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Culture of Nursing Care in Iranian Nursing Homes: An Ethnographic Study

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Abstract

Background: The aging of the population and an increase in the number of older adults require long-term care and a greater number of nursing homes (NHs). Consequently, identifying relevant cultural factors in NHs may contribute to meeting care needs. This study aimed to explore the culture of nursing care for older adults in NHs in Iran.

Methods: This interpretive ethnographic study was conducted in two NHs in Kerman. The data were collected through fieldwork, participant observations, field notes, and semi-structured in-depth interviews with 26 staff and 7 residents. The collected data were analyzed through content analysis.

Results: The culture of care in NHs revolves around 3 themes including "task-oriented care", "care deficiency", and "enthusiastic care".

Conclusion: The results emphasized the value of the cultural atmosphere embedded in NHs. The provided care mostly met the physical and immediate needs of older adults (task-oriented care). In addition, establishing an emotional relationship with older adults can help them better accept care and reduce illness and disability in them.

Keywords: Culture, Care, Nursing home, Elderly, Ethnography

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Introduction

The increasing growth of the aging population is a global phenomenon that has become a crisis. Older people are a vulnerable group and their undesirable care status makes them sensitive to developing diseases and increases their health costs (1,2). Iran's cultural heritage has undergone demographic, cultural, economic, and social changes. As a result, such changes have led to families' lack of attention to older people. Thus, they have no choice but to go to nursing homes (NHs) (3). Morally speaking, placing older people in NHs, though not illegal, is considered wrong due to some religious and traditional beliefs among families in Iran (4). In Iran, there are no accurately detailed published statistics on the number of older adults living in NHs. Over seven million (9%) of the Iranian population are aged 65 years or more (5). However, based on published articles, there are about 15 000 older adults under the supervision of the State Welfare Organization. NHs in Iran do not have enough facilities to meet the needs of older adults (4). Residents of NHs need holistic care to meet all their physical, mental, social, and spiritual needs (6,7).

Nurses, as the most important caregivers in NHs, are responsible for the diverse and changing needs of older people (8). As the cultural perspective toward care is a new issue, meaningful and deep investigation in NHs is necessary. On the other hand, since paying attention to care dimensions such as emotional, mental, and social aspects is necessary to provide more effective care (9,10), nurses can play a significant role in developing and promoting the culture of nursing care. Despite the increased number of NHs in Iran there is a paucity of evidence on the culture of care in NHs (3). Research on care for Iranian older adults is relatively new and ripe for more investigation. Researchers' experiences including years of service in clinical, managerial, and educational positions can greatly influence their perspective on care. This study aimed to explore the culture of nursing care in NHs using an ethnographic approach. Studies conducted

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by this approach can help researchers find cultural sensitivity and determine cultural effects on studied individuals and groups.

Material and Methods

Study design

An ethnographic method was used to find out specific cultural and social issues related to care services in NHs. In this study, first field data were collected through observation and interviews to identify cultural patterns associated with nursing care. Ethnography helps researchers collect a great deal of information about the phenomenon in question and enables them to gain a better understanding of the culture of care by exploring nurses' experiences and behaviors (11).

Participants

Two semi-private NHs were chosen with 83 older adults (37 women and 46 men). The inclusion criteria were no cognitive diseases with an average residency of six months to five years. The participants in this study were 26 staff, 2 administrators, 3 registered nurses, 3 members of a rehabilitation team (a physiotherapist, a social worker, and a psychologist), and 18 nursing assistants (NAs). The participants' age ranged from 24 to 35 years and they had an average work experience of six to seven years. Table 1 shows the participants' demographic characteristics:

Data collection

All people in the NHs were included in the study unless they were unwilling to take part in the interviews. As the phenomenon of caring concerns both caregivers and the elderly, both groups were interviewed. The data were collected through the researcher's observations, semi-structured interviews, and field notes over two years. Throughout the data collection, emic and etic approaches were taken. The researcher was a registered nurse who did not work in any NHs. Observations were conducted directly by the main researcher. All practices and communications between older people and staff in the NHs including the structure of the NH, older people's attendance and visits, staff's interactions with the older people, and the older people's participation, and decision-making procedures in care were carefully observed. To do so, after explaining the objectives of the study to the participants and obtaining the written consent form from them, the observation process started. The observations were conducted on different days of the week and at different working shifts to determine compassionate behaviors and their effective factors in nursing care. The researcher tried to use a participant observation approach so that participation in the care process would not disturb older people's care. Following Spradley's approach (1980), three types of observations were made in this study: descriptive, focused, and selective observations. Combinations of these three types of descriptive, focused, and selective observations helped the researcher obtain rich and accurate data. At first, the researcher met the administrators of the two NHs and after explaining the aims of the study, they guaranteed participation. The observations were carried out in the living room, residents' rooms, kitchen, and staff report room during one year in the morning, afternoon, and night shifts, lasting 15 to 40 minutes. The observations focused on caring behavior. Frequent visits and informal conversations helped to gain the residents' trust. The researcher also made arrangements to interview the participants informally during the observations. The semi-structured interviews lasted 20 to 110 minutes. An example of the interview questions was as follows: What activities do you do during the day? Clarifying and encouraging questions were also asked: 'Please explain more about…' or 'Can you provide an example'? A single question was asked from elderly participants: How do the staff care for you?

Data analysis

The data were analyzed using thematic analysis. Ethnography also looks for patterns in behaviors and attitudes. Thus, the two approaches are aligned. Thematic analysis is also congruent with a pragmatic or practical approach and allows for emerging themes to provide a practical basis for solutions to caring for older adults in this challenging environment. Therefore, in this study, it was tried to analyze the latent content as well

Table 1. Demographic characteristics of participants

Participants' role	The age range of participants (year)	Gender	Work experience (year)	Education level
Administrators (n=2)	35-42	Females	3-5	Master's degree
Nurses (n=3)	25-62	Females	5-7	Bachelor's degree
Nursing assistants (n=18)	24-35	Females (n=9) Males (n=9)	6-7	Elementary education (n=10), High school diploma (n=7), and Master's degree (n=1)
Social workers (n=1)	32	Female	5	Master's degree
Psychologist (n=1)	30	Female	5	Master's degree
Physiotherapist (n=1)	24	Female	3	Master's degree
Elderly individuals (n=7)	65-85	Females(n=2) Males (n=5)		Illiterate-elementary reading and writing ability

as manifest content using this method. The data were analyzed through six stages: Stage 1: Getting acquainted with the data: Data analysis began with word-by-word transcriptions of observations, hand-written field notes, and interviews recorded by the first author. Stage 2: Creating primary codes. Stage 3: Searching for categories and themes. Stage 4: Reviewing the categories and themes. Stage 5: Defining and naming categories and themes. Stage 6: Preparing reports (12).

Trustworthiness

The technique of time integration was used to ensure validity. Thus, sampling was performed three times a day. Furthermore, member checking was used to ensure the credibility of the data and codes. Moreover, some of the codes and categories were compared with the participants' statements, and comparative data were collected for two years. The researcher spent enough time on repetitive and unique events to come up with a thorough understanding of the phenomenon. To confirm the data, the research process was recorded. Dependability was ensured by collecting field notes. Transferability was ensured through interviews with different participants.

Results

After perusing the interviews and documents and separating conceptual units as codes, three main categories emerged: "task-oriented care", "care deficiency", and" enthusiastic care" as shown in Table 2. The nurses, older people, and nursing assistants are abbreviated with (N), (O), and (NA), respectively.

Task-oriented care

Care in the NHs involved routine activities such as helping older adults with hygiene, grooming, and cleaning their rooms. In addition, drugs were checked to ensure medication safety. All these activities were performed until lunchtime. Not only such activities overwhelmed nurses, but also they made older adults feel unimportant. Task-oriented care was subdivided into three subcategories including routine care, providing scheduled medications, and rehabilitative routine care.

Table 2. Main categories and subcategories derived from the thematic analysis

Categories	Subcategories
Task-oriented care	Routine care
	Providing scheduled medications
	Rehabilitative routine care
Care challenges	Non-compliance with standard nursing care
	Improper care environment
	Care with financial constraints
Enthusiastic care	Care with compassion and kindness
	Joyous care

a. Routine care

In this study, routine care for older people was highlighted to investigate the care in NH. Furthermore, task-oriented care affected holistic care in NHs.

"When I start my day, first I help the older adults with hygiene (changing diapers and clothes, cleaning, and washing). I do the same things every day (NA 1). That's a pretty bad feeling. Sometimes, it may lead to a sense of indifference to older adults …" (N2).

b. Routine schedules

The time allocated for different activities was determined by the administrator of the NHs and the schedule was attached to the notice board. The staff members seemed quite focused on routines and were completing their tasks (Observation).

c. Rehabilitative routine care

Physiotherapy treatments were routinely performed twice a week for four hours by physiotherapy students (observation). The physiotherapist said: *"Older people take part eagerly in their physiotherapy treatments because of muscular pains, but unfortunately I am not in the NH for a long time. Physiotherapy devices are all out of date …".* Physiotherapy is only done for those who pay a fee to the physiotherapist.

Care deficiency

The observations revealed that caring behaviors were not based on nursing standards. For instance, there was a lack of specific protocols for care, and there were some environmental and financial problems. This theme was divided into the following subcategories:

a. Non-compliance with standard nursing care

Despite all attempts made by the AINs and nurses, the provided care was not based on scientific and standard protocols, leading to the dissatisfaction of older adults (observation). Some staff ignored the older people when they spoke to them. The rooms in NHs are congested and they are in poor conditions (e.g., beds are worn out and not comfortable). The quality of food is poor and the basic needs of older adults are not met. From the participants' perspective, the non-standard atmosphere, lack of experienced nurses, the need for more caregivers, inadequate payment, and lack of training programs were the most significant reasons for inefficient care.

"… We do not have the skills to deal with diseases. For example, when we are told to inject an older person's insulin, we miss a dose. We do not have a comprehensive and specific care plan…" (NA8).

b. Environmental challenges

The staff considered improper care environment as an important reason for care deficiency. Shortly after arrival

based on my first observations in the NHs, I observed an improper on-call room. There was no isolated room for an infected older person, no bars, etc. There was only one bathroom with a slippery floor in both NHs which caused an older person to stumble. The presence of several older adults in one room, the presence of insects, and improper beds caused difficulties in providing care. Caregivers did not have enough control over the rooms. For example, when standing in the hall, one could not see all the residents (observation).

c. Care with financial constraints

Financial problems were among the other factors which affected care tasks.

> *"In these centers, families pay a small amount of money and some families do not pay any money at all. We always face financial problems. Sometimes the staff's salaries are not paid for several months … and we cannot even provide simple care facilities*" (N3).

Enthusiastic care

Enthusiastic care was a feeling of energetic inner desire in providing care to older adults and the participants had satisfaction with this kind of care. This theme was subdivided into compassion, kindness, and joyous care.

a. Care with compassion and kindness

One of the ways that caregivers could offer an easy passage for the old persons was to show love, compassion, and kindness: "… Our job is to provide compassionate care; …" (NA6). Some nurses and NAs expressed their love to the older adults by listening to them and using passionate words by stating they were like their father/mother and hugging them (observation).

b. Joyous care

Joyous activities which were performed by the staff resulted in psychological support for older adults. Excursions, pilgrimage trips, holding celebrations, and going to religious places were the older adults' wishes, giving them the feeling of being closer to God. …On the occasion of mother's and Father's Day celebrations, donors gave gifts to the older adults. The older adults expressed their happiness through laughter, joyful tears, and wishing them blessings. In addition, holding birthday parties for older adults and sometimes holding engagement parties for young couples in the NHs were part of the joyous care provided in NHs (observation).

Discussion

Research findings showed that the care focuses only on physical aspects and adversely affects holistic care. A qualitative study conducted by Lavallée et al among NH nurses, health care assistants, managers, and community-based wound specialist nurses in the National Health Service of England showed that physical care is one of the most important dimensions of nursing in NHs (13). Bahrami et al stated that physical care is one of the important aspects of nursing competence in caring for older people (14). Caregivers followed a one-dimensional approach to the needs of older people. Caring staff prioritized physical care and did not have a comprehensive look at other aspects of care. Routine care mostly involved serving food, bathing older adults, changing their clothes, cleaning, and washing. The results showed that care in NHs was a kind of routine care (15). Another study conducted at an NH in Norway showed that the lack of emotional relationships caused NAs to act like technical workers who just gave medicine or did routines without having any interactions with older people (16).

In this study, routine care for medication use was also observed. This finding was consistent with the results obtained by Rahim et al (17). Fuseini et al also reported that nursing care in NHs is mainly provided as a pre-planned daily schedule of nursing activities such as bed-making, bathing, meals, and changing underwear. When nursing care is routinely provided under time pressure accompanied by other problems such as the shortage of staff and less compassionate care, the dignity of the hospitalized elderly is severely compromised (18).

Morin et al also reported similar results in their study. The present study showed that rehabilitation was one of the routine services performed only for some older adults due to the unavailability of a rehabilitation team (19).

A study in Iran showed that older people are not satisfied with living in NHs. Therefore, it is critically important that relevant authorities not only provide healthcare services for older adults, but also offer comfort, and good physical, social, and psychological care for them (20).

In this study, the participants pointed out many barriers to the provision of good care including the shortage of staff and facilities, low payment, and lack of adequate training. Different countries have various cultural and social values as well as different economic conditions. As a result, a unified care guide cannot be developed if such instances are not taken into account. Nurses had little knowledge about care for older adults and were committed to daily routines and considered it as a taken-for-granted activity. In our study, there were only a few registered nurses working in NHs. The staffs were supervised by shift supervisors (registered nurses). Registered nurses are chosen by the technical officer based on their work experience.

Although practical nurses had completed a 3-year vocational training, due to the novelty of geriatric medicine and related care in Iran (21), they had not completed this syllabus in their college studies. They had only attended a three-day workshop for older people care and did the job based on their own experiences, not professionally.

Given the shortage of registered nurses, NHs have to

employ unprofessional staff to provide care to older people. These staff cannot meet the physical and psychological needs of older people. In this study, there were many cases of complaints about the staff's failure to respond to the requests of older adults. Such issues can be attributed to the lack of professional personnel, dissatisfaction with the job, and disregard for older people. There is an imbalance between the number of staff and the residents in NHs.

Rajan et al showed that the lack of nursing specialists and basic facilities was the main cause of deficiency in care (22). The results of a study in Uruguay showed that caregivers played a key role in providing standard nursing care (3). One of the causes of nonstandard care in NHs was that nursing duties and standards were not fully addressed by the Ministry of Health in Iran (23).

Nasiri et al showed that none of the NHs in Iran is designed well to accommodate older people (24). These NHs had been old houses converted into NHs by changing their structures. In addition, due to the lack of enough rooms, it was not possible to hospitalize mentally and physically ill people in separate rooms. According to research conducted in private NHs in France and Canada, the NHs had standard physical facilities and structure as the residents of NHs could afford to pay for fees (25,26). The results of the present study showed that limited financial resources, lack of sustainability, waste of resources, and low-quality services due to the increased number of older people were the factors affecting care in NHs. According to the holy Quran, one of the good-natured traditions is being kind and respectful to older people. Maintaining and promoting human dignity is the outcome of holistic care. Cultural beliefs and dominant values of communities as well as official supportive facilities and systems to preserve care all contribute to the formation of a culture of care and understanding it and its implications. The culture of care is influenced by various factors such as the cultural and social features of the community in which care is provided.

Enthusiastic care was another factor based on the findings of the present study. Some important issues such as cultural, social, religious, and family factors, as well as the viewpoints of NAs play a part in the process of care. One study in Iran showed that holding religious ceremonies not only affects the emotional status of other people but also their physical ability (27).

One of the major findings of the present study was joyous care. Joyous ceremonies are different among Muslims and western society. Donnelly and MacEntee showed that a visit arranged for older adults to meet their relatives and having occasional ceremonies can help them better cope with the environment of the NH (26).

Conclusion

This study provided unique insights into healthcare culture by describing the perspectives of nurses and residents of NHs. The findings showed that older adults experience a tedious and lonely life in NHs. In addition, the present study highlighted that holistic care plays a pivotal role in the quality of care for older people. Therefore, policymakers, health system administrators, and nursing managers should pay special attention to holistic care at NHs. For this reason, nurses should be trained on how to provide such services and training programs should be incorporated into nursing curricula because such training can form their future careers. In a similar line, providing enough money to improve the quality of care, employing a sufficient number of staff and nurses, providing good infrastructure in NHs, as well as holding training programs for staff are crucial in offering better care to older people. The findings of this study can have some implications for nurses, policymakers, and educational planners to improve the quality of care in NHs. Based on the findings, if rapport and emotional relationships are built, the result would be better acceptance of medication and care. Thus, NHs in our context require major changes and staff should participate in the process of change.

Limitations

This study was carried out with several limitations. This study was conducted in two semi-private NHs in Kerman, southeastern Iran. Thus, the findings have limited generalizability to non-private Iranian NHs. Another limitation of this study was related to the formalities required for entry into NHs as the main researcher was the first ethnographer in Iran who studied the NHs. Besides, at the beginning of the study, the researcher was not allowed in important rooms such as the supervisors' rooms, rehabilitation room, or the kitchen, but with time and as the researcher was a participant observer who helped the nursing staff, she was permitted to enter into these places. There was no special limitation affecting the results of this study as an intimate relationship was established between the researcher and the staff in NHs.

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Authors' Contribution

Conceptualization: Sedigheh Khodabandeh Shahraki.
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Writing–original draft: Sedigheh Khodabandeh Shahraki.
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Competing Interests

The authors declared that they have no conflict of interest.

Ethical Approval

Permission to conduct the study was granted by the Postgraduate Council of Razi Nursing and Midwifery School (research number: 940510). In addition, the Ethics Committee of Kerman Medical University confirmed the protocol for the study (IR.Kmu.REC.1395.561).

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