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Older Adult Residents' Perceptions of Daily Lives in Nursing Homes

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Abstract

Purpose: This study aimed to explore older adults' perceptions of their daily lives in South Korean nursing homes.
Design: We employed a qualitative descriptive study using semistructured interviews.
Methods: We conducted individual, semistructured interviews with 21 older adult residents from five nursing homes in South Korea and analyzed the data using thematic analysis.
Findings: Five themes related to older adults' perceptions of their daily lives in nursing homes emerged: enhanced comfort, aspiring to maintain physical and cognitive functions as human beings, desire for meaningful interpersonal relationships, feelings of confinement and limited autonomy, and acceptance of and adaptation to life in a facility. These themes indicated the positive and negative aspects of nursing home residence, and facilitators and challenges to enhancing older adult residents' quality of life (QOL).
Conclusions: Policy, practice, and research endeavors are required to improve older adult residents' QOL, such as adequate professional nursing care for physical and psychological comfort and residents' health and functional status, sufficient activity programs and meaningful relationships, person-centered care to enhance residents' autonomy, and homelike environments.
Clinical Relevance: This study demonstrates that healthcare providers, researchers, and policymakers should consider nursing home residents' QOL to examine the quality of care within the setting and facilitate the development of appropriate strategies to improve QOL among this population.

In South Korea, the population of older adults aged 65 years or older is increasing rapidly, accounting for 6.62 million individuals (13.1% of the total population) in 2015 and an expected 17.62 million (40% of the total population) in 2060 (Statistics Korea, 2011). This has led to a rapid increase in demand for long-term care (LTC) services for older adults in South Korea. Consequently, in July 2008, the South Korean government initiated national LTC insurance for older adults, as a part of the national social welfare (Lee et al., 2015; National Health Insurance Service [NHIS], 2010). This initiative, and the demand for LTC services in the country, led to a dramatic proliferation of LTC facilities, from 583 in 2005 to 2,935 in 2015. An estimated 1.4% of older adults resided in these LTC facilities in 2015 (NHIS, 2016).

The goal of LTC insurance is to promote older adults' health, reduce their families' care-related burdens, and improve quality of life (QOL) for both groups. Older adults 65 years of age or older and those who are younger than 65 years of age and have a geriatric disease (e.g.,

Alzheimer's disease, stroke, or Parkinson´s disease) can apply for LTC insurance. These applicants are assessed by NHIS employees to determine whether they qualify as beneficiaries (NHIS, 2010, 2016). Those who qualify are able to receive LTC services, including nursing home (NH) and home care (NHIS, 2010, 2016). In particular, NH residents typically receive 24-hr nursing care, rehabilitation, and social and recreational therapy (NHIS, 2010).

In the early stages of LTC insurance implementation for older adults, the governmental focus remained on increasing the numbers of and access to these facilities. However, there is now a need for considerable efforts to examine and improve the quality of LTC facilities. A survey reported that 63% of the employees at NHs answered that appropriate care is not provided to older adults when their health condition is changed or treatment is required (No et al., 2010). Lee, Park, Han, and Suh (2012) also reported that current NHs cannot meet the needs of older adults because of inadequate registered nurse (RN) staffing levels and the absence of advanced nurse practitioners. To control quality, the government evaluated all NHs established after 2009 and posted the results on the LTC insurance website, in addition to creating incentives for the NHs to score well on these evaluations (Choe, 2010; Lee & Kim, 2012). However, these evaluations focused on structural characteristics (e.g., environment) and operating procedures, rather than patient outcomes or service quality.

In South Korea, NHs should be considered a second home for older adults, as they are likely to remain in these facilities until they die (Choi & Lee, 2010). Therefore, understanding old residents' perceptions of their daily lives in nursing homes is an important component of assessment and outcome measurement in relation to care quality in NHs. Unfortunately, few studies have been conducted to examine older adults' perceptions of their daily lives in South Korean NHs. The purpose of this study was to fill this research gap by exploring older adults' perceptions of their daily lives in South Korean NHs. The research questions were "How do older adults perceive their daily life in nursing homes?" "What aspects of nursing home affect the daily life of older adults?" "How do older adults perceive their overall health status in nursing homes?" and "What kind of life do older adults want to live in nursing homes?"

Methods

Study Design

We employed a qualitative descriptive design using semistructured, in-depth, individual interviews with NH older adult residents (Sandelowski, 2000). A qualitative descriptive design was chosen to provide a "comprehensive summary" of their daily life in NHs using "everyday terms" (Sandelowski, 2000, p. 336).

Participants and Setting

Purposive sampling was used to recruit older adult NH residents to understand their perceptions of their daily lives. The inclusion criteria included (a) age of 65 years or older; (b) a minimum of 3-month residence at a participating NH; (c) normal cognitive function evaluated by a standardized Korean instrument that has demonstrated validity and reliability (Kang, Na, & Hahn, 1997); (d) ability to communicate without limitations; (e) ability to understand and reiterate the study purpose; and (f) willingness to participate in the study.

The participants were recruited from five NHs (three located in Seoul and two in the South Korean provinces of Jeollabuk-do and Gyeonggi-do). The number of beds in the NHs ranged from 65 to 296. Four of the NHs had received an "A" grade based on the 2013 national evaluation of NHs conducted by the NHIS, which placed them within the top 10% of the NHs selected for evaluation. The one remaining NH had not been evaluated because it was established after the evaluation took place in 2013.

Data Collection

The study was approved by the institutional review board at the university with which the authors are affiliated. Participant recruitment was performed in collaboration with facility administrators and nurses. Potentially eligible residents were identified by nurses working in the NHs, who also introduced the study to the residents and inquired about their interest. If a resident was interested in participating, the researcher met with the resident individually to explain the study purpose and procedures. All the residents who participated in the study provided written informed consent, and they were aware that they could refuse to participate or withdraw from this study at any time without any negative consequences on the services received from the NHs. We provided a break if the participants felt tired during the interview. To ensure anonymity and confidentiality, an identification number was used to identify each participant, and all the data including audiotapes and transcriptions were kept in a locked cabinet at a researcher's office.

Data were collected between February and June 2015. We designed the semistructured interview guide that facilitated the in-depth interviews (**Table 1**). Two researchers with extensive experience in qualitative

Table 1. Interview Guide

Question 1: Could you describe your everyday life in this nursing home?
How long have you been here? How did you come here?
How was your life before you came to this nursing home (e.g., at home or a long-term care hospital)?
What kind of life did you expect to have here (nursing home)?
Have there been any changes in your life since you came to this nursing home? If so, please tell me more about them.
How is your relationship with other residents here?
Question 2: Could you describe what aspects of this nursing home have affected or would improve/worsen your life?
Could you provide any examples?
Could you tell me what you like the most about your life in this nursing home?
Could you tell me what you like the least about your life in this nursing home?
Question 3: Could you describe your overall health status lately?
Have there been any changes in your health since you came to this nursing home? If so, what do you think the reasons are? Could you provide any examples?
Question 4: What kind of life do you want to live in this nursing home?
What kind of care would you like to receive in this nursing home?

research (J. Kim and S. J. Chang) conducted the interviews at the participants' convenience in quiet, private rooms at the facilities. Two researchers conducted the interviews because the NHs were located at some distance from each other. One of the researchers interviewed 11 participants at three NHs, and the other interviewed 10 participants at two NHs. The two interviewers used the same interview guide to ensure consistency. Before data collection, they discussed their approach based on the interview guide, and after completing their first interview, they listened to the audio and read the transcripts together and had discussions to identify consistent methods of interviewing. The interviews were conducted in Korean and lasted 60 min on average (range 20–80 min). During the interviews, the interviewers observed participants' behavior and nonverbal expressions and took field notes. The interviewers' impressions and feelings about the interviews were also documented in their field notes. All interviews were audio recorded and transcribed verbatim. The research team compared the transcripts with the original audio recordings to confirm accuracy, removed personal identifiers, and assigned random identifiers to the participants. All of the qualitative data, including those collected via interviews and field notes, were managed using NVivo 10 software (Qualitative Solutions and Research, 2015). Information regarding the general characteristics of the NH residents who participated in the study was obtained via a review of their medical records. We continued to recruit participants and collect data until data saturation was achieved.

Data Analysis

The interview transcripts and field notes were analyzed using thematic analysis according to the six steps described by Braun and Clarke (2006). Two researchers (J. Kim and S. J. Chang) carefully and independently reviewed the transcripts to familiarize themselves with the data and recorded their initial ideas regarding meanings and patterns related to the NH residents' perceptions of daily lives. The researchers then coded the data independently, searching for meaningful units that constituted sentences or paragraphs (i.e., coding units). After the initial coding, the independent coders compared their codes for congruency and reconciled any discrepancies through discussion. Related codes were grouped together to generate subthemes and themes. To ensure that the codes were consistent and coherent with the respective themes, all codes were re-examined by independent coders. Codes that did not fit the theme during this iteration were recategorized or moved to other themes. In addition, representative quotes and examples from each theme were selected and translated into English to elucidate the findings of the analysis.

Consistent with the criteria for rigor in qualitative studies (Lincoln & Guba, 1985), the trustworthiness of the findings was enhanced through several strategies, including multiple investigators for independent coding and categorization of the data, maintaining an audit trail, and comparing interview transcripts with the original audio recordings to ensure accuracy. Moreover, two bilingual researchers (E. Cho and H. Kim) independently translated quotes and examples selected for the presentation of the findings, compared their translations, and received confirmation from the other team members. The research team also documented details of the study procedures, created memos about data analysis, and requested that two qualitative research experts perform an independent audit.

Results

Sample Characteristics

In total, 21 NH residents 65 to 94 years of age (M = 83.6, SD = 7.1), of whom 14 were women, participated in the study. The proportion of participants 80 to 89 years of age was higher relative to the other age groups. The proportion of participants who were classified as requiring "Level-3 LTC," which indicates a requirement of partial assistance from others to perform activities of daily living, was higher relative to those requiring other levels of care. Moreover, the duration of their residence at the participating NHs ranged from

Table 2. Nursing Home Residents' General Characteristics ($N = 21$)

Characteristics	*n* (%)
Gender	
Female	18 (85.7)
Male	3 (14.3)
Age (years)	
60–69	1 (4.7)
70–79	3 (14.3)
80–89	14 (66.7)
90–99	3 (14.3)
LTC level	
Level 1	1 (4.7)
Level 2	3 (14.3)
Level 3	12 (57.1)
Level 4	2 (9.5)
>Level 4	3 (14.3)
Primary disease	
Cerebrovascular accident	10 (47.6)
Geriatric syndrome	6 (28.6)
Neurodegenerative diseases	3 (14.3)
Hip fracture	2 (9.5)
Duration of residence (months)	
3–12	7 (33.3)
13–48	3 (14.3)
49–60	3 (14.3)
>60	8 (38.1)
Environment prior to admission	
Home	16 (76.2)
Lived alone	6 (37.5)
Lived with spouse	2 (12.5)
Lived with child	8 (50.0)
Acute hospital	2 (9.5)
LTC* hospital	3 (14.3)

Note. LTC = long-term care.

3 months to 9 years. The most commonly reported condition was cerebrovascular accident. Details regarding residents' general characteristics are presented in **Table 2**.

NH Residents' Perceptions of Their Daily Lives in the NHs

Five themes emerged from the data collected from older adult residents regarding their daily lives in the NHs. These included the following: (a) enhanced comfort, (b) aspiring to maintain physical and cognitive functions as human beings, (c) desire for meaningful interpersonal relationships, (d) feelings of confinement and limited autonomy, and (e) acceptance of and adaptation to life in a facility.

Enhanced comfort. Many participants reported that their psychological and physical comfort had improved since their admission to an NH. Some of them enjoyed being freed from their familial responsibilities, as they no longer needed to worry about meals and housekeeping while staying in the NHs. An 82-year-old female resident said, "Housekeeping is always hard, isn't it? But I'm not responsible for anything here and feel respected. All [of the] staff [members] here treat me very well, so I feel very comfortable" (Resident F). Lack of interference from their children was another reason some residents felt comfortable in NHs, as stated by one resident: "Here, I can do whatever I want to do, but if I stayed with my children, it would be awful [because they wouldn't let me do things]" (Resident T, 82-year-old female).

Several residents appraised the NH staff positively as being responsible for and taking care of everyday chores, such as preparing meals, housekeeping, and managing the residents' medications and health needs. For instance, an 80-year-old female resident said, "This place is better than my house ... here, I just eat and sleep! Everything is done by staff, so I feel very relaxed" (Resident E). Some residents felt that the continuous skilled care they received increased their physical and psychological comfort and reduced dependency and burden on their families. An 81-year-old female resident explained: "Although my children take care of me very well, their care is not better than [the care received] here. Here, staff toilet us, bathe us, and do everything for us. Whose child can do all those things? No way!" (Resident P).

Aspiring to maintain physical and cognitive functions as human beings. Some participants reported satisfaction with improvements in their health, while others were frustrated and concerned about death because of worsening health. Residents often believed they had become healthier through following a regular routine in their NH lives and because of consistent exercise in the NHs. They reported increased mobility and cognitive capacity and well-controlled chronic conditions (e.g., diabetes, hypertension, incontinence). An 82-year-old female resident described the recovery of her physical function: "Every morning after breakfast, I go to the third floor to exercise, especially exercise appropriate for older people! I was unable to stretch this hand before, so I couldn't eat well, but I've become stronger since I came here" (Resident T). Another resident, an 86-year-old female, stated:

> Since I came here, I've been living in a regular pattern and eating whatever is given to me; so, my diabetes has been better, and I've been healthier. If I were home, I would have eaten whatever I wanted. As my blood sugar and blood pressure have gone down, my son and daughter like the facility. (Resident Q)

In contrast, some NH residents reported that despite their expectations for recovery they had become weaker, which led to reductions in their hope regarding their health. As a 65-year-old female resident described:

> If I got better, I could be more hopeful, but I feel weaker day by day. The distance that took 5 minutes for me to walk [before] now takes 10 minutes, which makes me frustrated. I don't have any confidence or hope. If there was any chance of getting better, I might feel hopeful, but I'm just getting worse, so I'm disappointed every time. (Resident G)

As residents' reliance on others increased, they felt they were losing their humanity:

> I don't feel like a human being because it's hard for me to move [by myself]. I need others' help to stand up and [sit] down or go to [the] hospital. Other residents assist me all the time. This is why I say I don't feel like a human being. (Resident U, 94-year-old female)

In addition, as their health deteriorated and they watched other residents dying, they became concerned about the future and death:

> As I've observed, several people die here yearly .... Now, I'm almost a dead person. There are no healthy residents [here]. Everyone's just lying in bed every day, all day long, relying on others for toileting. So who would want to live longer? I don't have any hope or thoughts. I just wonder whether it's better to die now or later. (Resident B, 89-year-old male).

Desire for meaningful interpersonal relationships. While some participants enjoyed their new relationships with others in NHs, others reported they felt lonely because of a lack of meaningful personal relationships. Moreover, several participants found it difficult to live with other older adults with cognitive impairment. Participants who lived alone prior to the NH admission were satisfied with their new relationships with nurses and other residents in the NHs, and they felt less lonely. A 75-year-old female resident said, "Staying here is better than being alone at home .... If I go home, I'll be alone ... and I'd feel lonely" (Resident A). Another participant, a 92-year-old female, stated, "I can still talk, so lots of people come to me. The nurses listen to whatever I say, and we laugh together. I think there are a lot of positive things here" (Resident J).

However, participants often reported that dementia and ambulatory limitations prevented many residents from engaging in meaningful conversations or developing personal relationships, leading to their feelings of boredom and loneliness. They believed they had no peers with whom they could engage in open communication. As an 81-year-old resident stated, "There are no normal people here. Almost every person has dementia or is wheelchair-bound ... it's hard to communicate with them" (Resident R, female). In addition, participants who experienced ambulatory limitation often felt isolated, as they found it difficult to participate in the planned or unplanned activities. For instance, one resident said:

> When I hear and see others laugh and enjoy [themselves], I desperately want to join them ... but now it takes a lot longer than before for me to walk ... anywhere, so it's hard for me to join others .... I'm very disappointed. (Resident G, 65-year-old female)

A few residents reported they found it difficult to live their everyday lives because some residents with dementia manifested verbal and behavioral problems, which interfered with the activities of the relatively healthy older adults. "When I wheeled around, residents with dementia said, 'Why don't you walk instead of using a wheelchair?' I told them, 'I want to walk by myself, but I can't,' but they kept saying the same thing" (Resident A, 75-year-old female). Another participant reported experiencing verbal abuse from some residents with dementia:

> I want to go home because ... when I practice walking, I walk slowly .... At times, residents in front of me who have dementia have asked me, "Why are you still alive?" I answered, "How can I die? It's beyond my control." Then, they said, "Die," and "You need to die." It's so hard to hear that from others. (Resident G, 65-year-old female)

Feelings of confinement and limited autonomy. Some residents perceived the rules governing group life in NHs as a new form of pressure. Although they wanted to do things as and when they wished, they experienced limitations because of group-focused rules and regulations. Moreover, they wanted to be free to go out, but they required staff members' permission; thus, they often felt confined. As an 84-year-old female participant described:

> I should feel free and relaxed, but I actually feel confined emotionally and physically. Even though I try to be active here, I can't do things as I wish, because staying here is group focused. I feel a little suffocated staying here. (Resident C)

Another participant said:

> I feel confined here. I really want to go out, but staff don't let me out because it's cold out there now. I understand that. They may worry about any possible injuries, but I am still disappointed with the fact that we need their permission to get out. (Resident A, 75-year-old female)

As NHs focused on groups, rather than individuals, several participants reported that individuals' opinions were often interpreted as complaints, which led to frustration. An 89-year-old male resident said,

> My opinions are not heard, and nothing has been fixed ... the staff [members] just follow their rules ... even though I say something to them, they don't listen. They may think, "This older person could be out of [his] mind or demented." (Resident B)

Acceptance of and adaptation to life in a facility. Although NH residents wished to go home or live with their children, they realized that it was not ideal or possible:

> I want to go home, but it's boring living at home .... I used to enjoy gardening, but now I can't do it because of my condition .... Instead, I need to have someone who can do it. This whole situation is hard to deal with. This is why I'm here ... so I just need to pretend to be a fool here. (Resident J, 92-year-old female)

They also worried about becoming a burden to their children and therefore did not inform them of their wish to go home.

> If I got a little better, I would want to get out of here. However, my son insists that I can't live alone at home anymore ... [he asked me to] stay here a little [while] ... that's why I'm staying here. (Resident B, 89-year-old male).

Accordingly, they accepted and adapted to their current situations and reality. One of the residents, an 86-year-old female, stated, "I don't think I can live at home any more. I will stay here until the end. I think staying here is the most convenient thing" (Resident N).

Discussion

This study explored older adults' perceptions of their daily lives in South Korean NHs. The data obtained from the residents revealed five themes. Many residents experienced enhanced physical and psychological comfort after their admission to NHs. While staying in NHs, residents aspired to maintain physical and cognitive functions as human beings and desired meaningful interpersonal relationships. Some residents also reported limited autonomy and feelings of confinement related to institutionalization. However, they tried to accept and adapt to life in an NH. These findings are largely consistent with previously published research (Bradshaw, Playford, & Riazi, 2012; Chang, 2013; Hall, Opio, Dodd, & Higginson, 2011; Hjaltadottir & Gustafsdottir, 2007; Kwong, Lai, & Liu, 2014; Murphy, Cooney, & Casey, 2014; Robichaud, Durand, Bedard, & Ouellet, 2006; Schenk, Meyer, Behr, Kuhlmey, & Holzhausen, 2013).

NH residents' comfort is an important component when healthcare providers assess residents' QOL (Gregersen, Jordansen, & Gerritsen, 2015). In our study, NH residents described their experiences of comfort in terms of both physical and psychological aspects. The "enhanced comfort" resulting from not having to prepare meals, perform household chores, and manage medications and health needs is similar to "feeling comfortable" with care in NHs that the family could not offer in the theme of "feeling optimistic about living in a nursing home" (Chang, 2013) and "securing the insecure body (being cared for and being safe)" (Hjaltadottir & Gustafsdottir, 2007). In addition, the participants felt "enhanced comfort" because they were freed from their familial responsibilities and the reduced dependency and burden on their families, which is consistent with feeling free from being a burden on the family in "feeling optimistic about living in a nursing home" (Chang, 2013). As they lived in NHs and received comprehensive care from staff for their needs, they reported relief from stress related to familial responsibilities (e.g., everyday chores for their families) and children's interference, as well as the fear of becoming a potential burden to their families. These findings highlight a possible need to develop and test measures appropriate for South Korean culture to assess residents' physical and psychological comfort.

Physical and cognitive function is an important factor that may contribute to NH residents' QOL. Our findings showed that some NH residents who experienced improvement in functional status were satisfied with their lives in NHs, whereas others experiencing worsening functional status were frustrated and concerned about their future and death. The participants aspired to maintain physical and cognitive functions. They were afraid of losing their humanity as their physical and cognitive function deteriorated. This is consistent with the findings of previous studies (Chang, 2013; Kwong et al., 2014). Elderly residents were eager to maintain their physical function to recover their roles (Chang, 2013) and perceived the deteriorating physical function as a loss of control over their lives (Kwong et al., 2014); thus, they were most concerned about this. Hall et al. (2011) and Schenk

et al. (2013) identified health status as one of the key dimensions of residents' QOL. In our study, NH residents described receiving ongoing, timely professional care and services as one of the benefits of living in NHs, primarily because family members were often unable to provide them with the necessary care at home. Consistently, in previous studies, NH residents reported feeling secure in NHs, as they received appropriate care and assistance when required (Bradshaw et al., 2012; Nakrem, Vinsnes, Harkless, Paulsen, & Seim, 2013; Schenk et al., 2013). As professional care and services contribute to NH residents' QOL, healthcare professionals and policymakers should endeavor to improve quality of care and services in order to improve or maintain residents' health and functional status.

The importance of meaningful interpersonal relationships with peers and staff members was prominent in the interviews with NH residents in our study. Some NH residents indicated that these relationships contributed to their positive perceptions of life in an NH; however, others experienced loneliness resulting from a lack of personal, meaningful relationships with others. This is consistent with the findings of previous studies (Chang, 2013; Roberts & Bowers, 2015; Schenk et al., 2013). For example, a grounded theory study conducted in the United States showed that once residents had been admitted to NHs, they were exposed to new relationships with other residents and staff members, and they tended to define these relationships as either positive (friendly) or negative (unfriendly) based on others' responses in conversations (Roberts & Bowers, 2015). Relationships and interactions with other residents occurred primarily while the participants were engaged in planned NH activities. Therefore, it may be imperative for NH management teams and healthcare providers to develop strategies that include the provision of support in accessing activities and opportunities to participate in them (e.g., low-threshold group exercise programs), to help NH residents, including those with ambulatory dysfunctions, to engage in activities (Quehenberger, Cichocki, & Krajic, 2014). In a previous study, older adults in NHs experienced a deep sense of loss and loneliness because of the frequent turnover of nurses in the NHs, as they perceived the relationships with nurses as very important and meaningful in their lives (Chang, 2013). Since older adults in NHs desire meaningful interpersonal relationships with staff members, especially nurses, policymakers and NH management teams need to develop strategies to improve the personal and meaningful relationships of older adults with nurses through nurse's turnover reduction strategies and therapeutic communication.

In a systematic review regarding QOL in NHs, autonomy was identified as one of the key components positively associated with residents' perceived QOL (Murphy et al., 2014). Unfortunately, limited autonomy is a frequently reported issue that affects residents' experiences of living in NHs. Consistently, in our study, for many residents, feelings of confinement often resulted from imposed limits to personal autonomy, such as permission being required from staff members to go out, residents' lack of opportunities to plan their days, and group-focused rules and regulations. Older adults spent most of their time indoors and felt confined. They expressed their desire to go outside for fresh air, which is consistent with "seeking solace (overstepping the confinement)" (Hjaltadottir & Gustafsdottir, 2007, p. 51). In addition, individual opinions were often ignored by the staff members; to protect and enhance residents' autonomy, person-centered care, rather than task or regulation-oriented care, must be implemented in NHs (Rodgers, Welford, Murphy, & Frauenlob, 2012).

In the present study, the residents tried to accept the NHs as their home and adapt to life in an NH. The theme of "acceptance of and adaptation to life in a facility" is similar to "seeking solace (feeling at home)" in a previous study (Hjaltadottir & Gustafsdottir, 2007). A qualitative systematic review showed that residents' positive attitudes toward life in an NH contributed to their acceptance of and adaptation to life in an NH (Bradshaw et al., 2012). Moreover, the creation of a homelike environment could help residents accept and adapt to their lives in NHs. Homey environments involve both physical factors and a homey atmosphere (Bradshaw et al., 2012). Physical factors include providing residents with their own rooms and bathrooms that are filled with familiar furniture and their own belongings, and ensuring there is sufficient outside space to allow them to enjoy outdoor activities (Bradshaw et al., 2012; Hjaltadottir & Gustafsdottir, 2007; Schenk et al., 2013). A homey atmosphere allows NH residents to plan their days and includes a variety of activity programs (Bradshaw et al., 2012). In a study conducted in Norway, having their own room, as well as having access to practical assistance, someone to communicate with, enjoyable mealtimes with others, easy living, and belonging to a group, contributed to residents' acceptance of NHs as their homes (Nakrem et al., 2013).

In this study, the residents wished to go home or live with their children; however, they did not inform their children of this wish because their children wanted them to stay in the NHs. The residents knew they would place a burden on their families if they went back home. Thus, they tried to accept and adapt to life in the NH for their families. This shows that family is very important to the elderly residents in the NHs, as is consistent with the findings of previous studies (Chang, 2013;

Hjaltadottir & Gustafsdottir, 2007; Tsai & Tsai, 2008). Previous studies reported that elderly residents perceived their QOL in the NHs based on their family relationships (Tsai & Tsai, 2008). Telephone communication and visits with family and children are perceived as the most important social resources for the residents (Chang, 2013; Hjaltadottir & Gustafsdottir, 2007). Thus, NHs need to develop strategies to support family bonds to help older adults maintain feelings of being part of a family, and to help family members feel welcome in the NHs (Hjaltadottir & Gustafsdottir, 2007).

The present study is among the first to report older adults' perceptions of their daily lives in South Korean NHs. Future research is needed to examine daily lives among Korean NH residents with cognitive impairment. When considering residents' QOL as one of the indices of NH care quality, it is necessary to develop culturally valid measures for assessing cognitively impaired older adults' QOL. Therefore, efforts to develop, test, and validate QOL assessment instruments suitable for South Korean NH residents are required. Further research is also required to develop culturally appropriate interventions to improve older adults' experiences and sense of autonomy in NHs in South Korea and to examine their efficacy with respect to QOL.

This study has some limitations. First, interviews were conducted with older adults with normal cognitive function; therefore, the results do not reflect the daily lives of NH older adults with cognitive impairments. Second, the quality ratings of the NHs included in this study were high. The experiences of residents in low-quality NHs could differ from those expressed by the participants in the present study. Nevertheless, our study is important given that little evidence exists regarding South Korean NH residents' perceptions of their daily lives. Thus, the results could provide important information upon which future programs may be conceptualized.

Conclusions

This study explored older adults' perceptions of their daily lives in South Korean NHs. The results demonstrated that residents' perceptions of their daily lives in NHs are complex and characterized by both positive and negative experiences. The study also identified the facilitators and challenges involved in enhancing residents' QOL. The findings of this study indicate that policy, practice, and education endeavors are required to improve older adult residents' QOL by focusing on adequate professional nursing care for physical and psychological comfort and residents' health and functional status. Our findings also show the need for sufficient activity programs, meaningful interpersonal relationships, and person-centered care to enhance the residents' autonomy, and create homelike environments. In addition, further research is required to improve understanding, assess NH residents' QOL accurately, and facilitate the development of appropriate strategies to improve QOL for this population.

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Clinical Resource

- National Health Insurance Service. Long-term care insurance: http://www.longtermcare.or.kr/npbs/e/e/100/index.web

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