysis. Thematic analysis is a method for identifying, analyzing, and reporting patterns or themes within the data. It organizes and describes the data set in rich detail. The following steps, as proposed by Braun and Clarke (2006), will be adopted in this study:

1. *Getting familiar with the data:* I will immerse myself in the data by first listening to the recorded data, then transcribing it, and reading the transcripts several times. During this phase, I will take notes, search for patterns and meanings, and mark ideas for initial coding.
2. *Generating initial codes:* Codes refer to “the most basic element of the data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63., as cited in Braun & Clarke, 2006, p. 88). In carrying out the initial coding, I will name ‘chunks’ of data with a label or initial code that categorized and summarized each piece of data. I will use qualitative data analysis software (QDA Miner) to help me organize my data, color code the data, and retrieve the codes easily.
3. *Searching for themes:* By ordering codes into categories, I will gather all relevant data into potential themes. I will start by analysing codes and considering how different codes may combine to form a category.
4. *Reviewing themes:* During this phase, I will review the categories under each theme. This will involve refinement of the formulated themes. First, I will verify the theme and then if there are not enough categories to support the theme, or the data under this theme is too diverse, I will reject the theme. Other themes may merge.
5. *Defining and naming themes*: By this time I should have a satisfactory thematic map for the analyzed data. By defining and refining, the essence of each theme should be realized.
6. *Producing the report:* I will extract rich and compelling examples from the analyzed data. The final analysis of selected extracts will relate back to the

research questions and the literature, producing a rich and scholarly report of the findings.

Scientific Rigor

Scientific rigor refers to the quality of qualitative inquiry (Liamputtong, 2009). In discussing the quality of qualitative inquiry, Lincoln and Guba (1985) proposed some criteria that qualitative researchers can use to ensure rigor or trustworthiness of their research. In contrast to the common terms used in quantitative research, Lincoln and Guba (1985) created a set of parallel evaluative terms that are specific to qualitative research methods. As a replacement for ‘internal validity,’ they used the term ‘credibility’ or confidence in the honesty of the findings. Instead of ‘external validity,’ they labelled the term ‘transferability,’ displaying how findings have applicability in other settings. ‘Reliability’ became ‘dependability,’ or showing how the findings are consistent and accurate. Finally, they substituted ‘objectivity’ with ‘confirmability,’ referring to the degree to which the study maintained neutrality. In this study, scientific rigor will be examined using the criteria proposed by Lincoln and Guba (1985), as discussed below:

Credibility.

Credibility will be established by ensuring that I am well informed about the context, the organization, the facility, and the people who reside within the ALF. In the summer of 2012, I was provided the opportunity to tour one of the two ALFs, where this study took place, and to look at different elements of the physical facility and the services provided. The administrators of the facility provided me with a thorough orientation to the site. Moreover, I had the chance to meet and talk with some residents in their personal living spaces and common areas. This provided me an opportunity to establish a sense of trust with some of the residents. Lincoln and Guba (1985) state that trust building minimizes misrepresentations of participant views. This will be achieved by getting close to each participant, carefully listening to him/her talk, and by showing empathy and respect. Further, the credibility of this research will be established by using an interview schedule/ protocol that consists of open ended interviewing techniques and semi-structured questions to guide me during the interview process. In addition, purposive sampling provides the research credibility (Carpenter & Suto, 2008; as cited in Liamputtong, 2009). Purposive sampling will be employed by selecting participants for their unique characteristics to enhance understandings of their experiences. Selecting information-rich cases provides insightful answers to my research questions.

Member checking or participant validation will also be used to increase credibility. It will allow participants to confirm their responses (Liamputtong, 2009). Carpenter and Suto (2008) defined member checking as “a process where researchers seek clarification from their research participants” (as cited in Liamputtong, 2009). In this research, member checking will be performed by allowing participants the opportunity to review their transcribed interview prior to it being included in the analysis. Moreover, I will employ a peer-review process to provide an external check of the findings. Specifically, my supervisory committee will serve as a peer review and assist as needed in the review of the transcribed interviews and themes in order to ensure quality and effectiveness.

Transferability.

Transferability refers to the degree to which the results from qualitative research can resonate with other contexts or settings. It addresses the question of “to what degree can the study findings be applied to other individuals, groups, contexts or settings?” (Liamputtong, 2009). Some researchers (Carpenter & Suto, 2008; Liamputtong, 2009; Padgett, 2008; Sandelowski, 2004) claim that transferability conveys that the theoretical knowledge obtained from qualitative research may be applied to other similar individuals, groups, or situations. Johnson and Waterfield (2004) argue that the trustworthiness of the research is enhanced by providing rich and thick descriptions of research process and research products. Such description is necessary to allow readers to gauge both the trustworthiness of the data and the context to which findings can be transferred to other settings. In this study, transferability will be attained by providing the readers with a detailed description of the data, time, and context in which the study took place (Geertz, 2002). Detailed descriptions of the research procedures, methods, setting, and recruitment considerations will also be provided. Direct quotes will be used to let readers gain a clear impression of participants' feelings, thoughts, and experiences.

Dependability.

Dependability can be compared to reliability in qualitative research. Dependability ensures that the research findings fit the data from which they have been derived (Liamputtong, 2009; Lincoln & Guba, 1985). To ensure the process and product of inquiry is reasonable, the researcher leaves an audit trail of the research process. The audit trail involves reviewing all documents relating to the study and keeping a clear and full account of things to ensure that complete records are kept of all phases of the research. This includes everything from problem formulation, to the selection of research participants, to fieldwork notes, to interview transcripts and data analysis (Bryman & Teevan, 2005). In this study, I will keep comprehensive documents of the research process, method of data collection, data management, analysis, and interpretations.

Confirmability.

The term confirmability used by Lincoln and Guba (1985) refers to the amount of neutrality (i.e., the state or policy of being neutral) established in naturalistic inquiry. The concept of confirmability is the qualitative parallel to objectivity in quantitative research (Lincoln & Guba, 1985). Here steps must be taken to manage any biases that the researcher brings to the study and to ensure that the findings are the result of participants' experiences rather than the characteristics and preferences of the researcher. In this qualitative study, confirmability will be enhanced by describing the research context and providing detailed background information about the ALFs and the organizations operating these facilities. The reader will benefit from getting a clear picture of the research context. Researchers commonly rely on reflexivity to protect against personal bias in making judgments. Reflexivity is the process of reflecting critically on the self as researcher, it is the conscious experience of the self as the researcher comes to know him/herself within the process of research (Denzin & Lincoln, 2005). Therefore, I will share information about my personal, professional, and academic background to show how my personal perspectives affect the research topic and to illustrate the possible influences of my personal values on the selected research method and on the interpretations of data from this study.

Ethical Considerations

Ethical issues are an essential aspect of qualitative research because of the close interaction and trust relationship between the researcher and the participants. Ethics are a set of moral principles that aim to prevent research participants from being harmed by the researcher and the research process (Israel & Hay, 2006; Liamputtong, 2009). Ethics approval for this research study will be (and was) granted by the following institutions: the University of Lethbridge Human Subject Research Committee (HSRC) and the Health Research Ethics Board (HREB). The research meets the requirements of the Tri-Council

Policy Statement on Ethical Conduct of Research Involving Humans (2nd edition), and of University policy as well as provincial, federal, and other legislation and requirements. Further, due to the small sample size, it is imperative that I take all steps to protect the identity of participants and the confidentiality of the data collected (Hesse-Biber & Leavy, 2010). To protect confidentiality in this study, participants will be assured in the initial recruitment contact, at the beginning of the interviews, and in the letter of consent, that no names or identifying characteristics will be revealed in the final transcripts, data analysis, executive summary, final report, or journal articles. All aspects of the data, including identities of the participants, will be kept confidential by using pseudonyms. Data will be stored in a secure locked cabinet in a designated office at University of Lethbridge that is possible only to my supervisor and myself. All data files, including audio files and transcriptions will be kept for a period of five years, after which they will be destroyed. The participants will be informed that interview records and transcriptions will be destroyed five years after the interview. In addition, interviews will be conducted in a private and secure place inside the facility based upon the convenience of the participants. However, since this study will be conducted in two facilities with a small sample, participants may be able to be identified by staff and other participants inside the facility. Only I (the principal researcher) will be aware of the names of the participants and potential participants derived from the convenience sample.

Seniors are a potentially vulnerable population and therefore, if a study participant reveals to me that he/she had experienced any sort of violence or abuse as a resident of the facility, I am obligated to bring this to the attention of my supervisor. She will then consult with the Director of the Graduate Programs within the Faculty of Health Sciences to determine the most appropriate way to address the situation. Thus, participants will be informed through the consent letter that disclosure of any elder abuse will be reported to the proper authorities as per legal requirements. However, no any sort of violence or abuse was revealed by participants.

Human research that involves a vulnerable population may evoke some strong emotions on the part of the interviewee. Therefore, it is important to devise strategies to appropriately manage emotional situations and to be ready to face human feelings (Dickson-Swift, James, Kippen, & Liamputtong, 2007). During the interviews, I will develop a good rapport with all interviewees in a way that facilitated a sense of trust, disclosure, and engagement. This will be achieved by showing respect and listening carefully to the participant, as well as by showing empathy and caring about their feelings as a human being. For example, if participants become emotional during the interview, I will turn off the audio recorder immediately and try to relieve the situation by offering emotional support (e.g., touching hand, rubbing back, wiping tears). I will also ask the participant if he/she wishes to continue with the interview or if they would prefer to re-schedule for another time. During the interview process, two participants became emotional which required me to stop the recorder and show empathy. These participants took a break to breathe and relax and after a while they asked to continue on with the interview. I listened carefully to each participant's responses and descriptions, noting certain phrases or words. In many questions, I probed to expand on meanings or to provide an illustrative example of certain ideas. My probes included phrases such as, "Go ahead," "Can you talk more about that?" and "Can you provide an example of that?" Moreover, I used non-verbal prompts such as head nodding, smiling, saying “aha” and maintaining eye-contact that motivated the participant to provide further details.

Dissemination

Upon reviewing all the results and completion of this study, I will disseminate the findings in the following way: a) I will publish my thesis through the University of Lethbridge library; b) I will report an executive summary to the participating facilities and their umbrella organizations; c) I will report a summary of the findings to the Institute of Health Service Quality at the University of Lethbridge; d) I will provide an executive summary to those participants who requested to receive a copy of the findings; e) finally, I plan to present the findings at scholarly conferences and publish in academic journals.

Chapter 4. Findings

The purpose of this study was to explore the perceptions of ‘quality of life’ among seniors living in ALFs. This goal was achieved by carefully examining participants’ unique characteristics and presenting their responses, supported by direct quotes. When using quotes, pseudonyms were created to enhance the natural sense of the conversation and to protect the anonymity of the participants.

This chapter begins with a description of the sample, including the socio-demographic characteristics of the participants such as age, gender, education, occupation, length of stay in the ALF, and the type of residence they lived in prior to moving into the ALF. In this chapter, I present the results from my thematic analysis. I developed three major themes from residents’ descriptions of their quality of life in ALFs: (a) physical environment, (b) social environment, and (c) home-like atmosphere.

Description of Participants

Using purposive sampling, I recruited 17 participants; 13 female (76.5%) and four male (23.5%) seniors from two ALFs. All participants were Caucasian with a mean age 84 years (range = 69 to 93). Eight participants (47%) were widowed while seven participants (41%) were married and two participants (12%) were divorced. Thirteen participants (76%) lived in their own homes before moving to ALF, and one participant (6%) moved from long term care, while two participants (12%) moved from other ALFs, one participant (6%) came from a rental retirement community. For all participants, the average length of stay in the ALF was 30 months at the time of interviews (range = six to120 months). Two participants (12%) were residents for more than 60 months (five years). Further descriptions of demographic data are provided below (Table 1):

Table 1. ***Demographic Data Descriptions*** **(n=17)**

Characteristic		Number	Percentage
Gender	Female	13	76.5%
	Male	4	23.5%
Age range (yrs.) (69-93)	65-75	4	24%
	76-85	5	29%
	> 85	8	47%
Race	Caucasian	17	100%
Marital status	Married	7	41%
	Widowed	8	47%
	Divorced	2	12%
Education	Bachelor	1	06%
	Diploma	7	41%
	High school	5	29%
	Middle school	4	24%
Occupation before retirement	Professional	6	35%
	Clerical/service	8	47%
	Unemployed	3	18%
Residence before moving to ALF	Own home	13	76%
	Long term facility	1	06%
	ALF	2	12%
	Retirement community	1	06%
Length of stay at ALF (months)	Range (6-120) months		
	6-12	5	29%
	13-36	6	35%
	37-60	4	24%
	> 60	2	12%

Themes and Categories

The participants (n=17) provided valuable perspectives on their personal experiences living in an ALF. The value of this study lies in its ability to bring the diverse views, perceptions and voices of members of the senior population, who have different experiences of living in ALFs. The approach of thematic analysis by Braun and Clarke (2006) helped me to extract meanings from the data, and led to a group of important categories organised within three major themes: (a) physical environment, (b) social environment, and (c) home-like atmosphere. A detailed description of the major themes and categories is presented in Table 2. The themes provide a sense of the main concerns and perceptions of seniors living in ALFs. Within each category, quotations are used to support findings from participants. To illustrate, I referred to the first facility as ALF-1, and to the second facility as ALF-2.

Table 2. ***Themes and Dimensions***

Theme #1: The Physical Environment	Theme #2: The Social Environment	Theme #3: Home-like Atmosphere
a. Physical space	a. Relationship with residents	a. Meaning of home
b. Design and accessibility	b. Relationship with former friends	b. Food and dining
c. Proximity to neighborhood attractions	c. Relationship with family	c. Autonomy
d. Proximity to family	d. Relationship with staff	d. Privacy
e. Personal possessions	e. Community integration and activities	e. Independence
f. Views and outdoor spaces		

Theme #1: The Physical Environment

The first theme described the impact of the physical environment on participants' perceptions of daily living. Participants perceived the physical environment in various ways and identified some strengths and limitations of many physical features. Numerous categories emerged from the participants' discussion of the physical aspects of the facility. The majority of participants wanted to have choices about their living space, possessions and furniture. They expressed the necessity of a barrier-free environment to facilitate their mobility and to access amenities and services within the facility. They also highlighted the importance of window views and outdoor spaces. Proximity to neighborhood attractions and services were imperative to create a sense of connection with the neighborhood. Below, the subthemes are explained in detail.

Physical space.

In looking for available ALF options and choosing the right fit, participants considered the physical space to be an important factor in decision making. Design standards and guidelines for construction of seniors care facilities are provided by the Alberta government. According to these guidelines, the size of the resident suite should not be less than 35.0 m² (Shultz & Chisholm, 2010). For the two facilities included in this study, a single suite consisted of 35.3 m² of area, whereas a couple suite consisted of 51.1 m². Participants perceived this space differently. While many described it as spacious and as working very well to fit their personal belongings, others perceived it as small and barely sufficient to fit their furniture. In addition, participants compared the size of their own room inside the ALF to the size of their former living space.

> *Researcher: What was your initial thought about the place when you came in here for the first time?*
> *Ben: The room was not very large but it was sufficient.*
> *Researcher: You have mentioned that the room wasn't really large, how did you feel about that first?*
> *Ben: I felt it was very small compared with the house that I was moving out of; it was quite a change to try and put all our furnishings and things into a small apartment from a large house. (ALF-2)*
>
> *Researcher: So what do you like most about this place?*
> *Tim: It's rather big and spacious with a kitchen in it so that we can make meals if you choose not to go to the dining room. And it's…when we came in and looked at the bedroom, "Oh you'll never get a king size bed in there," well, we put a king size bed in there, it worked very nice thank you very much. It's worked out very comfortably ever since.*
> *Researcher: Did you look at other options as far as assisted living facilities?*
> *Paula: I looked at the X facility on the north side, and I preferred this place.*
> *Researcher: And why did you prefer this facility?*
> *Paula: The rooms were bigger, um, I think basically that was the only reason- it was because these rooms were bigger than over there. (ALF-1)*

For many residents, the physical space became an issue when they rented a precise square footage suite. At the first facility (ALF-1), which was a non-profit facility, the monthly accommodation fees for a single suite and a couple suite were $1,485, and $1,685 per month, respectively. At the second facility (ALF-2), a privately operated and for-profit facility, a monthly accommodation fees for a single suite and a couple suite were $1,845 and $2,194, respectively. For the couple suite, an additional cost of $660 is incurred for the second resident. In light of these prices, Ben, a resident who lives at ALF-2, discussed the cost of living and how affordability affects room size and choices of living:

> *Researcher: Do people in this place allow you to choose whatever you want? Are there many options to choose from?*
> *Ben: No.*
> *Researcher: What are some examples of things that you cannot choose or decide about?*
> *Ben: Where to live. I find it hard to decide what or where to live; whether to stay here in the small apartment or to try and expand and develop my own facilities.*
> *Researcher: What are some other things that you can't decide about?*
> *Ben: Where to live; it's too expensive.*
> *Researcher: Do you think that this facility respects your personal choices?*
> *Ben: No.*
> *Researcher: How?*
> *Ben: Just by analyzing the cost, I don't know what I would do if I didn't have money. Some people are very depressed because of money. I have always managed my affairs quite well so I have sufficient to live on.*
> *Researcher: Can you talk more about your personal choices here?*
> *Ben: Well we chose to move to facilitate a larger bathroom or more facilities but that's the only thing. We have purchased equipment to suit the apartment and feel quite comfortable. (ALF-2)*

In response to the question about what attracted them to the facility, residents considered room size as the main attraction:

> *David: The size of the rooms particularly, they were bigger than what we saw anywhere else, that was probably the biggest reason, and getting two rooms*

> *separate for a bedroom and a living room kind of was our reason for it I think. (ALF-1)*

The conversation with some participants spoke to the importance of the physical space in supporting their activities and physical mobility. Considering a spacious room was imperative for some residents in light of their mobility limitations. Frequently, residents valued size, not only of their suites (e.g., bedroom, bathroom) but also of other spaces in the facility (e.g. dining room, public spaces):

> *Researcher: After moving in here, have you led to change the way you do things?*
> *Leanna: Well if you're looking for a spacious place to live that does have lots of activities- there are lots of activities- then I would say I find it here a good place to live. Yes, I've been in a place where I could barely get into the bathroom; maybe the rest of the room was bigger but the bathroom was so tiny that I'd have to hang onto the sink to be able to sit down on the commode, so this is much more accessible for me. (ALF-1)*
>
> *Researcher: what attracted you to this facility?*
> *Rita: The space.... the nice space around...particularly the dining room. (ALF-2)*

Design and accessibility.

Although ALFs are typically designed to maximise residents' ability to move safely and independently (Cutler, 2007), no uniform physical design was used to achieve these outcomes in either facility. In this study, the two facilities differed in terms of physical design and room layout. To illustrate this, I included a design blueprint showing the building floor plan for each facility. Both design blueprints were provided by the facilities managers. The ALF-1 consisted of two identical floors made up of three wings of suites and includes a dining room, kitchen and two lounge areas. Each floor accommodated 34 single suites and four double suites. The staff station was located at the center of the three wings (see Figure 1).

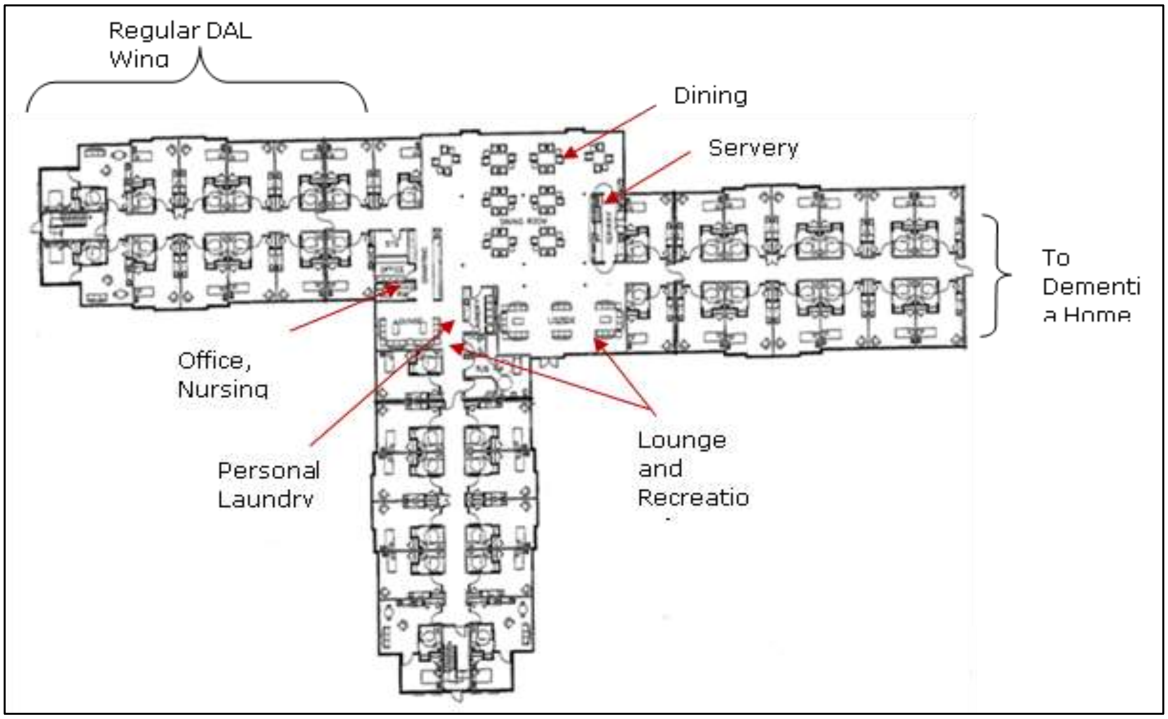


Figure 1. **First facility design footprint (ALF-1). Source: Covenant Health, 2012.**

The ALF-2 consisted of two identical floors designed with a small grouping of pods that each contain seven to eight suites and faces a shared leisure area. One hundred and twelve suites were distributed on 14 pods, seven pods per floor. One nursing station was placed on each floor, and two central dining rooms were located at the atrium and surrounded by three or four pods (see Figure 2).

Access to services within the facility acted as a strong environmental factor that affected the physical mobility for many residents. For some residents, having good access within the facility meant doorways and hallways clear of obstacles, simple layout of units, ability to move around easily, and finding clear way to units.

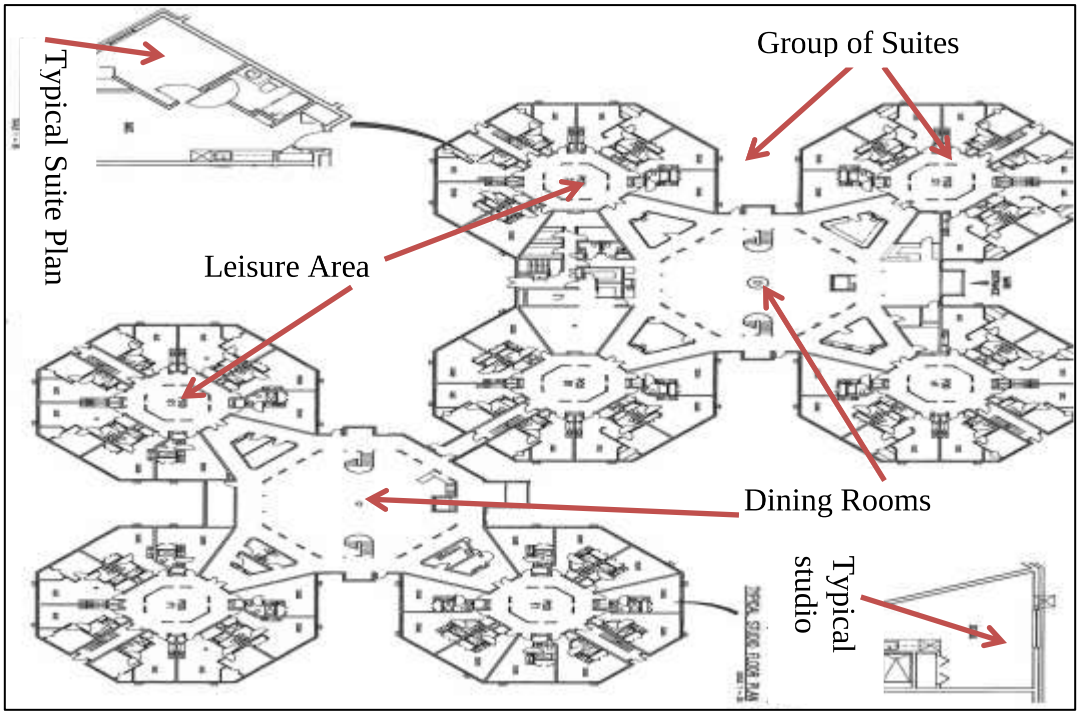


***Figure 2.* Second facility design blueprint (ALF-2). Source: Age Care, 2013.**

Leanna, a participant who moved from ALF-2 to ALF-1, highlighted the differences between both facilities' design in terms of accessibly and easiness of moving around. At ALF-2, she got confused with the room setup and doors that were difficult to open, and she kept getting lost. In contrast, she felt more comfortable with the configuration of ALF-1:

> *Leanna: I kept getting lost at X facility; it took a long time to find out which way was an easier way to go, and always somebody had to open my door - I could never open my door. So that was too confusing, so I was grateful here, there was straight - straight down to the dining room, and straight to the recreation room, straight to the lounge, yes. Researcher: is it easier getting every place here? Leanna: Oh very much so, and lots of room for people to pass each other - even two or three in electric wheelchairs, that's…if it's at all possible most of the senior's homes should be like this. (ALF-1)*

In contrast, another resident preferred the round setup of the residents' suites rather than having them longitudinally arranged across long hallways.

> *Researcher: Compared to other facilities, what is unique?*
> *Rita: Compared to some of the others, they couldn't provide what I needed. And ... I like this setup better than the long hallways that some facilities have, to get from place to place. (ALF-2)*

Proximity to neighbourhood attractions.

As they age, seniors require that their nearby surroundings encourage them to be as active as possible. Seniors tend to be more active in a well-serviced area with accessible attractions such as local shopping and services, pedestrian infrastructure, and public transportation (Gauvin et al., 2012; Michael et.al, 2006). In this study, many residents compared the facility with their home neighbourhood and repeatedly talked about this aspect and how it affected their daily life activities.

One of the residents highlighted the difference between home surroundings, where she kept active, and ALF-2 where she felt stuck between four walls:

> *Researcher: So what is it like living here at this place?*
> *Maureen: Quiet; I've gotten used to it. At first I almost hated it because you know, when you're in your own home you can go outside, you can pull weeds, you can do whatever, here you're stuck here- this is my four walls. (ALF-2)*

Alice, who is living at ALF-2, described how her home neighbourhood always kept her busy:

> *Researcher: What was your quality of life like before moving to this facility? Can you compare?*
> *Alice: That's like comparing apples and oranges.*
> *Researcher: How?*
> *Alice: Well there's no comparison between X facility and here. But between my house and here, no that isn't even a fair comparison because I would be out in the yard or visiting neighbours, or you know just keeping busy; I was always busy. (ALF-2)*

David, a resident living at ALF-1, lost his ‘daily entertainment’ by moving far from his home (which was located downtown) to the facility where no attractions exist.

David expressed his dissatisfaction with the location of the facility and it being far away from everything.

> *Researcher: Have you missed things you've been doing at home (e.g. your daily activities, hobbies, your own practices)?*
> *David: I would say, yes. The fact that I…my biggest entertainment back at home was getting to the senior's center down town- it was only five minutes away- and the activities that went on there. (ALF-1)*

> *Researcher: So what do you like least about this place?*
> *David: It's location I think, I wish it was downtown. It's…other than that, that's the only thing- we're too far away in the bush I would say (ha, ha). (ALF-1)*

Transportation seemed to be problematic for most of residents who lost their driver's licences. After suffering a stroke, David felt constrained due to his inability to drive and having no public transportation services within close proximity of the facility. As an alternative, he relied on his sons to drive him to and from the facility.

> *David: See, after I had a stroke and lost my eye they took my driver's license away and when that was gone, the anchor was thrown out and I was never able to get away. But we are fortunate, we have two sons in town and I can just phone them anytime and I'm out of here. (ALF-1)*

When asked how he would compare his current life here at the ALF to his previous living situation, he spoke about his feelings of isolation and not being able to move around safely:

> *David: Not near as good, home was much better, yup. But the reason here we seem so isolated out here, you know you can…I still am capable of getting to Super Store and over to Wal-Mart occasionally, but I have a little electric buggy a four wheel cart that I can drive over. I have walked that far, the only trouble is I come back one day and fell down and smashed my face and whatnot (ha, ha)- but that could happen. It's a different lifestyle altogether compared to what I was used to. (ALF-1)*

At ALF-2, Maureen felt locked up in given the lack of convenient transportation. Especially after losing her driver's licence, she found it hard to plan a week ahead when having to take the bus. Taxis were too expensive and not affordable for everyday use:

> *Researcher: So how would you compare a typical day here to a typical day back home?*
> *Maureen: Oh a world of difference- you're free at home, you're free in your own home. I can't drive a car now, in my own home I could get in the car and go down to the store or go anywhere and now you're like, locked up, yup, all the privileges have been taken away from us. (ALF-2)*

> *Researcher: So is there anything else you would like to talk about?*
> *Maureen: No, except that I don't have my own car (ha, ha) you know, and that's a privilege that has been taken away from me, and I have to phone for a bus, and you have to phone a week ahead of time to get on the bus, or you have to take a taxi and taxis are too expensive so I have to phone a week ahead of time, twice a week, to go visit my husband because Tuesdays and Thursdays I go. (ALF-2)*

Proximity to family.

For some residents, proximity to family is the reason for their preference of the facility. A resident has described the proximity of ALF-2 to the family location as a reason for her relocation from the United States**:**

> *Researcher: What are some other reasons you preferred to come over here?*
> *Loraine: Other reasons…oh, we have family living up here, that's why we come too. We have a daughter in Claresholm, then we have a son down in the States too, so they're just kind of...we have…ya, we have a daughter up in Grande Prairie, and so we wanted to get closer to our family. (ALF-1)*

Another resident stressed the importance of living in a location central to her sons, which makes it easy for family members to visit:

> *Researcher: How did you find out about this facility?*
> *Alice: My sister-in-law was here and a good friend from Good Sam’s lives here too…I haven't lived here…but I knew of the facility because my sister-in-law lives here. And it's….to get me into here it was central for my sons…I have one son that lives over here, and I have one son that lives over there…so it's central where they come and visit me. (ALF-2)*

Personal possessions.

A possession is a property interest over which an individual is able to exercise power over something to the exclusion of all others (Burton, 2008). In both facilities, suites can be personalized and residents are encouraged to bring in their personal possessions such as furniture, pictures, and other decorations to help make the space feel more home-like. Such decorations help to enhance residents' personalisation and foster remembrance of significant, enjoyable life events and activities (Evan, Kantrowitz, and Eshelman 2002; Frankowski, 2011). In this study, residents appeared to be comfortable and settled with their possessions. In a place where residents perceived the facility as home, rooms were customized by the residents' personal items. They modified their rooms to demonstrate a sense of self and belonging. They also decorated walls with family photos and exhibited their possessions. Maureen is a resident who considers ALF-2 as home, where she intends to spend the rest of her life. She expressed her feelings with a tone of sadness:

> *Researcher: So what does this place mean to you now?*
> *Maureen: Well it's everything I've got, I mean where else can I go- I can't, I mean, this is home; I intend to stay here until the day the Lord calls me home. (ALF-2)*

Residents spoke about the possessions they brought from their homes. Gloria appeared comfortable expressing her experience of moving in to ALF-1 with her own things around her:

> *Researcher: What was your initial impression when you moved into this place?*
> *Gloria: Well I had to bring my own furniture and so I was feeling…I knew I would feel comfortable you know, here with my own things around me.*
> *Researcher: So did you have your own furniture the way you want?*
> *Gloria: Well I wanted my dolls, I wanted a place to bring my family history books- I've got two shelves in the closet, also loose leafs, so there was room for my stuff because I do family research. I'm comfortable. (ALF-1)*

Views and outdoor spaces.

A unique design feature that has a significant impact on residents' life at ALFs is views of nature and outdoor spaces (Rodiek & Fried, 2005). In this study, there was considerable evidence that a window view was imperative. Many residents lacked a window view or a balcony. Some also lacked the physical ability to get outside as frequently as they wished. For these residents, it was common to have a more visual connection with the outdoor spaces through the window rather than a physical connection. In many situations, participants expressed their need to have an outdoor space within the facility (e.g., back yard, balcony). They also desired to have a nice outdoor view and large window in their rooms.

Ben, a resident who moved from his home in the United States, complained about the lack of outside space around ALF-2. He talked about the lack of outside space in comparison to his home where he had a spacious yard and a garage for carpentry work:

> *Researcher: And what do you not like about being here?*
> *Ben: The limit on space and the lack of facilities for extra outside space.*
> *Researcher: If there were extra outside space, what would you do there?*
> *Ben: I would do carpentry work, and build hobbies, and toys. (ALF-2)*

Alice is a resident who moved to ALF-2 from a senior retirement community. She compared ALF-2 to her former residence where she had a nice view and balcony:

> *Alice: The only thing I missed when I left Good Sam's was the lake.*
> *Researcher: Okay, the view?*
> *Alice: The view outside; I had a big double window and a balcony. And that's another thing that bothers me here, there are no balconies. You know I used to sit out on my balcony and watch the geese come in and… (ALF-2)*

Jill is another resident who talked about the window view at ALF-2. For her, it was a missed feature that could add more uniqueness to the facility:

> *Researcher: After living here for a period of time now, what do you feel is unique about living here at this facility?*
> *Jill: well …you have your own privacy and you have the help when you need it and… well I guess that the food is very well now…I just like living here... haha… I haven't got a view but that is okay. (ALF-2)*

Gloria spoke about her yard at home, which kept her busy in the summers with gardening and picking fruits. At ALF-1, there is no yard:

> *Researcher: So is a typical day here different from a typical day back home, can you compare?*
> *Gloria: Well ya, at home I had a garden in the summertime- the raspberries, I had to them every other day. I had an apple tree and in the fall I would make apple sauce and bottle it, and of course I can't do that here… Ya I was in the yard quite a bit when I was at home- in the summer time. (ALF-1)*

Eva is a resident of ALF-1 who discussed changes to her daily routine in relation to outdoor space. She talked about her home yard and how it kept her active and busy. At ALF-1, she missed this feature, especially her growing gardens and flowers:

> *Researcher: So it's different from your routine back home?*
> *Eva: Oh absolutely, ya.*
> *Researcher: Can you talk more about that?*
> *Eva: Well at home I was always active; there was always something to do. I loved being outside doing things and I miss growing gardens and flowers, but it's something you have to adjust to a change. (ALF-1)*

Residents had different perceptions about window views and outdoor space. Tim was satisfied with the windows and the outside space at ALF-1:

> *Researcher: What are some of the challenges that present to your quality of life here?*
> *Tim: Well…okay, I'm comfortable in here. The staffs in here are very considerate and they look after us well. Two big windows, the outside, grass and it's a nice place isn't it? (ALF-1)*

Summary of Theme #1: The Physical Environment

Properly designed physical features of ALFs seem to be important factors to improve residents' activity level and their sense of well-being, and facilitate their relocation and settlement inside the ALF. Participants valued the physical environment differently and discussed various physical attributes such as physical space, design features, window views, outdoor spaces, proximity to neighbourhood attractions, and proximity to family. Among these features, participants from both facilities considered physical space an important factor facilitating their movement and affecting their activities of daily living. As a whole, participants seemed to be most satisfied with their own personalized suites and personal possessions (e.g., furniture, books, pictures, decorative items). Many participants agreed that their personalized suites provided them with a home-like atmosphere. However, participants with relatively shorter durations of living in the ALF seemed to be less attached to the facility, which made it hard for them to consider it as a home. Participants from both facilities lacked window views and outdoor spaces; they compared these features with what they had before at home. One of the main concerns for most participants was the location of the facility; both facilities were located in a place that lacked neighbourhood attractions, sidewalks, and accessible public transportation. Therefore, improved physical access according to the physical needs of the residents can enhance the residents' experience of living in an ALF and also their adaptation.

Theme #2: The Social Environment

Four residents are sitting in the community room chatting and having tea together. They face each other on comfortable chairs and sofa. The place feels like a luxury hotel lobby. It is glorious and warmly decorated with pictures and plants, there is a lady playing piano in the corner of the room. A nice window view accompanied by background music makes the place peaceful and relaxing. Many staff are stopping by, they smile and greet the residents. There is spirited interaction among people here; generally, the place feels lively and welcoming! *(Field notes by researcher, ALF-1, Oct 31st 2013).*

Social relationships play an important role in the daily lives of seniors. It is one of the most important indicators to determine the physical and mental health of the senior population. In this study, participants highlighted their social interaction patterns inside ALFs. From different points of view, participants discussed the social aspects of their living environment in ALFs, and reflected on their physical and emotional well-being. Moreover, they discussed the changes in their social interaction patterns before and after moving into an ALF. Various subthemes derived from participants' talk were identified under the theme social environment. These subthemes included: (a) relationships with residents; (b) relationships with former friends; (c) relationships with family; (d) relationships with staff; and (e) community integration and activities.

Relationships with residents.

It is human nature that people tend to create bonds and live together. A main reason why many residents moved in to an ALF was the opportunity for socialization and to be around people. At home, residents often felt alone as nobody was living with them. Many residents expressed their need to feel alive by having friendships with other residents. Paula is a resident of (ALF-1), she felt at home and appreciated the opportunity of interacting with other people:

> *Researcher: So what was your quality of life before moving here?*
> *Paula: I really didn't have a life. Like I said, I was alone, my children busy in their work and raising their little ones, so I really didn't have any quality of life at being alone at home; where I feel alive here.*
> *Researcher: So you say that you feel alive here, so how would you describe your quality of life now?*
> *Paula: Well in comparison you know, it's this way. I do feel quality, I feel at home, I feel friendship, I feel my social needs are met, my medical needs are taken care of, so it's good, it's good.*
> *Researcher: Have you changed doing things after moving in to this place?*
> *Paula: I am more involved than I was at home. At home I kind of wasted my time; I was depressed living alone and where here, like I say, I'm more involved. (ALF-1)*

Many residents from both facilities described no difficulty making friends with other residents. However, some residents reported challenges in making friends from inside the facility because of differences in age, physical abilities, interests, and other social traits. Helen, a resident of (ALF-1), made many friends at the facility:

> *Researcher: Have you met people here at this place that you would call friends?*
> *Helen: Well you meet people from various fields; I made friends with the girl that is serving food, if I need something I ask her and when she has a moment she'll go out to maybe Wal-Mart or Costco or someplace like that to buy me what I would like. Because my son and daughter, they work, and they're just too tired to come and see me, and I say, "Come on the weekends," and if they stay they only stay for about ten minutes and then they've got their own life to live; so yes, for that reason, yes. I've met friends with nursing staff; I've met friends that sit at the table and other tables where it's a pleasure to know them, and I know that there's some that you can talk to and you know that it goes no further. So your friends are closer at hand versus being at home, the only way you get close to someone is by phone. (ALF-1)*

In contrast, Ben is a resident of (ALF-2) who reported challenges in making friends inside the facility:

> *Researcher: Have you thought about having new friends from inside this place?*
> *Ben: Not really.*
> *Researcher: Why?*
> *Ben: They're all more handicapped than I am; I can't relate to the physical activities which I'd prefer. (ALF-2)*

> *Researcher: Have you met people here that you would call friends?*
> *Maureen: Yes, a couple, you could call a friend, but not a friend- friend; you know I haven't got a close, close friend in here, which I had before. But I don't have that close, close friend in here.*
> *Researcher: And why is that?*
> *Maureen: It's because…well you know, in here I'm in phase two, we all go down and we eat together and my partner isn't like me, she's always complaining. But I could move…but it isn't my choice to move; I don't want to leave her alone. (ALF-2)*

> *Researcher: How long did it take you to adjust to living here?*
> *Paula: If I remember correctly I felt at home the very first day. I'm a social person so I like to be around people and visit with them. The table that I was assigned to, we became friends right off the bat, so I really don't feel I had to go through a big adjustment because I did feel very much at home.* (*ALF-1)*

As the residents always eat their meals together at the ALF, mealtime was considered to be an opportunity to connect with other residents. When residents dine in a comfortable environment with other residents, mealtimes become more enjoyable. Having a pleasant time with friends at the dining table was frequently reported by residents who spent considerable amount of time at the dining table. For many residents, mealtimes were valued as an opportunity to make friends and have fun with other residents:

> *Researcher: Have you made some friends here inside the facility?*
> *David: There are some very nice people here, yup. There's, as I say, amongst the six of us at our dining table- there's my wife- and the lady that sits next to me when we eat, she's a Canadian Army Veteran who went for the Canadian Army right to Berlin, whereas I never got out of England, and then another one who was a school teacher-she's always interesting to talk to, and then another one was in the Air Force as a mechanic after the war which is same as I was during the war. Amongst the six of us we get some nice…in fact we're nearly always the last table to clear at noon because we're still all talking together- the other tables are all gone and we're still there gabbing. We have a pleasant time at meals, a real pleasant time. (ALF-1)*

> *Researcher: You mentioned you've got good friends here; can you talk about some of the friendships that you have built here in this place?*
> *Gloria: Well the two best friends I have are at the table where I eat because of course we get to visit at every meal and we also play dominoes together. And then I have a friend upstairs who I've known for twenty/thirty years- she's kind of forgetful now but she still knows me, knows who I am and we visit, we got to church together. (ALF-1)*

Relationship with former friends.

Many residents regarded their former friends and wanted to connect with them. Former friends share the same interests and get along well together. Although residents wished to maintain close social ties to family and friends outside the facility, relationships tended to move into the facility because family and friends are busy and they cannot physically be in the ALF all the time:

> *Researcher: So would you recommend this facility to a family member or friend?*
> *Helen: I would because I do like company, especially someone I know from outside rather than making new friends inside. I've been finding it okay, but I do miss my other friends that I don't get to see any more. (ALF-1)*

> *Researcher: Can you compare between the assisted living, where you lived before, and here?*
> *Leanna: Oh big difference, yes.*

> *Researcher: Can you just talk more?*
> *Leanna: Well even though I could stand up at X facility, they don't have any lifts, so they have to all be able to stand up. So there was confusion, and there was difficulty meeting other people, and it was a lot more difficult to make friends there- but I still have a friend from there that used to come and visit her other friend, and she still visits me once in a while, but she's older than I am so I'm amazed she gets around. (ALF-1)*

> *Researcher: Have you met people here that you would call friends?*
> *Kate: I guess slowly you get to know them, ya- slowly. But I had my…like X friend here, she's been a friend of mine before so we're still friends; it's nice to have somebody that you know… that's nice. And slowly you do make friends, ya it takes time. So I wouldn't say I'm lonely, no. (ALF-1)*

Relationship with family.

Among all forms of social relations, family remains the most valuable connection that gives a sense of belonging and support to its members. According to the participants, frequent communication with family members was an imperative form of social connection. Many residents reported that family offered a huge support in accommodation as they moved to the ALF. Most of the residents have their own children, grandchildren, or other family members. Family members who are nearby are frequent visitors to the resident. However, those who are away or busy have not regularly visited the residents; even so, they do contact them frequently. Such relationships with family seemed to be very helpful for many residents to assuage loneliness and enhance their sense of belonging:

> *Researcher: Have you met people here that you would call friends?*
> *Nicholas: We have quite a bit of company here, our kids come at least once a week and my wife's family…my sister lives in Calgary so we don't see her too often. (ALF-1)*

As she moved to the ALF-1, Eva missed her family. She touched on the difference in family connection between home and the facility:

> *Researcher: In terms of your day to day life and living, have you changed the way that you do things, like your own practices, is it different from what you've been doing back home?*
> *Eva: Oh yes.*

> *Researcher: Can you talk about that?*
> *Eva: While I was living at home my family were nearby and they came often; I miss that-they come, but not as often as they used to, there have been a lot of changes you just have to adjust to. (ALF-1)*

In contrast, Linda appeared more comfortable in talking about her family connection after moving from home to ALF-2:

> *Researcher: Is your free time here different from home?*
> *Linda: Not really, no, except I don't go out as much as I…when we had the car.*
> *Researcher: Other than the transportation and the car, are there any differences between here and there?*
> *Linda: Not a great deal, no. And my family are very good, they come over and play games and…my daughter was here yesterday; so I have a good family. (ALF-1)*

Ben’s family comes once a month to once a year to visit him at ALF-2. Despite their few visits, Ben valued his family; he considered their visits as a source of happiness relieving the institutional atmosphere:

> *Researcher: Are you happy here?*
> *Ben: Yes.*
> *Researcher: Okay. Can you talk about this part?*
> *Ben: Oh I have a wife, and the family have visited, so they have provided quite a happy atmosphere around the apartment in spite of the limit on space*
> *Researcher: How often does the family visit you?*
> *Ben: Once a month; some members of the family. Or once a year-they're scattered all over the United States; it's quite a long ways to come sometimes. (ALF-2)*

Gloria’s expectations from family were higher than what reality reflected; she spoke while tears briefly formed in her eyes. She found it difficult not to see her five children as much as she thought she would:

> *Researcher: So what are some of the difficulties to your life being here?*
> *Gloria: I think the most difficult part is that I don't see my family as much as I thought I would. You know they've all got busy lives; I've got five kids and they've all got busy lives. Four of them are married; one's not married, so they have lots to do at home. I'm lucky if I see them once a week which I could…I like to see each one of them…Well I think I'm adjusting pretty good, it took a while but I think I'm adjusting better. (ALF-1)*

Relationship with staff.

How the residents perceived quality of life was largely dependent on relationships with staff, especially those who provide direct care to the residents. Staff who provide compassionate care and assistance contributed a considerably to residents' quality of life. Therefore, the attitudes and behaviour of staff members influenced their relationships with residents. Many residents from both facilities described close relationships with staff considering them as both friend and family:

> *Researcher: So what is unique about this place?*
> *Rita: The kindness of the staff, I like that ...they all very friendly ...and the main office staff is very friendly ... and maybe they made you feel like family ... Aha". (ALF-2)*
>
> *Researcher: How would you describe the quality of service that you receive from the staff?*
> *Loraine: Oh, oh, I'd say it's excellent; they really do a good job, they're friendly and sociable, yup they're real good. (ALF-2)*
>
> *Researcher: What is it like living here; can you talk about your experience of living at this place?*
> *Eva: Well I don't know just what you want to hear, but I'm glad I'm here. The staff are always very friendly and the doctors come to see you here, so everything we need is pretty well right in the building. They also have church services here- that's great. (ALF-1)*
>
> *Helen: The way everybody helps one another, not necessarily the patients, but you can see the co-workers, where if they're short a position they seem to pull together to get the work done. Their interaction is good. Sometimes you would like to talk to them a little bit more for which they don't have time, especially when there might be ten patients to one person. (ALF-1)*
>
> *Researcher: What other impressions did you have when you first moved in here?*
> *David: The efforts of the staff trying to look after us is very well done; they're great people trying to do a job, there's not enough of them I don't think, they could use a few more, but if they use a few more the price is going to go up. (ALF-1)*

Residents were not always happy with the staff and care provided. One of the active residents described the quality of services received as “up and down” based on her observations of staff reactions and behaviours with other residents:

> *I had an incident where…like my knees are getting stiffer all the time and I asked if the girls would take me for a walk, “I can't walk very far, but please take me for a walk.” So the first night was okay, second night was okay, third night I stood at my door and I said, “Is anybody able to take me for a walk?” And the LPN, “Walk, who's got time to take anybody for a walk?” But they can sit there for two hours and gossip; and that hurt. (ALF-1)*

> *Researcher: How would you describe the quality of services that you receive from the staff here?*
> *Paula: It's kind of up and down. Like I said, with the walking situation, that was a downer. I have a situation under my breast and under my tummy where I get absolutely raw and they're very good about vinegar washes and putting creams and cleaning me up, and they ask me, and so I feel good about that. (ALF-1)*

> *Paula: Like I have two at my table that need to be fed, and if they don't come and do it, I do it. And we…like I said, we just look out for each other. And some of the girls will say, “Oh thanks, Paula,” where they should be saying, “Paula, I'll do it,” because that is their job. But I like to help and so I do it, and I have done it for several of the ladies that have been at my table. (ALF-1)*

She proceeded talking about staff not attending to the dining table to serve residents in need:

> *Researcher: Suppose that you are the one who needs the help and no one is attending your table to help you, how would you feel about that?*
> *Paula: It would hurt. I would hurt that my needs weren't being met, but on the other hand there probably would be another one at my table that would help. The girls are not overly ambitious; they're here for the pay check. And in lots of cases I have seen with my own eyes that the residents were not getting what they should be getting. They just want to chat and talk all the time. (ALF-1)*

In talking about staff responses when residents called for help, many residents from both facilities expressed the need for more staff:

> *Researcher: Is there anything that you wish to change for the better of your life here?*
> *Rita: I think it was less in the summer months, when the staffs were changing and staffs were going on holidays... I think sometimes the dining room could be a little more efficient… Put it that way. (ALF-2)*

> *Researcher: Can you just talk more about your experience of living here? Like what it's like living here in this place?*
> *Leanna: Well mostly it's very enjoyable But it's become…there are so many of us that need to have two people to help us get ready for anything. And at first I could stand but not really walk, so as things got harder for me than they needed two people for safety sake, yes. And of course more people are getting older and more infirm and they need to have two people too, but we don't seem to get the staff…enough staff, so of course there's a lot of waiting but that's to be expected. (ALF-1)*

> *Researcher: What are some changes that you would like to see in this place that might improve your life?*
> *Linda: I'd like to see a little bit more cleaning done, a little more.*
> *Researcher: So can you talk a little bit about cleaning?*
> *Linda: Well I don't think they keep the place as clean as they should. We've asked them several times and I don't think they have enough staff, or the staff they have maybe don't know how to clean properly. I mean, it's okay, but if there happens to be an epidemic there's lots of things that could be done better. (ALF-2)*

> *Researcher: So how would you describe the quality of service that you receive from the staff here?*
> *Alice: Super good.*
> *Researcher: All aspects of services are super good?*
> *Alice: Mhmm. Well the only one, I find that after they've served us our meal and when I'm ready to go upstairs, they've all disappeared, but it's because they're serving the Alzheimer's section. And so I sit and wait and as soon as they see me with my hand up, they'll come and take me up, but they are really good. I haven't come across a girl that I did not like. (ALF-2)*

Community integration and activities.

The philosophy of ALFs is geared toward promoting physical and mental functionality of residents who often struggle with physical and cognitive impairment. Definitely, active engagement in social activities impacts residents' functional and emotional well-being. In this study, the ALFs have created community activities for residents as a group. However, residents expressed varied levels of interest in and satisfaction with these activities. From participants' point of view, the majority of these activities reflect programs regulated by the facility, which may or may not reflect the resident needs and preferences. Moreover, many factors seemed to comprise residents' abilities to interact with the larger community. For example, the facility must know when the resident is coming and going. In addition many residents lacked access to transportation.

Those who have a physical disability expressed a need for physical assistance outside the facility. Some of the residents, who missed activities at the level of the larger community, were drawn to the facility's internal programs. For example, Helen is a resident who had been diagnosed with multiple sclerosis, which resulted in osteoporosis; a disease that made her bones brittle with several breaks in her back. She looked upset when she talked about her active life before moving to the ALF-1:

> *Researcher: What is your life like being here?*
> *Helen: I was able to walk around with my walker, I was able to get out more to different cribs and going to the senior's club at Norbridge, going out of town to different crib tournaments, whereas I can't go now because they take their own bus and I can't climb the stairs; that part I truly miss because you get to meet people out of town Vauxhall, Vulcan, Milk River, Taber those places where we go to play, I miss that. And of course my partner and friend that I've had for the past ten plus years, some of those programs that we attended together as partners I can't go, so she's finding other partners to attend some of the crib tournaments that I can't get to, and that part I miss, because I miss those people you see just about on a regular basis- maybe you'll see them once a week or you might see them four times in a month, whereas now, I'm out at least once a month, whereas I was out Monday we'd go to Coaldale, and on Tuesday it's Coalhurst, Wednesday it's at the club, Thursday it's at Legion, and you rest on Friday, some competitions are held on Saturday or Sunday and…*
> *Researcher: So it's a full week of activities and travelling.*
> *Helen: Travelling yes, to Australia; now I don't think I'd be able to go. So those are the things that I miss. (ALF-1)*

Many residents remained withdrawn and isolated in their rooms because, from their perspective, the facility did not meet their social and physical needs. At ALF-2, Ben expected much more physical activities to fit his interests. He admitted his physical ability went down with age, but he was still looking for some physical activities that would match his age:

> *Researcher: So what are some of the challenges to your quality of life that present with living here?*
> *Ben: No activities. They have listed activities downstairs but I have not participated with them.*
> *Researcher: Why?*
> *Ben: I don't think they're suitable for me. They play BINGO; I don't like that… just not suitable for me. (ALF-2)*

> *Researcher: Okay, so what are other things that are important to you?*
> *Ben: The family and the activities which they are interested in that I could help with. But my age has not allowed me to work to the same limit that I used to as a teenager; I find it quite upsetting not to be able to lift a large piece of lumber, or anything else.*
> *Researcher: How about the activities here in the facility?*
> *Ben: There seems to be no activities for a man of my age; I find it quite downsizing. (ALF-2)*

After his wife was diagnosed with Alzheimer Disease, David moved to the facility to live with her. He looked physically powerful and energetic; however, he felt isolated and bored with the ALF-1 daily routine, and expected much more physical activity:

> *Researcher: So what does a typical day here in this place look like?*
> *David: Almost utter boredom (ha, ha).*
> *Researcher: Mhmm.*
> *David: They're physical…what I expected here would be an exercise room where there would be machines, walking machines- although I do have my own-and exercise rooms and whatnot that we could have activities and that type in, but here we just sit around and read the newspaper and have a few jokes about the things that have happened in court rooms and things like that, which are all right but I want more physical activity; I wouldn't even mind getting out and cutting the lawn for them actually. But that's been my trouble; I was so active all my life that…"*
> *Researcher: Other than the activities, how would you compare your day here to your day back home?*
> *David: Oh back home I was able to get out and go to the senior's center, I carved a bowl, and floor curl and sit around and have coffee with people and talk, I could probably do that here but I just don't know that many people here; it's kind of a…I guess we're sent here to die (ha, ha). (ALF-1)*

After transferring her husband from ALF-2 to the extended care facility, Eva became involved in a supportive community to compensate for her lost relationship:

> *Researcher: What attracted you to the facility?*

> *Eva: Well at the time it was the care my husband would get, but since then I've stayed and I'm glad I did.*
> *Researcher: Why?*
> *Eva: Why? Well I'm never alone, if I want activities there's activities, and they really care for people here. (ALF-2)*
>
> Rita felt restricted by her vision problem and not able to partake in all activities:
> *Researcher: How about activities? Are there lots of things to do?*
> *Rita: Yes, there are but because I can't see well it is hard to take part in some of them ...I like to go down whenever I can whether it's music... or something that I just can sit and listen to. (ALF-2)*
>
> *Researcher: So are you comfortable with the leisure and recreation activities?*
> *Loraine: Mhmm; they could have a little more entertainment- a little more of that I think. It just is kind of sparse at times; they might have more now that Christmas is coming. But yes…, we attend everything they do have most of the time. (ALF-2)*
>
> *Researcher: In terms of your day to day life, what things are important to you?*
> *Jill: Yes, I used to net lot and crochet…now I can't and that hurt…but I watch TV and sleep ha…ha…but I don't have to; I just can walk to the library here get books and read them if I want but I don't feel like reading..*
> *Researcher: So do you feel the substitute things like reading is not satisfying you?*
> *Jill: I don't like it but I can't do anything about it, because my left hand is really bad and never came back but my right hand came back little bit. (ALF-2)*

Summary of Theme #2: The Social Environment

In summary, participants stressed the importance of having people in their life. Family and friends were among the most important people in participants' lives. Specifically, participants signified the role of their families and friends in supporting their transition and adjustment to the new facility. Most participants valued social relationships; however, some participants valued relationships more than others. Most of the participants from both facilities appreciated the social atmosphere of the facility as an opportunity to socialize with other residents and staff, rather than living alone at home. After moving to the facility, few participants reported that the felt lonely and they expected many visits from family and friends. Few participants expressed challenges in forming relationships with others, and preferred to stay alone in their rooms, especially at the beginning of their stay at the ALF. However, the majority seemed to be engaged in relationships with other residents. Participants who had frequent visits and contact with friends, children, and other family members, reported positive attitudes toward the facility and seemed to be happier. Participants repeatedly described how close relationships with loved ones (e.g., children, spouse, relatives, close friends) positively impacted their social life and helped them escape the loneliness.

Theme #3: Home-Like Atmosphere

Despite offering a home-like atmosphere, a move from home to an ALF remained a significant transition and major life alteration in the lives of residents. Adjustment to an assisted living life remained a difficult process. In this study, I was able to capture diverse views on residents' sense of being home at the facility. The main philosophy of ALFs is to foster the home-like features or atmosphere that enhances this sense. However, the philosophy as stated by the facility is often different from what is actually offered to residents and what is actually understood in relation to the residents' own philosophies and reported experiences. This study revealed a range of feelings and perceptions about the importance of creating a home like atmosphere in such facilities.

The meaning of home.

For seniors, the meaning of home is an important factor that affects the process of relocation to another place of residence; it signifies the consequence of adjustment to a new environment. For participants, different patterns in the meaning of home reflected differences in values, needs, moving decisions, and coping mechanisms. I encouraged participants to share descriptions of the meaning of home.

Paula referred to ALF-1 as her home. She rationalized her sense of being at home to the sense of independence she felt, to her tendency towards socialising, and her adjustment and adaptation:

> *Researcher: So if someone were to ask you to describe this place what words would you use to describe?*
> *Paula: Home; ya, its home to me. Some of the patients or the residents here can't say that. I don't know if it's because I'm more of a social person, I'm more independent, I don't know what it is, but I fit, I get along with everybody, and it's home. (ALF-1)*

Kate reflected on the sense of belonging and being surrounded by friendly people at ALF-1. The facility was comfortable and much better than her life on the farm:

> *Researcher: If someone were to ask you to describe this place what words would you choose to describe?*
> *Kate: It's a lovely place-very nice, and I enjoy it, ya, it's very, very nice. The staff is nice, and it's a big change but you're comfortable here. At home on the farm you're not when you're by yourself. There's people all around here, you can visit with people with you like and they're all friendly, it's just…it's a lot different and much better.*
> *Researcher: What does this place mean to you?*
> *Kate: It's home now; it's home, ya. (ALF-1)*

Nicholas referred to cleanliness, brightness and safety of the ALF-1:

> *Researcher: If someone were to ask you to describe this place what words would you use to describe?*
> *Nicholas: Well it's…the staff is good, and the building is clean, and it's quite bright, you know it isn't dreary here or anything like that, it's just a nice place.*
> *Researcher: So what does this place mean to you?*
> *Nicholas: A safe place to be. (ALF-1)*

Tim considered his medical needs in addition to the merit of living together with his wife in the same residence at ALF-1:

> *Researcher: If someone were to ask you to describe this place what words would you use to describe this facility?*
> *Tim: Good residence.*
> *Researcher: Okay, what else?*
> *Tim: Considerate people. Good at taking care of your medication needs. And it's really joyous to be here with my wife, she's the love of my life. (ALF-1)*

It was hard for Gloria to describe ALF-1 as home given her attachment to the former home where she lived for thirty years:

> *Researcher: So what does this place mean to you?*
> *Gloria: Well its home now.*
> *Researcher: Is it a typical home just like the home you left?*
> *Gloria: No.*
> *Researcher: Can you explain some differences?*
> *Gloria: Well we lived in our home for over thirty years here in town, and so living in the same place for that long you know, meant a lot. So I found it hard to leave. (ALF-1)*

Leanna reflected on the physical environment. Having easy access and spacious areas within the facility made her feel comfortable:

> *Researcher: Okay, so if someone were to ask you to describe this place, what words would you choose to describe?*
> *Leanna: I would just tell them that I feel very comfortable here, yes.*
> *Researcher: So going back to the question, if someone were to ask you to describe this place, what words would you choose other than comfortable?*
> *Leanna: Ya, easy to get around in; the hallways are wide, they're accessible. I just don't open my doors; but because of fire hazards they have to be heavy. (ALF-1)*

> *Researcher: What does this place mean to you?*
> *Jill: This is my home, I moved from Manitoba to here and I love this city, it is very nice place to be, like I said I wouldn't want to move away from here but maybe might come a time when I need too much help…I have to move but that would be hard. (ALF-2)*

> *Researcher: If someone were to ask you to describe this place, what words would you use to describe?*
> *Maureen: If a person needs a home it's a good place to come. If you're not cooking your own meals, it's a good place to come. I've gotten used to their way of eating, but if a person needs a home, fine.*
> *Researcher: So would you say this is home?*
> *Maureen: Yes, this has to be my home now, yup. (ALF-2)*

Food and dining.

The food quality and dining atmosphere is considered a strong predictor of residents' satisfaction that contributes to ALFs being perceived as home-like (Street et al., 2007). Apparently, this aspect of ALF living was important for the participants; it played a vital part in creating home-like atmosphere. At home, residents prepared the food the way they liked, and they had as many choices as they want. In addition, they had control over their food restrictions and allergies. In direct opposition to this, participants from both facilities discussed their limited choices of food, and how nutritious meals were replaced by more convenient options that contradicted their preferences:

> *Researcher: Do you choose your food?*
> *Jill: Well, we have two choices*
> *Researcher: What if you don't like them both?*
> *Jill: Well…they would give you sandwich that you want it.*
> *Researcher: So something that you prefer?*
> *Jill: Well ...not mostly because they don't have everything I guess out …for lunch it is okay because they have the stuff ready but for supper but for supper they just have two different kind like fish and another dish and if you don't like them they will give you a sandwich*
> *Researcher: And you okay with that*
> *Jill: yes that is fine…I mean I like everything …I eat. (ALF-2)*
>
> *Researcher: Is there many options of food that you can pick from?*
> *Alice: There's always an option. They give you…say they made veal cutlets and mashed potatoes and vegetables, and then they have another option which is just a sandwich; so you do have…you always have two options.*
> *Researcher: Have you ever disliked any food and maybe the two options were not for you…*
> *Alice: So you pick the lesser of the two (ha, ha).*
> *Researcher: Yes.*
> *Alice: Well, do I really want a sandwich…no I didn't want that. But I'd take the sandwich over say, liver and onions. (ALF-2)*

Others felt challenged with the quality and the variety of food available, which was complicated by their food restrictions. Being on a special diet made managing choices more difficult:

> *Researcher: How long did it take just to adjust living here?*
> *Maureen: To adjust? Oh it took me a good year because I'm on a special diet and it's just hard when you first come in, it's the food… they had to get that all straightened out.*
> *Researcher: You had mentioned the food; can you talk a little bit about it?*
> *Maureen: Well I am on a special diet, I'm a candida* sufferer *which means I can't eat wheat, no milk and no eggs, so that cuts a lot of food out, so they do look after my food pretty good. Like they'll have special…they buy the special bread with no*

gluten in it, they see I have no eggs and they have no dairy products in it. So my dessert usually is jello, no sugar in it, I always say, "Diet sugar," because I'm not supposed to have sugar either. So I'm cut out from all sweets that come by, but I don't…I've gotten used to it, it doesn't bother me now if I have dessert or not, if I have a good meal I don't care if I have any dessert. But they have lots of fruit usually, banana, apple, orange, cut up fruit, you know, so…
Researcher: Do you think the given choices of food are enough to satisfy your tastes?
Maureen: No, no.
Researcher: It's not like before?
Maureen: No, no, no, well the food isn't cooked like I would cook it, like it gets dry after a while, well they start early in the morning and get what's left at noon, and then you get something at supper and goodness knows when they started on it. (ALF-2)

Researcher: So what is it like living here in this facility; can you talk more about your experience living here?
Paula: The only problem I had was the food. I just could not tolerate the food, and I became sicker because I quit eating 'cause I just couldn't take the food, and then I ended up in hospital for two months. Since that time the head fellow from the kitchen does everything in his power to make sure that things are better than what they were and I've got so that if I can't eat what they're cooking, I'll ask for an alternative. (ALF-1)

Researcher: What are some other challenges or limitations in this place?
Ben: Variety of lunch menu; it's quite a chore to keep various cooks around but it's also a challenge to keep a variety of food.
Researcher: So how many options of food do you have on a meal?
Ben: Oh at least four.
Researcher: Are you happy with these options?
Ben: Yes I think so.
Researcher: So what if you don't like any of the offered meals?
Ben: You can go without.
Researcher: And then how do you manage?
Ben: Starve.
Researcher: Starve?
Ben: Fast.
Researcher: Okay.
Ben: Go without.
Researcher: You go without…so if you're not happy with the food do you go out to a restaurant?
Ben: Very, very seldom…no. (ALF-2)

Meals cooked at home were very different compared to what was offered by both facilities. Home- prepared meals tended to be tastier to residents who had prepared their own food using their favourite spices, and according to their own tastes and preferences. Maureen and Rita talked about the taste of the food prepared at ALF-2 in relation to what they used to prepare at home:

> *Researcher: Do you think the given choices of food are enough to satisfy your tastes?*
> *Maureen: No, no, no, well the food isn't cooked like I would cook it, like it gets dry after a while, well they start early in the morning and get what's left at noon, and then you get something at supper and goodness knows when they started on it. You don't know when it was made up, a lot of things are dry when you get…like the chicken you get is dry, fish is dry, you know and what can you do? It's made so long ahead of time.*
> *Researcher: So you eat it…do you enjoy it?*
> *Maureen: Sometimes I do, like last night I enjoyed my supper, and there's other times well, I play with my food (ha, ha) just to say I ate something. (ALF-2)*
>
> *Researcher: What do you like least about this place?*
> *Rita: Hmm... I would say when you used to your own cooking, then you have to get use to the meals... Aha…*
> *Researcher: Can you explain more?*
> *Rita: Well, I think everyone has his own way of cooking things...and may be spicy little... That way or this way ...you have to learn to get used to, if you are here.*
> *Researcher: So, would you say that the food is not tasty as the one you prepare by yourself?*
> *Rita: I would say ... a lot of it is tasty, but …sometimes it is not at all.*
> *Researcher: Do you have an option for the meals to pick from?*
> *Rita: Yes, We have an option two choices for lunch, and two for supper.*
> *Researcher: Are they satisfying you?*
> *Rita: Aha … (ALF-2)*

ALFs provide two to three meals a day as a basic service (Carpenter et al., 2006). In this study both facilities served three meals a day. This service was a strong reason for some residents to move in to the facility:

> *Researcher: Prior to moving to this place, did you look into a few options as far as assisted living facilities?*
> *Ben: Yes.*
> *Researcher: Can you talk about that?*

> *Ben: They did not supply full meals and one thing I was interested in was full food, so I thought this was appropriate. I had known about this place five years before.*
> *Researcher: So what is it like living here in this place? Can you talk about your experience of living in this facility?*
> *Ben: I like the fact that we have three meals a day. I find it very advantageous to have breakfast, lunch and dinner at certain times. (ALF-2)*

Autonomy.

Kane and Cutler (2009) indicated community-based residential settings such as ALFs tend to be less institutional when residents exercised more autonomy. The authors specified that autonomy in such facilities included residents' control over their private rooms, their freedom to spend free time the way they liked, their freedom to use shared spaces according to their own desires, and their freedom to connect with others from inside and outside the facility. In other words, the more control residents have over their environment, activities, food, time, and the way they manage their lives, the more home-like the setting becomes. Repeatedly, participants in this study discussed their sense of autonomy in many aspects of their lives and described how the facility treated their personal choices.

Having the freedom to go to and from the facility was one of the significant aspects that appeared in participants' reports:

> *Researcher: What other things do you feel that you have control over?*
> *Gloria: I can go out whenever I want to- I can go somewhere, whether my kids take me shopping, or I go to a doctor's appointment, you know I can go whenever I want to go. I could even go overnight if I wanted to, and I have done that. I go out to Magrath and spend the night on vacation. So I have a lot of choice of what I do. (ALF-1)*

At both facilities, participants talked about their choices to take part in activities and entertainment programs:

> *Researcher: Do people in this facility allow you to choose whatever you want?*
> *Gloria: Ya, I have my choice, if I don't want to go to the entertainment I don't have to go. The food choices, like I said, I'm kind of restricted on what I can eat but I have to live with that and I know that. (ALF-1)*

> *Researcher: Do people in this facility allow you to make your own choice (in general)? [What are some examples of things that you can choose or decide about it?]*
> *Jill: Well, to a certain extent*
> *Researcher: Can you explain?*
> *Jill: They don't bother you if you don't want to play cards…they don't argue with you…if you want to go to crafts or whatever they are happy to see you there and they do things for you…and like I said the food is very good here.*
> *Researcher: Do you think that this facility respects your personal choices?*
> *Jill: I think so, they are very good with that…*
> *Researcher: How?*
> *Jill: Well, they don't get mad at you if you don't want this or you don't want that…it is your choice and that's good…that is all my explanation. (ALF-2)*

> *Researcher: Do you think the facility respects your own choices?*
> *Rita: Oh yes... I'm sure they do*
> *Researcher: How they do?*
> *Rita: Well, they invite you to go down and tell you what's going on. But if you don't care to go that's fine... (ALF-2)*

Some participants adjusted to the facility schedule and accepted changes that limited their control in daily living. Rita appeared comfortable with meal times at ALF-2 even though they were more scheduled than what she had at home:

> *Researcher: Can you talk about your choices among activities of daily living, for example, your bed time and meal time...?*
> *Rita: Well I would think there are some time schedules that you have to follow because of the two phases here, we need to be down for our meal on time: the first phase eight, twelve, and five. The other phase is eight thirty, twelve thirty, and five thirty... So we need to be down there.*
> *Researcher: Do you feel comfortable with this schedule?*
> *Rita: Yes, it's fine. We were used to having three meals like that a day … So it's just that they may be little more scheduled than we were at home but that's fine. (ALF-2)*

Kate is another participant who liked to sleep longer in the mornings, but she got used to waking up early to start her day as scheduled by ALF-1:

> *Researcher: So what do you like least?*
> *Kate: Getting up in the morning I guess (ha, ha), but I get up…that's okay, you've got to get up anyway, that's fine.*
> *Kate: Breakfast time, you know a person likes to sleep longer… Ya, probably longer, but its' okay, you get used to it; I'm used to it already anyway, I wake up anyway - time to wake up, get dressed and go for breakfast. (ALF-1)*

In contrast, Gloria appeared less adaptable to the early breakfast time at ALF-1; she preferred to sleep until noon and to miss breakfast rather than getting up early:

> *Researcher: Can you describe a typical day living here?*
> *Gloria: I should get up for breakfast but I don't very often, if I can sleep in till noon- I sleep till dinner time, get up and I go to dinner, and then I come home and wash my hand with soap, and then I either nap or watch more TV.*
> *Researcher: So what kind of things here you don't enjoy?*
> *Gloria: I don't enjoy…I don't enjoy getting up for breakfast, I like staying in bed. Pretty much else I go with the flow. (ALF-1)*

In some cases participants expressed lack of control. Loraine is a resident who lived with her husband at ALF-2. They used to visit family and friends outside the facility. Loraine felt restricted by the facility's rules to sign out upon leaving and estimating the return time:

> *Researcher: Okay. Do you think that this facility respects your personal choices?*
> *Loraine: I think so.*
> *Researcher: How?*
> *Loraine: Chose our room, and we have to sign out downstairs when we go, and approximate the time we'll return, which is kind of…I guess it's okay, but it's kind of hard to know when you're going to be coming back all the time. So there's a little bit of restriction there- of freedom, but other than that I think its fine. And we have a choice of our…usually at meal time they'll give you one thing or another and you can choose, so that's pretty good. (ALF-2)*

Autonomy and control is influenced by the level of functionality. The high levels of autonomy in ALFs have been linked to lower levels of residents' disability, enhanced quality of life, and enhanced quality of care (Sikorska, 2006; Street et al., 2007; Zimmerman et al., 2003). Leanna felt constrained by her physical immobility and frailty, she felt less energetic to catch up on evening entertainment:

> *Researcher: Okay. So do people in this facility allow you to choose whatever you want?*
> *Leanna: Well I imagine within limits.*
> *Researcher: Within limits.*
> *Leanna: Within their limits.*
> *Researcher: What are some of their limits?*
> *Leanna: Well I would think the choices for the extra things that we want to do. Like they're having different groups at six o'clock but I'm just getting back to my room at six o'clock, so I don't find it convenient to go downstairs and take part. But that's for those who want more, you know, they want to make it available for them if they want more. So they've either been having music, or games, or things like that. So I'm sure they're working very diligently on how to make it more interesting and more fun for those that have got the energy to do that. (ALF-1)*

> *Researcher: If someone were to ask you to describe this place, what words would you chose other than comfortable?*
> *Leanna: Ya, easy to get around in - the hallways are wide, they're accessible. I just don't close my door because I find it very difficult. I have rheumatoid arthritis and it's hard to open my doors but because of fire hazards they have to be heavy. (ALF-1)*

On the contrary, David is an energetic resident who wished to have more activities and longer evening entertainment. He expressed not only his dissatisfaction, but also his feeling that changes to his liking would not come easily in a place where most of the residents are bedridden and less energetic:

> *Researcher: So what are some changes that you wish to see in this place that might improve your quality of life?*
> *David: If they had an activity…I'll call it a physiotherapy room where they had exercise machines and weightlifting and all that type of stuff. And if they could have a little more and longer evening entertainments, like they do have entertainment in the evenings but it starts at six o'clock and it's over by seven- well that's not near long enough for me (ha, ha), it should be extended till nine o'clock anyway, but that's just what I think. It's surprising how they tell me there's two hundred people in here but I don't think I've ever seen more than fifty at any particular due- of course many are bed ridden and can't get out. But I'd like to see a lot more activity. (ALF-1)*

Privacy.

Personal privacy is considered one of the core values that differentiate assisted living from other residential care settings. Usually, assisted living residents have private living spaces (e.g., room, suite, or apartment) and shared public spaces within the facility (e.g., dining room, recreation room, or exercise room). Residents have their privacy in their personal room but their access to the shared spaces is bounded by facility regulations. In comparing the value and cost of private versus shared rooms in nursing homes, Calkins and Cassella (2007) indicated the value of better outcomes for residents associated with private rooms outweighed the high cost of construction. However, privacy of residents goes beyond this physical attribute of the residential setting. Kane and Cutler (2009) discussed the complexity of the personal privacy in residential care settings. Residents with varying levels of physical and mental function are in need of continuous and intimate care by different staff members. These staff access residents' personal spaces, possessions, and documents. Therefore, how staff members behave in respecting residents' privacy is critical, as they are in a position of accountability. In this study, residents from both facilities discussed privacy from different angles and expressed different levels of satisfaction.

Paula talked about her personal privacy within her own suite. She felt dissatisfied with the staff attending to her suite when she is away:

> *Researcher: Do you feel private in this room?*
> *Paula: There's time where…when they come in my room and I'm not here, I feel very…oh what's the word I want… well I just don't feel that it's private anymore when they come in when I'm not here. I mean they may be putting something away or what not, but I still…when I'm not here, that door is shut and that's how I want it to remain. When I'm here my door is open and they're more than welcome to come in. Those are the two things that really bother me. (ALF-1)*

Paula continued the conversation and commented on the staff talking loudly about other residents and not considering the privacy in providing care. She found that annoying and violating other residents' integrity and privacy:

> *The hollering is…they talk very loud- number one, but instead of going to the person that they're talking to, they holler from one end of the dining room to the other, you know, and they'll say, "Well so and so is in the bathroom," I don't want to know that about somebody else. You know, that bothers me, that should be private; I don't care who's on the toilet, you know, and that shouldn't be… (ALF-1)*

Helen found it hard to seek assistance in toileting from others; she lost her independence and was forced to wear a diaper. That affected her control over her own body and to her, was degrading and constituted a lack of privacy. She found herself miserable since she got to ALF-1:

> *Researcher: So what are some of the challenges to your quality of life inside this place?*
> *Helen: Nothing yet, other than not being able to get out of bed, go to the washroom when you need to go. Now I have to ring a buzzer and I may wait up to a half an hour to forty-five minutes to be able to get to the washroom; that feature I don't like because once you used to do it and now you can't Especially personally I would like not to wear diapers but I'm forced to for some of those reasons; and to me that's degrading. I don't know, it's as I say, it's truly, truly a change in life and one's got to accept it otherwise they're going to be miserable, miserable, miserable, because I've been miserable since I got here. But I'm just starting to turn around, I think that will be good for me to be able to accept what God has handed me - sent me, this may be just another stepping stone to heaven. (ALF-1)*

Loraine was reasonably satisfied with the facility as a place to live. She described the privacy in the facility as adequate, but not optimal like in her own home:

> *Researcher: Would you recommend this facility to a family member or a friend?*
> *Loraine: Mhmm, yes I would.*
> *Researcher: And why is that? Why would you recommend?*
> *Loraine: Yes I would recommend it if they needed a place to live and didn't mind lots of people around because that's what you have is quite a few people around. You have your privacy and that you know, but it's not like your own, but it's adequate. (ALF-2)*

Jill considered her privacy at the facility as a unique feature for living:

> *Researcher: After living here for a period of time now, what do you feel is unique about living here at this facility?*

> *Jill: Well …you have your own privacy and you have the help when you need it and… well I guess that the food is very well now…I just like living here... haha… I haven't got a view but that is okay. (ALF-2)*

Maureen felt at liberty to come and go whenever she liked. She has her own keys which allowed her to keep the door locked all the time whether she is inside her room or she is away:

> *Researcher: Can you give an example of something that will affect your freedom here?*
> *Maureen: No, I don't think so. I mean, we take what we like. Like, this is my home, I can do…I can come, I can go, basically whenever I like. If I want to be out till midnight I could go out till midnight, as long as I tell them I won't be in till certain hours.*
> *Researcher: Okay.*
> *Maureen: But I mean, I have a key to get in anyway, you know, we've got keys to get in and out, and the main door, it locks at a certain hour at night, you know, so strangers won't come in. And I always make sure my door is locked, nobody walks in on me, unless I know it's my son coming, then five minutes before I know he's coming I'll unlock it so he can just walk in. (ALF-2)*

Independence.

A core philosophy of ALFs is independence, which refers to the physical function of the resident and his/her capacity for self-care (Perkins et al., 2012). Seniors tend to live independently in their personal dwellings as long as they are functional and can perform the activities of daily living such as bathing¸ eating, mobility, dressing, and grooming. They move to more supportive forms of housing when they become frailer and need assistance with daily living (Cranswick, & Dosman, 2008; Erickson et al., 2006). Frankowski (2011) marked independence as a crucial characteristic in the adjustment of many residents to ALF. She revealed that how residents express independence is affected by their social and cultural background, physical and emotional wellbeing, self-perception of the concept of independence, and the particular environment of each facility. These findings are in harmony with what I heard from many participants in discussing their independence before and after moving in to ALF. Participants showed a wide range of perceptions and expressions of independence.

Paula perceived herself as independent despite a disability that put her in a wheelchair, whereas Jill, who is a physically independent resident most of the time, felt she lost independence by moving from a retirement community into ALF-2. Jill found it difficult to rely on others at the ALF, while she was looking after herself at her retirement community:

> *Researcher: What's a typical day like living in this place?*
> *Paula: Because I'm basically independent I'm kind of left on my own to do my own thing. I get up when I want to get up, I do my own washing- I have to put a basket on the floor and I push it with my wheel chair down to the laundry room. I'm trying to stay as independent as I possibly can, because I know that it's not always going to be like this (ALF-1)*

> *Researcher: Were you looking forward to this move?*
> *Jill: I didn't want to move... I was looking after myself over the Gary drive, and doing everything myself, I drove myself and I was really happy over there…then I got sick after*
> *Researcher: How long did it take you to adjust to living here?*
> *Jill: Well… it was a while… may be …I don't know …three …four months …until I got to know people and visit with them sometimes…yah … it took a at least that because I was so used to being over Gary drive… doing everything I want to do by myself, then I have to end up in a place where I couldn't do anything. (ALF-2)*

Maureen has a strong sense of independence and autonomy; despite all the help and care she is receiving, she felt self-sufficient and unrestricted in her own space:

> *Researcher: So would you say this is home?*
> *Maureen: Yes, this has to be my home now, yup.*
> *Researcher: What do you like most about this place?*
> *Maureen: I've got my own…I have it cool or else I can have it hot. Nobody comes in and interferes with me. I don't see anybody, I can pull the cord and I will get attention right away. But I mean, I'm in here by myself and I don't have to depend on somebody, you know, that much, and if I do, they're there for me; they'll make sure I'm down for my meals and make sure I'm okay and you know, I'm clean and make sure that I'm not lagging behind in doing certain things. The nurses are good; they are very good I have found them. (ALF-2)*

Some participants would not mind depending on somebody, they do not perceive that negatively. Kate felt comfortable and satisfied with all the care and services offered to her by the facility and by family:

> *Researcher: So what is it like living here at this place? Can you talk a little bit about your experience of living here?*
> *Kate: It's really very nice because they make the meals and they clean the rooms for you, and my daughter washes my clothes, how much better can you have it, really? It's very nice actually, very comfortable really. And the care is good, you know they…the staff is very nice, so I just enjoy it; much better than being by myself. (ALF-1)*

Summary of Theme #3: Home-like Atmosphere

Assisted Living Facilities strive to provide medical and personal care in a home-like environment. Both ALFs, included in this study, promoted home-like atmospheres to their residents through the physical environment and different design features. In addition, both facilities strived to promote a sense of hominess by maximizing residents' dignity, autonomy, privacy, socialization, independence, choice, and safety. In discussing the ALFs' home-like features, participants emphasized physical features, social relationships, activities, care and services, food and dining, autonomy, privacy, independence, choice, and security and safety. Participants compared the ALF to their own homes and they agreed that the facility became their current home. Participants expressed their own meaning of home based on their personal experiences. Different attributes contributed to participants' feeling at home. These attributes were differentially rated by participants; while some participants considered independence and choices as a main attributes that made them feel at home, others mentioned the safety and security as a major aspect that enhanced their sense of being at home.

Most participants indicated that their privacy was highly promoted inside the facility. However, two participants felt that the privacy of all residents was not highly respected. Most participants agreed that they had enough choices and freedom in their daily living such as mealtime, going and coming, recreation, and activities. However, some participants complained about a lack of choices in their meal menu compared to their meal at their own homes. A major loss of independence for most of participants was the lack of ability to get somewhere without having to rely on others. All participants described the ALF as their current home. However, this description was different from participants' own homes. The reason for labelling the facility as “home” was simply because when deciding to move into the facility, there was no other choice for participants who found themselves frail and no longer able to live independently at home. Despite the fact that participants did not want to be dependent on others, even their family members, they found the ALF was the best place to provide them assistance with daily living activities and health-related needs given the physical and medical conditions they faced.

Summary

In this chapter, I displayed the findings from careful and in-depth analysis of semi-structured interviews conducted with 17 senior residents who lived in two ALFs. Participants in this study described several losses and gains that they experienced in their daily livings. Through detailed analysis of the data, I extracted three major themes: (a) physical environment, (b) social environment, and (c) home-like atmosphere. I supported my findings with meaningful descriptive quotes and stories told by participants. These plentiful quotations identified the complexity of elements contributing to quality of life in ALFs. Findings from these themes will be further discussed in Chapter Five.

Chapter 5. Discussion

In this study, I examined the quality of life as perceived by senior residents living in ALFs. Employing descriptive exploratory design, I interviewed 17 residents from two ALFs in Southern Alberta to understand their living experiences. This thesis was one of the first studies within the region of Southern Alberta that focussed on seniors in ALFs. It encompassed the perspectives of the residents whose daily life experiences shape their perceptions of quality of life. Looking across the participants' interview data, this study revealed convincing personal experiences imperative for evaluating and determining quality of life among residents of ALFs. In this chapter, I discuss these findings in relation to the existing literature. I also examine the findings in relation to Lawton's theoretical model. Finally, I draw conclusions and discuss the implications for future research and practice on quality of life among senior residents of ALFs.

Demographics

The mean age for all participants was 84, and the age range was 69 to 93 years. Most of participants in this study were female (76.5%) compared to (23.5%) male. Moreover, participants aged older than 85 represent (48%) of the total sample and they were all female. There is a lack of information about characteristics of Canadian seniors in supportive living settings, particularly in living in ALFs. Such information is necessary to confirm the demographic profile of Canadian seniors living in ALFs, and to support findings from this study that seniors in ALFs are more likely to be older and predominately female. However, demographics from this study are congruent with percentages discussing the profile of Canadian seniors receiving home care (Hoover & Rotermann, 2012). The overall percentages of senior women receiving home care (30%) were higher than male percentages (18%) in all ranks; (18 %) of women aged 65 to 74 has received home care compared to (12%) of men within the same age rank. For seniors aged 85 years and older, the percentages grew for both sexes; (59%) of women reported home care compared to (44%) of men.

Although both facilities included in this study adopted the philosophy of assisted living of a home-like environment, residents who moved from home (76%) identified a difficult transition and slower adjustment to facility atmosphere in contrast to those who moved from other types of residence. Among residents holding different levels of education and employment, those with higher educational levels (Bachelors, Diploma) and professional occupations were generally less satisfied and had higher expectations of the facility. Despite the availability of diverse activities and recreation programs in both facilities, many residents did not take part in these programs. They did not interact with other residents in light of their differences in current and former life experiences, social class, interests, or physical and mental health.

Physical Environment

Many factors appeared to influence perceptions of a home-like atmosphere within the facility. In this study, the physical environment was discussed by residents in relation to many aspects of daily living. The existing literature pertained to several features of physical environment of ALFs. Suitably designed and maintained physical features of ALFs can help improve residents' perception of quality of life (Frankowski, 2011). Furthermore, environmental manipulations that increase resident comfort and privacy, may improve resident satisfaction and well-being (Bicket et.al, 2010). Physical attributes of the facility positively impacted residents' feelings of being at home. Yet, some residents were dissatisfied with many features (e.g., physical space, lack of neighbourhood attractions, room configuration and design features). The various perceptions of physical environment stem from residents’ personal expectations, compared to their former living conditions and their physical and functional abilities. Oswald et al. (2007) linked housing satisfaction to successful aging. They found that seniors who lived in accessible environments perceived their residence as being meaningful and useful. Oswald et al. concluded that when the housing environment maximised residents’ independence and autonomy, seniors reported a better sense of well-being. Although environmental manipulations that increase resident privacy may improve resident satisfaction and well-being (Bicket et.al, 2010), few studies have examined the perceptions of senior residents on housing and how it impacts their well-being (Iwarsson, 2007). Moreover, evidence regarding this relationship is still remarkably limited in a supportive living option known as ALFs. Findings from this study highlighted a need to confirm a relationship between physical conditions of housing and subjective sense of well-being among seniors. More specifically, evidence is needed to understand the relationship between physical attributes of living environment that contribute to the sense of well-being and the quality of life in ALFs.

Social Environment

Street and colleagues (2007) revealed that social relationships within the ALF is the most significant indicator of self-reported life satisfaction, improved quality of life, and a perception of the facility as home. In this study, the social environment played an important role in fostering a sense of well-being and influenced residents’ satisfaction in many ways. Many residents reported that they became more social by moving from home where they lived alone to the facility where they felt more socially engaged with residents, staff, and friends. However, building relationships with others remained a challenge for some residents who stayed isolated in their rooms and felt lonely in the facility. Park and colleagues (2012) confirmed that social engagement in ALFs frequently poses challenges to residents, because the social context and environment are unfamiliar and unlike their past social systems.

Social ties with family and friends represent a vital source of support for residents of ALFs (Park, 2009). Findings from this study were consistent with that notion; family and friends played a significant role in supporting residents' transitions to the ALF and adjustments to the new atmosphere. Many residents were expecting more support and more visits from their families and friends. However, more evidence is needed to understand social relationships inside ALFs (Park, 2009; Zimmerman et al., 2003). Attitudes and behaviours of staff seemed to significantly impact residents' sense of being at home. Street and colleagues (2007) found that residents who reported positive relationships with staff were more likely to report stable/improved quality of life than residents without such relationships. In this study, stories presented by residents revealed the social aspect of care and how interaction with staff affected their life. Most of the residents had positive interactions with staff; they labeled relationships with staff and different aspects of care provided to them as *'very good,' 'excellent,'* and *'nice'*. Although one resident complained about lack of services and observed dissatisfying staff attitudes, the main complaint from most residents was about a staff shortage. These findings are prevalent in the literature. Chou and Robert (2008) indicated that ALFs are overwhelmed by high worker turnovers, which result in staff shortage. Their study linked the shortage of assisted living workers to the quality of care and health outcomes as they play a vital role in shaping the quality of care, and therefore quality of life.

Engagement in Social Activities

In this study, the facilities have created community activities for residents as a group. However, residents expressed varying levels of interest and satisfaction in these activities. From participants’ points of view, the majority of these activities reflected programs regulated by the facility which may or may not reflect residents’ needs and preferences. Moreover, many factors seemed to comprise residents’ ability to interact with the larger community. For example, the facility must know when the resident is leaving and returning, many residents lacked access to transportation, and those with a physical disability expressed a need for physical assistance outside the facility. Some residents were involved with the facility internal programs. However, many residents remained withdrawn and isolated in their room because their needs were not in alignment with the programs the facility offered. These findings are largely congruent with the existing literature. Kane and Cutler (2009) argued that residential care settings tend to resemble community status to the extent that residents have access to the greater community for activities of interest. Activities must be appropriate for residents’ age and match their social profile including education, employment, and recreation. Kane and Cutler (2009) also stressed the role of friends and family in integrating seniors in to the larger community; residents are more integrated in the community when people visit them more frequently in an unstructured way.

Evidence from existing literature on ALFs also confirmed a positive relationship between residents’ active engagement with different social activities and quality of life (Horowitz & Vanner, 2010). Park (2009) suggested that ALFs could promote residents’ psychological well-being by encouraging them to develop meaningful relationships.

However, findings from my study revealed that integration within the community of assisted living had two potential consequences - benefit or hindrance. It could help residents to become involved in a supportive assisted living community to compensate for the lost relationships with the greater community. Conversely, the assisted living community may create more tension and controversy in interpersonal relationships among residents; especially for those who are not in alignment with other residents, and who are not interested in the social programs offered by the facility. While some residents in this study remained withdrawn into themselves and did not interact much with other residents, the majority of the residents interacted with fellow residents.

Food and Dining

Food and dining were regarded as important factors contributing to residents' quality of life in many ways. Meal schedules and menu options affected the residents' autonomy and appeared frequently in residents' talk. Many residents expressed dissatisfaction with their limited food choices and the strict meal times. This is compatible with results from Liu and Kwon (2013), who looked at the attitudes of residents toward healthy food choices in ALFs and they found that seniors living in ALFs were willing to choose healthy food, but felt a lack of control over food choices. While most residents in my study found themselves adjusting to the mealtimes and food options after a period of residency, there were some that did not. These residents felt restricted by being on a diet in addition to the limited menu options. Most residents valued the dining table and enjoyed socializing with other residents during meal times. However, residents preferred home cooked food to institutional food given the differences in methods of food preparation and seasoning. Similar findings were reported by Frankowski et al. (2011) who intensively interviewed residents in ALFs. They described how residents perceived the dining room table as a means to connect with each other three times a day in a communal manner. Frankowski et al. observed how the regular meal times and the predictive nature of the dining room helped incoming residents to adjust successfully to their new living space.

Autonomy, Independence, and Privacy

Assisted Living Facilities are distinguished from other residential care settings by providing a home-like environment that maximises autonomy, independence, and privacy (Hawes & Kimbell, 2009; Mollica, and Johnson-Lamarche, 2005; Zimmerman et al. 2003). However, maximising the independence of physically disabled and cognitively impaired residents remains a challenge for ALFs. In the literature of quality of life among residential home care elders, Lee et al. (2009) claim that older people perceive their ability to maintain independence, autonomy and individuality as the most important criterion for determining quality of life. In this study, residents constantly linked these same values to their transition experience and living in ALFs. They expressed varying levels of autonomy, perceptions of self-sufficiency, and independence, which are highly affected by residents' personal profiles and coping mechanisms.

Some residents felt more independent despite their frailty and disability; others were physically able, but voiced less freedom and control over choices. Similarly, Robison et al. (2011) found that seniors' experiences of privacy, autonomy, and dignity in a residential care setting is influenced by residents' personal characteristics such as age, perceived health, involvement in the decision to move to the residence, and length of stay in the residence. Robison et al. also assessed the perceived quality of life in relation to many indicators including autonomy, privacy, and independence. Among the different residential settings, the authors looked at residential care homes, nursing homes, and

ALFs. Robison et al. noticed that assisted living residents reported the highest levels of privacy and autonomy. They also noticed that satisfaction with coming and going to facility and communicating with family and friends were higher in ALFs. However, this last point was contradicted in the present study, as many residents expressed their dissatisfaction with the inability to freely come and go. Part of this was related to the lack of convenient transportation options. Nevertheless, the ALFs contributed to other aspects of it such as the logging of residents' whereabouts.

Lawton's Model of Quality of Life

The theoretical framework that guided this study was the quality of life model by Lawton (1991). This model helped me to see a holistic picture of quality of life. Lawton constructed a comprehensive model of quality of life by combining four major components: (a) behavioural competence, (b) objective environment, (c) perceived quality of life, and (d) psychological well-being. These four major components interact with each other to configure the shape of quality of life. From a theoretical perspective, quality of life is built on the idea of person-environment fit which has been thoroughly discussed in the literature as integral for seniors in any form of dwelling (Frankowski, 2011; Lawton, 1977; Lawton, 1983; Lawton & Nahemow, 1973; Oswald et al., 2007). The main notion of person-environment fit is that quality of life, in any space of living, is an output of balance between individual competence and the limiting aspects of the surrounding environment. The balance between environment and individual is negatively impacted by aging. As persons age, they face many physical and mental changes that affect their functional and adaptive capacities, resulting in their environments becoming less appropriate (Frankowski, 2011; Oswald et al., 2007). Therefore, elderly are more liable to have low competence for their environment and need to increase their competence by adjusting the environment to meet their needs. Thus, a barrier free environment is required for the elderly to maintain a good level of adaptation and therefore good health status.

The major findings from this study were congruent with this theoretical assumption. Within the context of assisted living, quality of life (based on the residents' views) is a personal and dynamic balance. This balance can be achieved when the changes of personal needs and preferences of the resident are harmonised with what is actually offered by the facility. In this study, participants linked their quality of life to the surrounding environment; they discussed their relationships and connections with others and also discussed their lives in light of their competencies and physical abilities. Therefore, attaining the balance within these domains appeared imperative to all.

Lawton's Model can be applied in ALFs to meet the needs of residents for their environment. A majority of participants stressed the importance of the social and physical attributes of the surrounding environment. The appropriateness of the facility's environment is imperative to help residents in meeting their demands and staying at the facility for longer times. Therefore, environmental modifications should be offered to meet the needs of the residents of ALFs and to allow for successful aging in place inside these facilities. Appropriate levels of services must be applied; for example, on-site medical care (e.g., medication administration, wound care, lifting and repositioning), personal care (e.g., bathing, toileting, feeding), food and dining services (regular meals, snacks, beverages, dining room), social services (e.g., social events, activities, entertainment programs), house-keeping services, and all sorts of other services should be provided for residents based on their personal needs including physical, mental, and social needs. Modification of physical attributes of environment may include: (a) spacious space (e.g., bathrooms, suites, dining rooms, hallways, outdoor spaces), (b) barrier free space (e.g., grab bars and shower seats, wheelchair accessibility, bed mobility), and safe space (non-slippery floor, side rails, secured exit doors and gates).

In light of these findings, residents' involvement in quality of life assessment will be important to achieve the discussed quality balance. I gained many invaluable insights by listening to the residents assessments of their quality of life. However, as I discussed earlier in the theoretical framework, objective components of Lawton's model should be examined through different lenses. All of the major components of Lawton's model should be considered in a comprehensive assessment that encompasses the viewpoint of all parties. The view of healthcare providers and other stakeholders must be considered to recognise the capacity of the facility and the applicability of desired assisted living model.

Chapter 6. Conclusion

This study evaluated seniors' perceptions of quality of life in order to develop a comprehensive understanding of what this means within the context of ALFs. The diversity of ALFs' residents makes it impossible for quality of life to mean the same thing to all people or to make a given ALF a 'one place fits all'. Quality of life in ALFs remains predominantly an outcome of fit between the personal capability of residents to adapt changes and the capacity of the facility to meet the diverse needs of residents.

Findings from the current study are congruent with findings from similar studies. A review of the literature by Lee et al. (2009) examined eighteen studies about quality of life in residential care settings, which revealed that quality of life of seniors in residential care settings is a complex issue that may be determined by the elders' independence, individuality and autonomy and influenced by quality of residential care and facilities. Lee et al. (2009) suggested environmental modification to enhance the quality of services and thereby improve the quality of life in these settings. Findings from my descriptive exploratory research have disclosed how quality of life is rooted in the personal experiences of residents, because it signified different aspects of life among different residents. In reviewing the literature, quality of life among seniors frequently perceived as a multi-dimensional concept that describes individuals' understandings of how living conditions and life situations shape their own physical, social and psychological well-being (Haas, 1999; Kane et al. 2005; Lee et al., 2007).

Results from the current study draw attention to the most important aspects in considering the quality of seniors' lives in ALFs. Within the context of assisted living, residents expressed different levels of satisfaction and displayed a wide range of expectations not only of the facility but also of family and friends. Whether these expectations were positive or negative was highly influenced by residents' physical, mental and social status. Residents' satisfaction was achieved to the extent that their needs and expectations were met. Indeed, a complex set of dynamic factors has contributed to residents' lives in ALFs. These factors go beyond what was actually offered by the facility. Quality might be affected by the residents' level of adaptation and adjustment to the environment. It might be also influenced by their reactions toward physical changes such as physical dysfunction and immobility. Residents who accepted these changes and adapted themselves to the institutional environment experienced higher levels of satisfaction.

In-depth interviews with residents revealed the transition to ALFs as a journey. Throughout this journey, residents faced different challenges and changes to adapt themselves and achieve a successful transition into the new environment (ALF). How they adapt to these changes remained a challenge for many residents. With different levels of adaptation and adjustment, attaining optimal quality for all residents continued to be a challenge. One of the main goals of ALFs is to provide a setting to age in place, which means to continue living in the facility with the highest level of independence and not be moved to a higher level of care (Burdick et al., 2005; Rosenblatt et al., 2004). In light of the findings from this study, aging in place will continue to represent a desired outcome for residents and their families. However, it will remain a challenge for administrators, health providers, policy makers and other stakeholders. Therefore, involving expertise from different disciplines is needed to discuss differences among residents. The engagement of the residents themselves and their family members in decision making, and soliciting their perceptions of quality of life, before moving into an ALF and after having the experience of living there will help to understand how they weigh the dimensions of their lives. In addition, *special skills or areas of expertise* would also help negotiate differences and *advocate* the *rights* and interests of the *residents*, such as social workers or counsellors who can be involved on a regular basis. It is important to solicit the perceptions of staff in terms of seniors' quality of life both prior to and during employment. The involvement of staff will help reduce any disengagement or misperceptions that could happen between staff and residents. Incorporating all stakeholders will help recognise areas of weakness that can be addressed and considered in seeking solutions to maximise quality of life among senior residents of ALFs.

Implications for Research

The existing body of literature gives limited attention to quality of life in ALFs and there is little research examining the views and voices of seniors who reside in these settings. While early research in the assisted living domain yielded evidence on the design, structure, services, philosophies and research addressing dimensions of quality as perceived by seniors themselves is limited. Therefore, further research in needed in this domain. It is important to continue to strive to understand quality of life for senior people living in ALFs. Taking into account all aspects identified by seniors themselves will be the key for achieving a successful ALF that recognises quality as a multi-faceted concept. The findings also demonstrated the need for further research that considers quality as a dynamic process over time. This is especially important for seniors who experience many physical and mental changes as they age and therefore express dynamic and various needs.

Implications for Practice

Assisted Living Facilities should look to promote a dynamic environment that embraces residents’ needs at all stages of transition to ALFs. An important recommendation for health professionals, policy makers and administrators is to find a dynamic balance that considers the relationship between residents’ personal needs and expectations, and what the facility can actually offer. Moreover, a facility can never be a ‘one home fits all’ approach because of the diversity of the clients within and the diversity of their needs and expectations. Therefore, residents’ personal needs should be embraced at all stages of transition to ALFs. Organizations are encouraged to regularly assess the personal needs and expectations of the residents upon their admission and throughout the duration of their stay. Organizations should ensure that an advocate is provided for each resident as and when needed. In addition, it is important to apply a process for continuous quality improvement/quality assurance and ensure that all residents and their family members are involved in the process. It is also important to assess the approach for quality assessment to ensure that it is truly meaningful and also find out how the data is being used to bring about positive change.

Theoretical Contribution

Results from the present study highlighted a connection between the objective and subjective aspects of Lawton’s model of quality of life. The participants who spoke to their perceived quality of life also spoke to other dimensions such as the physical and social environment. The diverse perceptions of the participants revealed that there is no clear distinction between the subjective and the objective dimensions of Lawton’s model of quality of life (from the perspective of residents). Although Lawton’s model offers a systematic conceptualization of quality of life in older adults, this study perceives blending between the subjective and objective dimensions of quality of life. The researcher found that given the context and the population under study, the model lacked a health related quality of life measure such as physical, emotional and social well-being. As a theory within the domain of seniors' health, Lawton's model should presume an account to the frailty of the population under study. Therefore, the study findings encourage an expansion to Lawton's model that includes health related measures of quality of life. Moreover, the study encourages perceiving Lawton's model as a dynamic construct where all the components of the model are connected and interrelated.

Limitations of the Study

This study was limited by being conducted in two ALFs in one geographic region. Assisted Living Facilities show variation within the province and nationwide in the types of residents they serve and in the way they approach meeting residents' health needs. Future studies may consider the involvement of ALFs from different geographic regions across the country to enhance the applicability and transferability of the findings. In this study, interviews were conducted with residents who were cognitively intact. Residents diagnosed with dementia and Alzheimer's disease were excluded given the cognitive problems that may affect the reliability of the study. Therefore, a further limitation of this study is that I did not examine how cognitively impaired residents might describe their own quality of life. In addition, all included participants were from the same racial group (Caucasian). Therefore, the findings may be limited by lack of diversity among participants. Finally, transferability of findings is limited by the sampling method.

Reflection and Reflexivity

In qualitative inquiry, reflexivity refers to the researcher's awareness of his/her own values, biases, and experiences that influence the study (Creswell, 2013). In carrying out this research, I worked in a natural setting and I interviewed a potentially vulnerable group of people. I was exposed to an intense human experience that evolved a wide range of ethical and personal dilemmas. As a researcher, it was imperative for me to be aware of my personal feelings and biases and how they contributed to the meaning I constructed. Therefore, I would like to share information about my personal perspectives, including my professional and academic background, to show how these things may have influenced the research topic and my interpretation of the data.

I am a middle class Arabic woman, married, and a mother to three children. In my home country, I earned a Bachelor's Degree in Nursing in 2001, and I worked for over ten years as a Registered Nurse in the Middle East. During the last six years of my clinical work (in the Arabic Gulf States), I had the chance to work in an affluent setting with multicultural workers who came from different origins and different cultural backgrounds. I developed a strong experience in cross-cultural care and I learned how to interact and communicate with people using their own languages. I found my skills very helpful in relieving patients' suffering, easing their fears and recognizing their actual problems. Being a culturally competent and culturally aware nurse who has dealt with a wide range of diverse values, beliefs, and behaviours among migrant patients was the key to facilitating my communication with the Canadian population who have different cultural backgrounds and who share different values and experiences.

As a new immigrant who moved to Canada from the Middle East, and having different ethnic and cultural background, I faced many challenges in adapting myself to a new environment. I lived the experience of immigrants who want to learn a great deal about languages, people, places, cultures, and values in Canada. This made me curious to learn about Canadian society in all components, including people's lives, thoughts, beliefs, and values. This inspired me to conduct human research that explored quality of life with focus on seniors. As a new resident, I felt this research was an excellent opportunity to integrate with and contribute to Canadian society. Such an opportunity was necessary to refine my experiences and to help me recognise myself as a successful individual socially, academically, and professionally. The seniors who participated in this research disclosed essences of their extensive life experiences, they offered significant wisdom and invaluable life lessons which enriched my personal life experience, and encouraged me to reflect more deeply on the personal and social aspects of my life.

I found a close relationship between my nursing care experience and my research topic. Through my nursing experience I have learned that effective communication with clients is key to providing quality care. In this research, I found communication and relationships between seniors and others were influential factors to quality of life. I learned how important it is to listen to the voices of these vulnerable people who had lost a large part of their autonomy and independence, and who felt empty with no families, friends, or significant social supports around. Seniors need to connect with people to fulfill their social and emotional needs, rather than having someone who only stands for their medical and physical needs. Furthermore, this research opportunity has empowered me with skills and knowledge necessary for conducting future research confidently. It also broadened my horizons on different opportunities in the field of seniors' health.

In doing research, the inability to gain access to the research site is considered one of the most common obstacles facing researchers (Johl & Renganathan, 2010). In this research, I faced many challenges to gain access to the first facility. I perceived this problem as a major challenge that affected the progress of my work. Despite having the research approved from all regulatory bodies, and for many reasons that go beyond the scope of this research, and beyond my control, I had a difficult time acquiring access and initiating data collection within the proposed timeline. After spending a considerable amount of time and effort, I was allowed to start working at the first facility with the recruitment limited to posters mounted in certain places at the facility. Given all the challenges that I encountered, I realised that I needed to recruit more participants from another facility. Finding another facility required more time and effort. However, a backup plan was proposed and made ready to be implemented as soon as needed. An important lesson that I learned that I would like to share with other researchers is the importance of gaining and securing access. There is no one right way to decide about how and when to begin fieldwork, particularly in dealing with health institutions that have major concerns about confidentiality and privacy of participants, which was exacerbated by the vulnerable nature of the studied population. Therefore, gaining access requires time, patience, sensitivity to the site and group under study and much preparation to fit the schedule of the institution and the participants.

Through this interesting work, I practiced a piece of qualitative research that taught me many important lessons. First, qualitative research is a mode of inquiry that studies social phenomena in the natural world, which means it is research inspired by human insights that encompasses real experiences, feelings, and emotions. In this study, I learned how to be patient, sympathetic, respectful, and appreciative to my participants, because they trust my research skills in capturing their humanistic experiences. Engagement with participants in a natural setting helped me to understand the reality of holistic and complex social world. Finally, as a novice researcher, I encountered many challenges that I did not anticipate, but I learned from them and coped with them. Through intensive research work, I trained myself on commitment to a time-consuming and long process of learning, and I gained many more skills and much more knowledge than what I expected. In doing this research, I went through a journey of learning about myself and about others, I discovered new insights about quality of life in ALFs, and I looked at the world through a different lens.

References

Adams, G., & Schvaneveldt, J. (1985*). Understanding Research Methods*: New York, NY: Longman.

Alberta Health Services. (2009). *Designated supportive living*. Retrieved from Alberta Health Services website on November 10, 2012: http://www.albertahealthservices.ca/Seniors/if-sen-dsl3.pdf

Alberta Health Services. (2011). *Designated supportive living.* Retrieved from Alberta Health Services website November 18, 2012: http://www.albertahealthservices.ca/Seniors/if-sen-sl4.pdf

Alberta Health Services. (2011). *Seniors living options assessment*. Retrieved from Alberta Health Services website November 18, 2012: http://www.albertahealthservices.ca/seniors/if-sen-living-options-assessment.pdf

Alberta Health Services. (2012). *Information for: Care options for seniors*. Retrieved from Alberta Health Services website September 1, 2012: http://www.albertahealthservices.ca/604.asp

Alberta Health. (2012). Supportive living guide. *Alberta Health.* Retrieved on November 17, 2012 from http://www.health.alberta.ca/services/supportive-living-guide.html

Alberta Health. (2013). Supportive living guide. *Alberta Health.* Retrieved on October 28, 2013: http://www.health.alberta.ca/services/supportive-living-guide.html

Auquier, P., Thomas, P., Antoniotti, S., Doddoli, C., Boyer, L., & Barlési, F. (2005). The place of patient satisfaction in quality assessment of lung cancer thoracic surgery. *Chest Journal*, *128*(5), 3475-3481.

Ball, M. M., Perkins, M. M., Whittington, F. J., Connell, B. R., Hollingsworth, C., King, S. V., & Combs, B. L. (2004). Managing decline in assisted living: The key to aging in place. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 59*(4), 202-212.

Batalden, P. B., & Davidoff, F. (2007). What is “quality improvement” and how can it transform healthcare? *Quality and Safety in Healthcare, 16*(1), 2-3.

Becker, M., Boaz, T., Andel, R., & DeMuth, A. (2011). Predictors of avoidable hospitalizations among assisted living residents. *Journal of the American Medical Directors Association, 13*(4), 355-359.

Beerens, H. C., Zwakhalen, S. M. G., Verbeek, H., Ruwaard, D., & Hamers, J. P. H. (2013). Factors associated with quality of life of people with dementia in long-term care facilities: A systematic review. *International Journal of Nursing Studies, 50*(9), 1259-1270.

Bicket, M. C., Samus, Q. M., McNabney, M., Onyike, C. U., Mayer, L. S., Brandt, J., & Rosenblatt, A. (2010). The physical environment influences neuropsychiatric symptoms and other outcomes in assisted living residents. *International journal of geriatric psychiatry, 25*(10), 1044-1054.

Bilawka, E., & Craig, B. (2003). Quality assurance in healthcare: past, present and future. *International Journal of Dental Hygiene, 1*(3), 159-168.

Billson, J., Shaw, I., & Shaw, B. (2012). A review of the changes in functional abilities in the elderly: geriatrics. *African Journal for Physical Health Education, Recreation and Dance, 18*(4), 672-683.

Bodenheimer, T., & Berry-Millett, R. (2009). Care management of patients with complex healthcare needs. *Policy, 1*, 6.

Bodgan, R.C., & Bilken, S.K. (1992). *Qualitative research for education: An introduction to theory and methods*. Boston, MA: Allyn & Bacon.

Boldy, D., & Grenade, L. (2001). Promoting empowerment in residential aged care: Seeking the consumer view. *Empowering frail elderly people*, (pp 41-52). Westport, CT: Praeger.

Bond, J. (2004). *Quality of life and older people.* New York, NY: McGraw-Hill International.

Borglin, G., Jakobsson, U., Edberg, A. K., & Hallberg, I. R. (2005). Self-reported health complaints and their prediction of overall and health-related quality of life among elderly people. *International Journal of Nursing Studies, 42*(2), 147.

Bowling, A., Banister, D., Sutton, S., Evans, O., & Windsor, J. (2002). A multidimensional model of the quality of life in older age. *Aging & Mental Health, 6*(4), 355-371.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Bryman, A., & Teevan, J. J. (2005). *Social research methods*. Don Mills, ON: Oxford University Press.

Burdick, D. J., Rosenblatt, A., Samus, Q. M., Steele, C., Baker, A., & Harper, M., et al. (2005). Predictors of functional impairment in residents of assisted-living facilities: The Maryland assisted living study. *Journal of Gerontology: Medical Sciences, 60*(2), 258-264.

Burns, N., & Grove, S. K. (Eds.). (2011). *Understanding nursing research: Building an evidenced-based practice*. Philadelphia, PA: Elsevier, Saunders.

Burton, W.C. (2008). Personal possessions. *TheFreeDictionary*. Retrieved on December 10, 2013, from http://legal-dictionary.thefreedictionary.com/Personal+possession

Calkins, M., & Cassella, C. (2007). Exploring the cost and value of private versus shared bedrooms in nursing homes. *The Gerontologist, 47*(2), 169-183.

Canadian Institute for Health Information. (2010). *Supporting Informal Caregivers – The Heart of Home Care*. Ottawa, ON: Canadian Institute for Health Information.

Canadian Institute for Health Information. (2011). *Healthcare in Canada 2011: A Focus on Seniors and Aging*. Ottawa, ON: CIHI. Retrieved on September 1, 2102 from https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf

Carpenter, C., & Suto, M. (2008). *Qualitative research for occupational and physical therapists: A practical guide*. Oxford, UK: Blackwell.

Carpenter, D., Sheridan, S., Kelly Haenlein, M. H. A., & Dean, D. (2006). Environmental Scan of Instruments to Inform Consumer Choice in Assisted Living Facilities.

Casarett, D., Karlawish, J. H., & Sugarman, J. (2000). Determining when quality improvement initiatives should be considered research. *The Journal of the American Medical Association, 283*(17), 2275-2280.

Castle, N. G., (2003). Searching for and selecting a nursing facility. *Medical Care Research and Review, 60*(2), 223-247.

Centre for Health Services and Policy Research (2012). Who uses assisted living in British Columbia? An initial exploration. *UBC Centre for Health Services and Policy Research.* Vancouver, BC: University of British Columbia. Retrieved on September 21, 2013 from http://www.chspr.ubc.ca/sites/default/files/publication_files/assistedliving.pdf

Chou, R. J. A., & Robert, S. A. (2008). Workplace support, role overload, and job satisfaction of direct care workers in assisted living. *Journal of health and social behaviour, 49*(2), 208-222.

Chou, S. C., Boldy, D. P., & Lee, A. H. (2002). Resident satisfaction and its components in residential aged care. *The Gerontologist, 42*(2), 188-198.

Cleary, P. D., & Edgman-Levitan, S. (1997). Healthcare quality. *The Journal of the American Medical Association, 278*(19), 1608-1612.

Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Boston, MA: Sage.

Cranswick, K. (2003). *General social survey cycle 16: Caring for an aging society 2002.* (Catalogue no. 89-582-XIE). Retrieved from Statistics Canada website on November 19, 2012: http://www.statcan.ca/bsolc/english/bsolc?catno=89-582-X

Cranswick, K., & Dosman, D. (2008). Eldercare: What we know today. *Canadian Social Trends, 86*(1), 49-57.

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* London, UK: Sage.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* Boston, MA: Sage.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches.* Thousand Oaks, CA: Sage.

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social Science Information, 45*(4), 483-499.

Cummings, S. (2002). Predictors of psychological well-being among assisted-living residents. *Health & Social Work, 27*(4), 293-302.

Cutler, L. J. (2007). Physical environments of assisted living: Research needs and challenges. *The Gerontologist, 47*(suppl 1), 68-82.

Davis, B. A., & Bush, H. A. (1995). Developing effective measurement tools: A case study of the consumer emergency care satisfaction scale. *Journal of Nursing Care Quality*, *9*(2), 26.

Denzin, N. K., & Linclon, Y. S. (Eds.). (2005). *The SAGE handbook of qualitative research*. Thousand Oaks, CA: Sage.

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: what challenges do qualitative researchers face? *Qualitative Research, 7*(3), 327-353.

Donald, M. B. (2009). What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs*, *28*(3), 555-565.

Eckert, J. K., Carder, P. C., Morgan, L. A., Frankowski, A. C., & Roth, E. G. (Eds.). (2009). *Inside assisted living: The search for home*. Baltimore, MD: Johns Hopkins University Press.

Erickson, M. A., Krout, J., Ewen, H., & Robison, J. (2006). Should I stay or should I go? Moving plans of older adults. *Journal of Housing for the Elderly, 20*(3), 5-22.

Evans, G. W., Kantrowitz, E., & Eshelman, P. (2002). Housing quality and psychological well-being among the elderly population. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *57*(4), 381-383.

Farquhar, M. (1995). Definitions of quality of life: A taxonomy. *Journal of advanced nursing, 22*(3), 502.

Farquhar, M. (1995). Elderly people’s definitions of quality of life. *Social Science & Medicine, 41*(10), 1439-1446.

Fralich, J., & Hawes, C. (2004). Results of focus groups interviews with residents and family members in Maine and North Carolina. *College Station: Texas A&M Health Science Center, School of Rural Public Health, Program on Aging and Long-Term Care Policy.*

Frankowski, A. C. (2011). *Quality assisted living: Informing practice through research.* New York, NY: Springer Publishing Company.

Frankowski, A. C., Roth, E. G., Eckert, J. K., & Harris-Wallace, B. (2011). The dining room as the locus of ritual in assisted living. *Generations, 35*(3), 41-46.

Gauvin, L., Richard, L., Kestens, Y., Shatenstein, B., Daniel, M., Moore, S. D., & Payette, H. (2012). Living in a well-serviced urban area is associated with maintenance of frequent walking among seniors in the VoisiNuAge study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 67*(1), 76-88.

Geertz, C. (2002). Thick description: Toward an interpretive theory of culture. *The interpretation of cultures* (pp. 537-56). London, UK: Fontana.

Gillis, A., & Jackson, W. (2002). *Research for nurses: Methods and interpretation*. Philadelphia, PA: Davis Company.

Golant, S. M. (2001). Assisted living: a potential solution to Canada's long-term care crisis. Vancouver, BC: *Gerontology Research Centre, Simon Fraser University.* Retrieved on Sep 3, 2012 from http://www.sfu.ca/uploads/page/10/GRC_030.pdf

Government of Alberta. (2010). Aging population policy framework. *Alberta Health.* Retrieved Nov 18, 2012 from http://www.seniors.alberta.ca/Seniors/AgingPopulation/docs/AgingPopulationFramework.pdf

Government of Alberta. (2012). Quick facts & statistics. *Alberta Health.* Retrieved on August 20, 2012 from http://www.seniors.alberta.ca/media_room/facts_stats/

Government of Canada. (2011). Canadians in context: Aging population. *Employment and Social Development Canada.* Retrieved on August 25, 2012 from http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=33

Grbich, C. (2007). *Qualitative data analysis: An introduction*. London, UK: Sage.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In Denzin, N. K., & Lincoln, Y. S. (Ed.), *Handbook of qualitative research*, 2nd ed. (pp163-194), Thousand Oaks, CA: Sage.

Haas, B. K. (1999). Clarification and integration of similar quality of life concepts. *Journal of Nursing Scholarship, 31*(3), 215-220.

Hawes, C., & Phillips, C. D. (2007). Defining quality in assisted living: Comparing apples, oranges, and broccoli. *The Gerontologist, 47*(1), 40-50.

Hawes, C., & Kimbell, A. M. (2009). *Detecting, addressing and preventing elder abuse in residential care facilities.* Retrieved on April 2, 2013 from National Criminal Justice Reference Service website: http://www.ncjrs.gov/pdffiles1/nij/grants/229299.pdf.

Hawes, C., Phillips, C. D., & Rose, M., (2000). A national study of assisted living for the frail elderly: Results from a national survey of assisted living facilities. *U.S. Department of Health and Human Services.* Retrieved on August 12, 2012 from http://aspe.hhs.gov/daltcp/reports/hshp.htm

Hawes, C., Phillips, C. D., Rose, M., Holan, S., & Sherman, M. (2003). A national survey of assisted living facilities. *Gerontologist, 43*(6), 875-882.

Health Canada. (2005). *Searchable database of supportive housing for seniors in Canada: Final report*. Retrieved from Health Canada by Social Data Research website on October 12, 2012: http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-seniors-aines/2005-seniors-aines-eng.pdf

Health Canada. (2011). *Canada's healthcare system*: *Trends/changes in healthcare.* Retrieved from Health Canada by Social Data Research website on Aug 22, 2012: http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2011-hcs-sss/index-eng.php#a12

Health Council of Canada. (2010). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* Retrieved from Alzheimer Society website on Feb 20, 2013 from http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%20 2012/HCC_HomeCare_2d.ashx

Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*. Thousand Oaks, CA: Sage.

Hirdes, J. P., Mitchell, L., Maxwell, C. J., & White, N. (2011). Beyond the 'iron lungs of gerontology': using evidence to shape the future of nursing homes in Canada. *Canadian Journal on Aging, 30*(3), 371.

Hollander, M. (Producer). (2012). *An overview of home and continuing care in Canada* [Video]. Available from http://summit.sfu.ca/item/10846

Hoover, M., & Rotermann, M. (2012). Seniors' use of and unmet needs for home care, 2009. *Health Reports/Statistics Canada, Canadian Centre for Health Information.23*(4), 55.

Horowitz, B. P., & Vanner, E. (2010). Relationships among active engagement in life activities and quality of life for assisted-living residents. *Journal Of Housing For The Elderly, 24*(2), 130-150.

Howell, D., & Cleary, K. (2007). Rural seniors' perceptions of quality of life. *Physical & Occupational Therapy in Geriatrics, 25*(4), 55-71.

Hyde, J., Perez, R., & Forester, B. (2007). Dementia and assisted living. *The Gerontologist, 47*(suppl 1), 51-67.

Inzitari, D., Simoni, M., Pracucci, G., Poggesi, A., Basile, A. M., Chabriat, H., & Pantoni, L. (2007). Risk of rapid global functional decline in elderly patients with severe cerebral age-related white matter changes: the LADIS study. *Archives of Internal Medicine, 167*(1), 81.

Israel, M., & Hay, I. (Eds.). (2006). *Research ethics for social scientists: between ethical conduct and regulatory compliance.* London, UK: Sage.

Iwarsson, S., Wahl, H. W., Nygren, C., Oswald, F., Sixsmith, A., Sixsmith, J., ... & Tomsone, S. (2007). Importance of the home environment for healthy aging: Conceptual and methodological background of the European ENABLE–AGE Project. *The Gerontologist, 47*(1), 78-84.

Jairath, N., Hogerney, M., & Parsons, C. (2000). The role of the pilot study: A case illustration from cardiac nursing research. *Applied nursing research: ANR, 13*(2), 92.

Jeon, Y., Fethney, J., & Ludford, I. (2012). Measuring client satisfaction in residential aged care settings: A narrative review of instruments. *The Internet Journal of Healthcare Administration, 8*(1), 1531-2933.

Johl, S. K., & Renganathan, S. (2010). Strategies for gaining access in doing fieldwork: reflection of two researchers. *The Electronic Journal of Business Research Methods (EJBRM), 8*(1), 42-50.

Johnson, R., & Waterfield, J. (2004). Making words count: the value of qualitative research. *Physiotherapy Research International, 9*(3), 121-131.

Kane, R. (2001). Long-term care and a good quality of life: Bringing them closer together. *The Gerontologist, 41*(3), 293-304.

Kane, R. A., & Cutler, L. J. (2009). Promoting homelike characteristics and eliminating institutional characteristics in community-based residential care settings: Insights from an 8-state study. *Seniors Housing and Care Journal, 17*(1), 15-37.

Kane, R. L., Kane, R. A., Bershadsky, B., Degenholtz, H., Kling, K., Totten, A., & Jung, K. (2005). Proxy sources for information on nursing home residents' quality of life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 60*(6), 318-325.

Karlawish, J. H., Zbrozek, A., Kinosian, B., Gregory, A., Ferguson, A., Low, D. V., & Glick, H. A. (2008). Caregivers' assessments of preference-based quality of life in Alzheimer's disease. *Alzheimers Dement, 4*(3), 203-211.

Kim, Y. (2011). The pilot study in qualitative inquiry identifying issues and learning lessons for culturally competent research. *Qualitative Social Work, 10*(2), 190-206.

Kring, D. L. (2008). Research and quality improvement: Different processes, different evidence. *Medical-Surgical Nursing, 17*(3), 162.

Lawton M. (1991). A multidimensional view of quality of life in frail elders. In J. Birren J., J. Lubben, J. Rowe, & D. Detchman (Eds.), *In the concept and measurement of quality of life in the frail elderly* (pp. 3-27). San Diego, CA: Academic Press.

Lawton, M. P. (1977). The impact of the environment on aging and behavior. *Handbook of the psychology of aging,* 276-301.

Lawton, M. P. (1983). Environment and other determinants of well-being in older people. *The Gerontologist, 23*(4), 349-357.

Lawton, M. P., & Nahemow, L. (1973). Ecology and the aging process. In C. E. M. P. Lawton (Ed.), *The psychology of adult development and aging* (pp. 619-674). Washington, DC: American Psychological Association.

Lawton, M. P., Moss, M., Fulcomer, M., & Kleban, M. H. (1982). A research and service oriented multilevel assessment instrument. *Journal of Gerontology, 37*(1), 91-99.

Lee, D. T., Yu, D. S., & Kwong, A. N. (2009). Quality of life of older people in residential care home: a literature review. *Journal of Nursing and Healthcare of Chronic Illness, 1*(2), 116-125.

Li, L. W., & Conwell, Y. (2009). Effects of changes in depressive symptoms and cognitive functioning on physical disability in home care elders. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 64*(2), 230.

Liamputtong, P. (2009). *Qualitative research methods* (3rd ed.). Australia & New Zealand: Oxford University Press.

Lin, W. (2007). An empirical of service quality model from the viewpoint of management. *Expert Systems with Applications, 32*(2), 364-375.

Linclon, Y. S., & Guba, E. G. (Eds.). (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Liu, P., & Kwon, J. (2013). Perceived availability of and attitudes toward healthy food choices in assisted-living facilities in Kansas. *Journal of Foodservice Business Research, 16*(2), 183-196.

Marshall, C., & Rossman, G. (Eds.). (2011). *Designing qualitative research.* Thousand Oaks, CA: Sage.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Qualitative Social Research*, *11*(3), 1-19.

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Newbury Park, CA: Sage.

Maxwell, J. A. (2012). *Qualitative research design: An interactive approach* (Vol. 41). Newbury Park, CA: Sage.

Meeberg, G. A. (1993). Quality of life: a concept analysis. *Journal of advanced nursing, 18*(1), 32-38.

Michael, Y. L., Green, M. K., & Farquhar, S. A. (2006). Neighbourhood design and active aging. *Health & Place, 12*(4), 734-740.

Mitchell, J. M., & Kemp, B. J. (2000). Quality of life in assisted living homes: A multidimensional analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *55*(2), P117-P127.

Mollica, R. L., Johnson-Lamarche, H., & O'Keeffe, J. (2005). *State residential care and assisted living policy:2004*. Retrieved from U.S. Department of Health and Human Services website on July 28, 2012: http://aspe.hhs.gov/daltcp/reports/2005/04alcom.htm

Morse, J. M. (1994). Designing qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (pp. 220-235). Thousand Oaks, CA: Sage.

Neuman, L. (2011). *Social research methods: Qualitative and quantitative approaches.* Boston, MA: Allyn & Bacon.

Oermann, M. H., Dillon, S. L., & Templin, T. (2011). Indicators of quality of care in clinics: patients' perspectives. *Journal for Healthcare Quality, 22*(6), 9-12.

Oswald, F., Wahl, H. W., Schilling, O., Nygren, C., Fänge, A., Sixsmith, A., & Iwarsson, S. (2007). Relationships between housing and healthy aging in very old age. *The Gerontologist, 47*(1), 96-107.

Park, N. S. (2009). The relationship of social engagement to psychological well-being of older adults in assisted living facilities. *Journal of Applied Gerontology, 28*(4), 461-481.

Park, N. S., Zimmerman, S., Kinslow, K., Shin, H. J., & Roff, L. L. (2012). Social engagement in assisted living and implications for practice. *Journal of Applied Gerontology, 31*(2), 215-238.

Parmenter, T. R. (1994). Quality of life as a concept and measurable entity. *Social Indicators Research, 33*(1), 9-46.

Patton, M. (2002). *Qualitative research and evaluation methods*. London, UK: Sage.

Perkins, M. M., Ball, M. M., Whittington, F. J., & Hollingsworth, C. (2012). Relational autonomy in assisted living: A focus on diverse care settings for older adults. *Journal of Aging Studies, 26*(2), 214-225.

Phillips, C. D., Hawes, C., Spry, K., & Rose, M. (2000). *Residents leaving assisted living: Descriptive and analytic results from a national survey.* Retrieved from U.S. Department of Health and Human Services website on March 12, 2013: http://aspe.hhs.gov/daltcp/reports/2000/alresid.pdf

Phillips, D. (2012). *Quality of life: Concept, policy and practice*. New York, NY: Routledge.

Phillipson (Eds.), *The SAGE handbook of social gerontology* (pp. 111–124). London, UK: Sage.

Porter, E. (2001). An older rural widow's transition from home care to assisted living. *Care Management Journals, 3*(1), 25-32.

Ramage-Morin, P. L. (2005). *Successful aging in healthcare institutions*. Retrieved from Statistics Canada website on October 29, 2012: http://www5.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=82-003-S20050009089&lang=eng

Raphael, D. (Ed.). (2010). *Health promotion and quality of life in Canada: Essential readings*. Toronto, ON: Canadian Scholars Press.

Robison, J., Shugrue, N., Reed, I., Thompson, N., Smith, P., & Gruman, C. (2011). Community-based versus institutional supportive housing perceived quality of care, quality of life, emotional well-being, and social interaction. *Journal of Applied Gerontology, 30*(3), 275-303.

Rodiek, S. D., & Fried, J. T. (2005). Access to the outdoors: Using photographic comparison to assess preferences of assisted living residents. *Landscape and urban planning, 73*(2), 184-199.

Sampson, H. (2004). Navigating the waves: The usefulness of a pilot in qualitative research. *Qualitative Research, 4*(3), 383–402.

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in nursing and health, 23*(4), 334-340.

Sands, L. P., Wang, Y., McCabe, G. P., Jennings, K., Eng, C., & Covinsky, K. E. (2006). Rates of acute care admissions for frail older people living with met versus unmet activity of daily living needs. *Journal of the American Geriatrics Society, 54*(2), 339-344.

Shultz, J., & Chisholm, S. (2010). Supportive living resident suite evaluation: Using simulation to evaluate a mock-up. *Proceedings of the Human Factors and Ergonomics Society, 54*(12), 937-941.

Sikorska-Simmons, E. (2006). The effects of organizational context on autonomy-enhancing policies in assisted living. *Journal of Aging Studies, 20*(3), 217-226.

Speziale, H. J. S., & Carpenter, D. R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Statistics Canada. (2010). *Population projections: Canada, the provinces and territories*. Retrieved from Statistics Canada website on September 10, 2012: http://www.statcan.gc.ca/daily-quotidien/100526/dq100526b-eng.htm

Statistics Canada (2012). *Births and total fertility rate, by province and territory*. Retrieved from Statistics Canada website on December 18, 2012: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth85b-eng.htm

Statistic Canada. (2012). *Generations in Canada*. Retrieved from Statistics Canada website on December 9, 2012: http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-311-x/98-311-x2011003_2-eng.cfm

Statistics Canada. (2012). *Informal caregiving for seniors*. Retrieved from Statistics Canada website on November 25, 2012: http://www.statcan.gc.ca/pub/82-003-x/2012003/article/11694-eng.htm

Statistics Canada. (2013*). Residential Care Facilities 2009/2010*. Retrieved from Statistics Canada website on February 13, 2013: http://www.statcan.gc.ca/pub/83-237-x/83-237-x2012001-eng.pdf

Strain, L., Maxwell, C., Wanless, D., & Gilbart, E. (2011). *Designated Assisted Living (DAL) and Long-Term Care in Alberta (LTC): Selected highlights from the Alberta Continuing Care Epidemiological Studies (ACCES)*. Edmonton, AB: ACESS Research Group. University of Alberta.

Street, D., Burge, S., Quadagno, J., & Barrett, A. (2007). The salience of social relationships for resident well-being in assisted living. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 62*(2), 129-134.

Sutherland, K., Leatherman, S., Law, S., Verma, J., & Petersen, S. (2012). Chartbook: Shining a light on the quality of healthcare in Canada. What can be learned to catalyze improvements in healthcare quality? *HealthcarePapers, 12*(1), 10-24.

Terner, M., Reason, B., McKeag, A. M., Tipper, B., & Webster, G. (2011). Chronic conditions more than age drive health system use in Canadian seniors. *Healthcare Quarterly, 14*(3), 19.

Thorne, S. (2008). *Interpretive description.* Walnut Creek, CA: Left Coast Press.

Tompkins, C., Ihara, E., Cusick, A., & Park, N. (2012). Maintaining connection but wanting more: The continuity of familial relationships among assisted living residents. *Journal of Gerontology Social Work, 55*(3), 249-261.

Turcotte, M., & Schellenberg, G. (2007). *A portrait of seniors in Canada, 2006.* Retrieved from Statistics Canada website on January 27, 2013: http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report*, 15(3), 754-760.

Wahl, H. W. (2001). Environmental influences on aging and behaviour. *Handbook of the Psychology of Aging, 5*, 215-237.

Wahl, H. W., & Oswald, F. (2010). Environmental perspectives on ageing. *The SAGE handbook of social gerontology*, 111-124.

Walker, L.O., & Avant, K.C. (1995). *Strategies for theory construction in nursing.* New York: Simon & Schuster.

World Health Organization (WHO). (2012). Ageing. *World Health Organization.* Retrieved on March 7, 2013 from http://www.who.int/topics/ageing/en

World Health Organization. (1948). Constitution of the World Health Organization. *World Health Organization.* Retrieved on February 14, 2013 from http://www.who.int/governance/eb/who_constitution_en.pdf

Zimmerman, S. (2001). *Assisted living: Needs, practices, and policies in residential care for the elderly*. Baltimore, MA: Johns Hopkins University Press.

Zimmerman, S., Gruber-Baldini, A. L., Sloane, P. D., Eckert, J. K., Hebel, J. R., & Morgan, L. A., et al. (2003). Assisted living and nursing homes: Apples and oranges? *The Gerontologist, 43*(suppl. 2), 107-117.

Appendix A: Invitation Poster

"Seniors' Experiences in Assisted Living Facilities"

You are invited!

You are invited to participate in study called ***Seniors' Experiences in Assisted Living Facilities.*** Elham Al-Omari, a graduate student in the Faculty of Health Sciences at the University of Lethbridge is conducting this research in requirement for her Master's Degree in Nursing. The purpose of this study is to explore the concept of *quality of life* for those seniors residing at *Assisted Living Facilities*, located in Lethbridge, Alberta.

Elham is looking for seniors who are interested in participating. Participation will involve a one-hour interview where she will ask questions pertaining to what life is like living at the facility. A criterion for participation is that seniors must have resided at the facility for a minimum of six months, and must be able to speak and understand English.

Participation is voluntary, all responses will be kept confidential, and your anonymity will be protected. If you are interested in participating, please contact Elham for more information either by telephone: 403- ******** or by email: alomari@uleth.ca.
Thank you for your time and consideration.

Sincerely,

Elham, Al-Omari BN, MSc Candidate
Graduate Student
Faculty of Health Sciences
University of Lethbridge

Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet	Elham Al-Omari alomari@ulet

Appendix B Invitation Letter

***Project Title*: “Seniors’ Experiences in Assisted Living Facilities”**

Dear Potential Participant,

You are invited to participate in a study called ***Seniors’ Experience in Assisted Living Facilities.*** This study is being conducted by Elham Al-Omari, a graduate student of the Faculty of Health Sciences at the University of Lethbridge under the supervision of Dr. Claudia Steinke.

I am looking for residents of this facility who are seniors (65+) of age, have lived at the residence for a minimum of six months, who are able to speak and understand English, and who are willing to participate in an interview. I would like hear about what your life is like living at this facility.

Your participation in this study is voluntary, all data will be kept confidential, and your anonymity will be maintained. Your name and any identifying information will not appear in any documents released from this study. A pseudonym will be assigned to you, only the pseudonym will appear on your responses and in all documents released from this study.

If you agree to participate in this study, you will be asked to participate in an interview of 60 minutes in duration. You may withdraw from the study at any time, and you may choose not to answer certain questions at any time without any aspect of your care or services that you receive from the facility will be withheld or withdrawn. I would like to record the interview upon your consent, as this will help me with the transcription process. All recordings and transcriptions will be kept in a locked file in a designated office at the University.

If you are interested in participating, please contact me and we will set up a time and place to meet that is convenient for you. I hope to meet with you and learn about your experiences living at your facility.

Thank you for your time and consideration.
Sincerely,

Elham Al-Omari BN, MSc Candidate
Graduate Student
Faculty of Health Sciences
University of Lethbridge
Email: alomari@uleth.ca
Telephone: 403- ********

Appendix C: Informed Consent

University of
Lethbridge

Project Title: “*Seniors’ Experiences in Assisted Living Facilities*”

Dear Participant,

You are invited to participate in a study called ***Seniors’ Experiences Assisted Living Facilities*.** This study is being conducted by Elham Al-Omari, a graduate student in the Faculty of Health Sciences at the University of Lethbridge, under the supervision of Dr. Claudia Steinke. This study will serve as a requirement for attaining a Master in Nursing degree. The purpose of this study is to explore the experiences of life among seniors living at this Assisted Living Facility, located in Southern Alberta. I am interested in learning about what your life is like living at this facility and what matters most to you in term of quality of life.

I am looking for residents of this facility who are seniors (65+) of age, have lived at the residence for a minimum of six months, who are able to speak and understand English, and who are willing to participate in an interview. I would like hear about what your life is like living at this facility. If you agree to be in this study, you will be asked to participate in an interview of approximately 60 minutes in duration. I will ask to audio record the interview with your permission, and you can request to turn off the recorder at any time during the interview. The interview will take *place* at a *time* and location *convenient for you*. Your participation is voluntary and your responses will be kept confidential. Your names and any identifying characteristics will not be revealed to anyone nor appear in any documents released from this study. A pseudonym will be assigned to you, only the pseudonym will appear on your responses and in all documents released from this study.

You may withdraw from the study at any time and you may choose to not answer certain questions at any time without affecting your care or services received from the facility. There is no monetary compensation associated with this study. However, your participation in this study will contribute in the knowledge of enhancement of seniors’ quality of life in Assisted Living Facilities. All data collected from you will be used with your permission and will be discarded appropriately upon completion of the study.

If you disclose any sort of violence, I will report the information to the proper authorities as per legal requirements. Because of the personal nature of the questions that will be asked, you may reflect on unpleasant memories while responding to the interview questions and you may become upset or feel some emotional discomfort, you may also become fatigued. In such a situation, you may take a break and request to stop the audio recorder, choose not to answer a particular question, or end the interview if you wish. I will make sure that you have the support you need before I depart from the interview.

A report of the findings will be presented in summary form. If you wish to receive a summary of the results, you may indicate this on the following page. If you have any questions about the study please feel free to contact me or my supervisor Dr. Claudia Steinke.

Questions regarding your rights as a participant in this research may be addressed to the Office of Research Services, University of Lethbridge:
(Phone: 403-329-2747 or email: research.services@uleth.ca)
University of Alberta Research Ethics Office:
(Phone: 780-492-2615 or email: reoffice@ualberta.ca)

If you agree to participate, please sign the attached form to indicate your consent.

Thank you for your time.

Sincerely,
Elham Al-Omari
Graduate Student
Faculty of Health Sciences
University of Lethbridge
Email: alomari@uleth.ca
Telephone: 403- ********

Claudia Steinke
Assistant Professor / Supervisor
Faculty of Health Sciences
University of Lethbridge
Email: claudia.steinke@uleth.ca
Telephone: 403- ********

Signature Page

I have had the opportunity to ask questions about the research and all of my questions have been answered. I understand that I am free to ask any questions at any time about the nature of the study and the methods that the researcher is using. I understand that I can contact the researcher at any time through the addresses/phone numbers listed below.

Consent to Participate

I hereby give my *consent to participate* in this research. Yes _____ No ______

Consent to be Audio-recorded

I hereby give my *consent to have the interview audio-recorded.* Yes _____ No _____

Consent to Receive a Copy of the Audio-recording

I hereby request to receive *a copy of the audio-recorded interview.* Yes____ No______

Consent to Review the Transcribed Interview

I request to review *a copy of the transcribed interview and to edit any necessary changes* prior to it being included in the analysis**.** Yes ___ No ______

Request to Receive Summary of the Results

Upon completion of the study, I hereby request to *receive a summary of the results.*

Yes ______ No ______

Email or mailing address: _________________________________

____ Date ________________
(Signature of Participant)

____ Date ________________
(Signature of Researcher)

[Note: A copy of this consent will be left with the participant and a copy will be retained by the researcher.]

Appendix D: Resident Interview Protocol

Project Title: “*Seniors’ Experiences in Assisted Living Facilities*”

Date: ____

Pseudonym: ____

Gender: ○ Male ○ Female

Age: 65 and older

Marital Status: ____

Education: ____

Occupation: ____

Location of primary residence prior to residing at DAL Facility: _______________

Introduction

Hello, my name is Elham Al-Omari and I am a graduate student of the Faculty of Health Sciences at the University of Lethbridge. The research study that I am conducting will explore experiences of life among residents living in Assisted Living Facilities located at Southern Alberta.

Purpose

The purpose of my research is to explore the experiences of life among seniors living at this Assisted Living Facility. I am interested in learning about what your life is like living at this facility and what matters most to you in term of quality of life. This information will assist me in developing insights on ‘quality of life’ as perceived by residents themselves.

Consent Form

Before we start I would like to go through the consent form with you?

[Read through the consent form with them; ask if they have any questions; do they understand the consent form; if they are okay with things, have them to sign off on the consent which will indicate their agreement to participate in the research.]

Audi-Recorder

As I mentioned earlier, I would like to audio record this interview, upon your consent, to ensure accuracy in the transcription of the data. Do you consent to have the interview recorded? *[Ensure their consent; if consent provided, have them sign off on this on the consent form.]*

Review of Transcription

I plan to have this interview transcribed within a four week period; do you anticipate that you would like to see a copy of the transcribed interview and to make any necessary changes on the provided transcription prior to it being included in my analysis? *[If they would like to see a copy of the transcribed interview, have them check this off on this on the consent form, then you will have to contact them in four weeks to allow them to review the document.]*

Questions

Now before we start, do you have any questions that I could answer for you at this time?

[Turn on the recording device.] Participant will be notified that recording will start at this point.

Interview Questions

1. ***The Facility:***
    a. How long have you been living at this facility?
    b. Prior to moving to this facility, did you look into a few options as far as assisted living facilities? Please elaborate.
    c. How did you come to know about this facility?
    d. What attracted you to this facility?
    e. Were you looking forward to this move?
    f. What were your initial impressions when you moved into this facility?
    g. How long did it take you to adjust to living here?
    h. What is it like living here at this place? *[Tell me about your experience of living at this facility … I want to get a better idea of life here at this facility.]*
    i. What is a typical day like living in this place? *[Have them describe a typical day.]*
    j. After living here for a period of time now, what do you feel is unique about living here at this facility?

2. ***Values:***
    a. In terms of your day to day life and living, what is important to you ... what things are important to you? *[Are you able to practice these things e.g. praying, meditation, playing music…]*
    b. Is what was important to you before you moved here still important? Please explain.
3. ***Meaning:***
    a. If someone were to ask you to describe this place, what words would you use to describe?
    b. What do you like most about this place? What kinds of things here do you enjoy?
    c. What do you like least about this place? What do you not enjoy about this place?
    d. Are you happy here?
    e. Have you met people here that you would call friends?
    f. What does this place mean to you?
4. ***Quality:***
    a. What was your quality of life like before moving to this facility? How would you describe your life before?
    b. How would you describe your quality of life now living here? Has it changed? How so?
    c. How would you describe the quality of service that you receive from the staff here?
    d. Has something happened over time that has changed your perception of this … e.g. an incident that may have influenced your definition of quality of life while living here at this facility? [*Can they provide a specific(s) example?]*
    e. Would you recommend this facility to a family member or friend?
5. ***Challenges:***
    a. What are some of the challenges to your quality of life that present living in a facility such as this?
    b. How to you cope with or manage these challenges?
6. ***Autonomy:***
    a. Do people in this facility allow you to choose whatever you want? *[What are some examples of things that you can choose or decide about it? What are some examples of things that you cannot choose or decide about it?]*
    b. Do you think that this facility respects your personal choices? How?
7. ***Change:***
    a. Have you changed the way that you do things at this facility? *[Probe: activities of daily living (e.g. eating habits, bed time), communication with*

    family and friends, leisure and recreation activities, hobbies …] Are you comfortable with these changes?
   b. Can you give an example of when a change in the way of doing things was necessary? How has this affected you and your day-to-day life?
   c. What are some changes would you like to see in this place that might improve your life quality?

8. ***Other:***
   a. Before we conclude the interview, is there anything you would like to add … any additional comments?

[Thank the interviewee for their time and for participating in the study.]

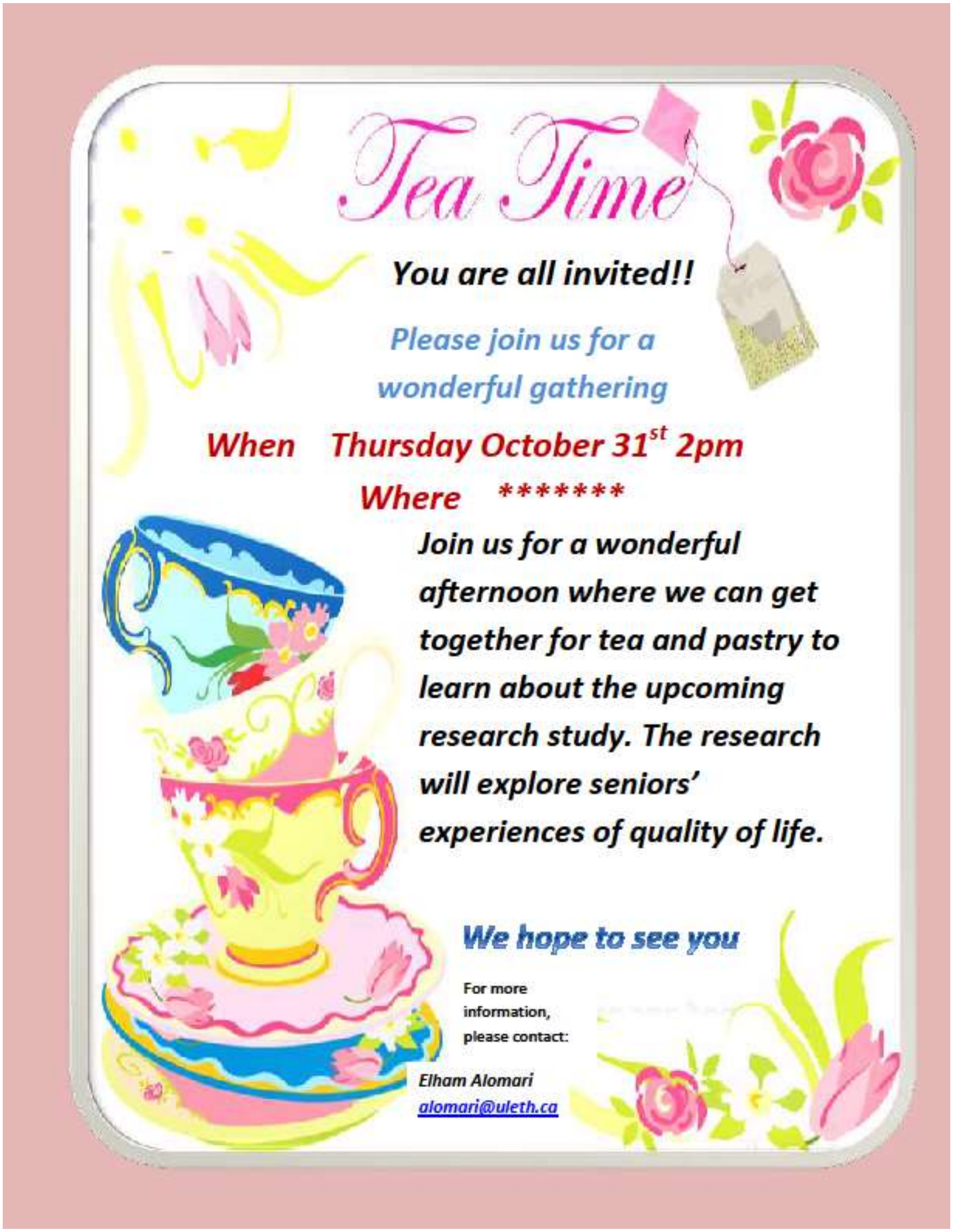
[Turn off recording device.]

Appendix E: Oath of Confidentiality

In taking part in the research study entitled ***"Seniors' Experiences in Assisted Living Facilities"*** I agree to treat all information gained from this study in a confidential manner. I will not identify participants or discuss the contents of the interviews with anyone other than the researcher.

Name   Date

Appendix F: Tea Party Invitation



Tea Time

You are all invited!!

Please join us for a
wonderful gathering

When Thursday October 31st 2pm

Where *******

Join us for a wonderful afternoon where we can get together for tea and pastry to learn about the upcoming research study. The research will explore seniors' experiences of quality of life.

We hope to see you

For more
information,
please contact:

Elham Alomari
alomari@uleth.ca