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Nursing staffs' views on physical and psychosocial care provision in Slovenian nursing homes

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ABSTRACT

The aim of this study was to explore nursing staffs' perceptions of the physical and psychological care needs of elderly residents, their views on the relative importance of these needs and their perceived ability to meet them. The literature reveals that the quality of elder care in nursing homes should comprise both physical and psychosocial care. Despite this, the nursing staffs' perceptions of the physical and psychosocial care provision have not often been researched. As a method cross-sectional research design was used, with structured questionnaires and unstructured interviews. Our sample consisted of members of the nursing staff from four nursing homes in Slovenia (survey: N=148; interview: N=16). The resulting data was processed by means of statistical analysis and conventional content analysis. The nursing staff reported more knowledge of, skills with and willingness to meet residents' physical needs than psychosocial needs. On the other hand, communication, conversation, self-care and a home-like environment were considered by nursing staff as marking quality elder care. Consequently, nursing home administrators should try to strengthen psychosocial care provision to improve the residents' quality of life. Conversation, as the most often recognised aspect of psychosocial care, should be promoted, since improvements in this area would not be costly, and each nursing staff member may decide individually how best to include more conversation in the daily routines of elder care provision.

Key words: *nursing home, nursing staff, physical care, psychosocial care, quality*

Introduction

According to research results from the literature, nursing homes are being criticised because the current living conditions of their residents include little engagement or interaction[1,2], while exhibiting communication barriers[3,4], inappropriate physical environment[5,6] and a lack of consideration for individual needs[7,8]. Solutions, on the other hand, seem difficult to accomplish because the satisfaction of nursing staff and the quality of care are not at the forefront of the agendas of politicians and nursing home administrators[9]. Furthermore, recommendations from nursing staff about improving the quality of care are not sought[10]. After Independence in 1991, Slovenia patterned its organisation and operation of nursing home care on the example of the European community founder members. Some research conducted in Slovenian nursing homes has revealed staff shortages and, as a consequence, hasty care without much communication[11,12], conditions similar to international findings. Recently in Slovenia, public media started their own investigation and revealed that the duration of care provision in the morning is set at 3–10 minutes per resident. Public media mostly highlight negative experiences, yet nursing home administrators made no official denial of this information.

The Slovenian population is growing older, as in other European countries, and this circumstance will probably increase the need for institutionalised long-term care. In 2008 Slovenia had about two million inhabitants, whose average age was 40. Older people (65 years and over) represented 16.5% of the whole population in Slovenia[13]. At the end of the year 2008, 5.7% of inhabitants over 65 years of age were accommodated in nursing homes, a figure which is similar to other countries. The major problem at present is that all 19,000 available beds in nursing homes are taken, and an additional 5% of the older population is waiting to get accommodation. Nursing homes in Slovenia

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have on average about 170 beds; the largest complex has 608 beds and was built in former Yugoslavia, before Slovenia become independent in 1991[14]. Nursing homes in the United Kingdom and Norway, for example, have on average fewer beds and more single-bed apartments[15,16]. Newly built nursing homes in Slovenia are now following examples from those countries. The latest calculation of the average residents' age in Slovenian nursing homes produced the figure of 78 years[17]. According to statistical data about activities of daily living (ADLs), residents are independent in 5% of cases, mainly independent in 20% and mainly or fully dependent in 75%[17] which is similar to United Kingdom[18].

Background and Context

Overview of the literature

The quality of elder care in nursing homes should comprise both physical and psychosocial care[19,20]. A good quality of care results in a good quality of life for older clients, which means that their physical and psychosocial needs are met[21-23]. In this paper, for easier distinction between physical and psychosocial care, nursing care will be referred to as a physical care. The quality of physical care in nursing homes was conceptualized in terms of freedom from deficiencies and was measured in outcome variables, such as the number of pressure ulcers, death rates, nutrition status, dehydration, change in status of ADLs, cognitive status and behavioural problems[24-29].

The nursing staffs' perceptions of the physical and psychosocial care in nursing homes have not been researched widely in the past. The literature review started with a search of journals in the electronic databases of CINAHL, Medline and Science direct. The primary search strategy was to use the terms »physical care« and »psychosocial care« and »nursing home« as a single search item, a strategy which, unfortunately, produced zero hits. After this we decided to concentrate the literature review on psychosocial care alone. The search terms »psychosocial care« and »nursing home« were used in selecting the period of the last 20 years, from 1990 to 2010. We also used the terms »long-term care«, »institutional care«, »elder care« and »older person care« since some authors used this when referring to nursing homes. The term »psychosocial care« was also replaced by the term »psychosocial needs«. After applying all combinations, we completed the literature search with 85 non-overlapping hits. The inclusion criteria for the literature search required the terms to be found in titles, abstracts or keywords. The literature search was made as suggested by Whittemore and Knafl[30]. After a review of the abstracts, 16 papers were found to be related to psychosocial care in nursing homes. The papers that were excluded from our survey dealt with topics such as psychosocial care in relation to one specific illness like stroke (5), cancer (2), dementia (8), HIV (3), mental health problems (3), anxiety (2) or depression (4). Further papers were excluded since psychosocial care was studied in relation to home care (7), in primary health care (2) or in conjunction with palliative care (4). Four papers were excluded because they were reports about nursing home financing. An additional five papers were omitted because they dealt with the well-being of nursing personnel. Among the excluded results were individual papers about spirituality (1), resident aggression (1), pain assessment (1), alcoholism (1) and resident cooperation in ADLs (1). Three papers were rejected because psychosocial care addressed food intake or nutrition. Four papers were excluded because they addressed the long-term care issues of children, and finally, eight papers excluded addressed resident's physical heath problems, injuries or chronic diseases.

The literature revealed that nursing homes must address psychosocial needs and that outcome data should indicate whether this care results in improved quality of life. Findings by Williams et al.[31] and Isola et al.[20] indicated that elder care mostly aims to respond to the physical needs of older people. Two of the major problems were reported as staff shortages[32,33] and provision of competent staff in adequate numbers[34,35]. Psychosocial indicators, such as promoting patient dignity or assessing and providing services to maintain social engagement, or to lessen the symptoms of depression, were deemed less important and generally more complex and time-consuming to measure and target for quality improvement[19]. Early results of the implementation of Resident Assessment Instrument (RAI) in the European Union showed that training and instruction concerning the RAI method focussed more on the use of the Minimum Data Set (MDS), and less on the use of the Resident Assessment Protocols (RAPs) and on how to incorporate comprehensive information on a resident into everyday care for that resident[36]. Findings supported the hypothesis that, by the nature of the instrument, assessment using RAI led to better fulfilment of residents' physical needs. The improved version of MDS will give nursing home residents a voice in reporting on their status rather than having staff do so, which has the potential to improve resident care and outcomes[19].

Communication was revealed as a major tool to address the psychosocial needs of residents. Williams et al.[31] suggested shifting communication from ADLs to personal-social utterances in order to find out more about the residents and their needs. Not knowing the resident as a person was seen as huge barrier in psychosocial care provision[37]. As in the case of communication, the behaviour of nursing staff towards residents must be well considered and knowledgeable in order to deal with potentially disruptive situations[37,38]. Communicational and conversational abilities are assets difficult to acquire or develop during regular, primarily theoretical education. It is thus very important for nursing home administrators to ensure specific educational programmes or training for their employees[39]. Several authors asserted that nursing staff should make efforts to provide opportunities for meaningful or leisure activities and in such manner also strengthen relationship among residents themselves[40-42]. Hartig[43] concluded that psychosocial care may maintain or promote residents' emotional and mental health.

Aim

The aim of this study was to explore nursing staffs' perceptions of the physical and psychological care needs of elderly residents, their views on the relative importance of these needs and their perceived ability to meet them.

Methods

Research design

Methodological triangulation, as a strategy to confirm quantitative findings and to provide differing but complementary insights, was used in this study[44]. Data were collected by structured questionnaires (1st phase) and unstructured interviews (2nd phase) in a cross-sectional research design. The idea behind this strategy was to reveal discrepancies between the nursing staff view on how to ensure quality in elder care and the current situation in nursing practice. Another advantage of such a study design may be sought in improved verification of the results, because the interviews should yield a picture similar to that from the questionnaires. A brief research design flowchart with basic outcomes is presented in Figure 1.

Sample

The data were collected in Slovenian nursing homes, in the period from December 2006 till March 2007, using a structured questionnaire for nursing staff from two major cities, Ljubljana and Maribor, and their surroundings. In this manuscript, the terms »nursing staff«, »staff members« or »nursing personnel« were used as common phrases when referring to registered nurses, nursing assistants and caregivers at the same time, similarly to other international scholars. The survey sample consisted of nursing staff employed at three public nursing homes and one private nursing home. One hundred and fifty questionnaires were distributed and 148 questionnaires were returned, all without missing data and suitable for analysis; the response rate was 98.7%. The response rate was high because the head nurses coordinated the distribution of questionnaires and also asked the participants not to leave items unanswered. The procedure was as follows: head nurses notified staff members that they could participate in the study by taking a questionnaire from a box in the staff room and, after completion, delivering it to another box in the doorman's office. Convenience sampling was used, and the sample size represented about 5% of the Slovenian workforce in nursing homes. Some stratification was applied in consideration of Slovenian Society of Social Institutions records on the gender of the employees, nursing home status and nursing home wards. In 2006, the personnel in Slovenian nursing homes comprised 90% female and 10% male workers; about 50% of these worked on nursing wards and around 25% in residence wards and dementia wards; 75% of nursing homes had public status[45]. The complete background data is presented in Table 1.

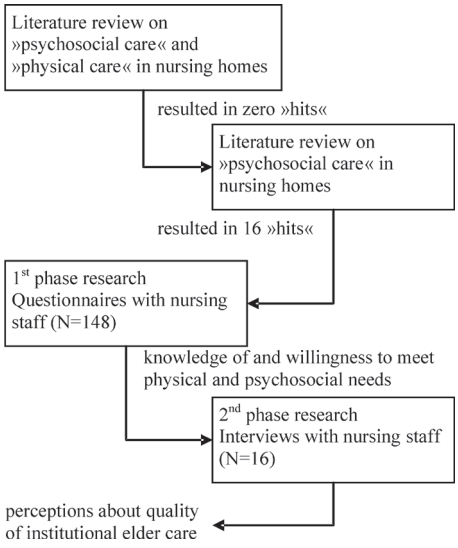

Fig. 1. Research design flowchart and basic outcomes.

TABLE 1
SURVEY SAMPLE BACKGROUND INFORMATION

Background		Total	
		N	%
Gender			
	Female	134	91
	Male	14	9
Education			
	Caregiver	62	42
	Nursing assistant	72	49
	Registered nurse	14	9
Institution status			
	Public nursing home	127	86
	Private nursing home with concession	21	14
Ward			
	Residence ward	31	21
	Nursing ward	83	56
	Dementia ward	34	23

	$\overline{X}$±SD
Age (years)	37.3±8.6
Nursing experience (years)	13.3±9.0
Experience in present job (years)	11.0±8.5

The 1st phase

The structured questionnaire used in the 1st phase was developed by Voutilainen and Laaksonen[46] based on need

theories[47,48] and was later modified to its present form[49]. The structured questionnaire consisted of 42 items and included two instruments. The first instrument consisted of 28 items assessing willingness to meet residents needs (Table 2). The scale consisted of items on physical, psychological and social needs. The scale used was a five-point Likert type scale, with 1 indicating that a need was never met and 5 that it was always met. The second instrument measuring nursing staff knowledge and skills in meeting residents' needs was also assessed with 14 items (Table 3). The scale used was a four-point Likert type scale, with 1 indicating no knowledge at all, and 4 indicating enough knowledge to help the client. Our search in the literature for a suitable questionnaire, prior to selection of this Finnish questionnaire was unsuccessful because most authors applied qualitative methods when researching psychosocial care in nursing homes. We were not able to find a specific questionnaire including items of psychosocial care in order to assess its provision. We had the opportunity to apply a Finnish questionnaire developed by researchers from Finland who at that time were visiting the Faculty of Health Sciences in Maribor. In 2006 the questionnaire had been translated into English, yet its scientific usage was published only in Finnish language journals; the first international publication[20] was in preparation.

Statistical analysis

The object of the statistical analysis was to gain insight into the relation between physical and psychosocial care provision by nursing staff. For each subcategory, sum variables were calculated by adding up the items and dividing the calculated sum by the number of items. The sum variables thus had the same scale as individual items. Consequently, the range of the sum variables was the same as that of the original items[50]. The independent samples T test was used to compare mean values between physical and psychosocial care. The ANOVA test was used to compare mean values of physical and psychosocial care by education and ward. Correlations between physical and psychosocial care and nursing experience were calculated by the Pearson's correlation coefficient. The statistical analysis was done with SPSS software (SPSS Inc., Chicago, IL). SPSS supported all the statistical methods used in this study. A p-value of <0.05 was considered statistically significant.

Reliability of the quantitative part of the study

The two instruments in this study have been used several times before in various Finnish and international studies[20,51,52]. The English version was translated into Slovene. In order to guarantee a quality translation of the English questionnaire into Slovene, cooperation among three independent official translators was organised. The questionnaire was translated into Slovene by the first official translator with the researchers' help. Then the questionnaire was translated back into English by the second official translator. Both English versions were afterwards compared by the third official translator, who ascertained that all the items had preserved the original meaning[53]. The original questionnaire items did not provide any inconvenience or offence for study participants with regard to cultural sensitivity. Therefore, all items were translated into Slovene without changes.

TABLE 2
NURSING STAFF ASSESSMENT OF WILLINGNESS TO MEET RESIDENTS' INDIVIDUAL NEEDS (N=148)

Needs	$\overline{X}$±SD	% with highest grade of 5
1. Physical care items (sum variable)	4.4±0.5	
Help with eating and drinking	4.8±0.5	79.7
Accompanying the elderly to the toilet	4.5±0.7	64.9
Accompanying the elderly with limited mobility	4.3±0.8	46.6
Maintenance of suitable temperature and moisture in the room	3.9±0.9	25.2
2. Psychosocial care items (sum variable)	3.9±0.4	
Providing the elderly with an adequate feeling of safety	4.5±0.6	58.8
Responding to an elderly person's call	4.5±0.6	56.1
Providing the possibility for self-care	4.1±0.8	34.5
Taking time to listen	3.3±0.9	11.5
Using a soothing touch	4.1±0.8	32.0
Expression of thoughts, experiences and emotions	4.1±0.7	27.7
Allowing hygiene and dressing in your presence	3.8±1.0	28.4
Establishing peace before going to sleep	4.1±1.0	40.0
Expressing sexual needs	1.7±1.1	4.8
Contact with relatives and friends	4.8±0.5	88.5

Cronbach's alpha coefficient: 0.78

TABLE 3
NURSING STAFF ASSESSMENT OF THE ADEQUACY OF THEIR KNOWLEDGE OF AND SKILLS TO MEET INDIVIDUAL NEEDS (N=148)

Needs	$\overline{X}$±SD	% with highest grade of 4
1. Physical care items (sum variable)	3.8±0.2	
Offer safe nursing	3.8±0.3	86.5
Provide food and drink	3.9±0.3	87.7
Help with personal hygiene	4.0±0.1	99.3
Help with respiratory troubles	3.5±0.6	54.8
Help in connection with urination and excretion	3.9±0.4	88.4
Help residents in their mobility	3.6±0.5	66.2
Help with troubles in resting and sleeping	3.6±0.5	64.1
Appropriate dress in order to maintain normal body temperature	4.0±0.2	95.2
2. Psychosocial care items (sum variable)	3.4±0.5	
Communicate with relatives and friends	3.6±0.6	63.7
Help express sexual needs	2.7±1.1	28.7
Recognise the expression of pain	3.4±0.6	47.3
Help or advice in solving more difficult problems	3.3±0.6	36.4
Work with the resident in terminal phase	3.4±0.7	52.9
Deal with a death among the residents	3.7±0.6	72.8

Cronbach's alpha coefficient: 0.82

The reliability of the two instruments was tested by Cronbach's alpha coefficient (Table 2 and Table 3). Based on the coefficients, both instruments showed good internal consistency ($\alpha>0.70$)[54].

The 2nd phase

The theme of each interview was based on the research question: »How members of the nursing staff define quality in institutional elder care?«.

Sample

The qualitative part of the study included unstructured interviews with the nursing staff (N=16). The criterion for the selection of staff members for the interviews was possession of at least ten years of working experience in nursing homes. A sample of eight caregivers, four nursing assistants and four registered nurses participated in the interviews, four from each nursing home. This selection was made according to nursing home employee status, where The Health Insurance Institute of Slovenia[55] mandates the presence of one registered nurse per 30 beds, one nursing assistant per 10 beds, and one caregiver per seven beds. All participants were women. Subjects were selected who were judged to be typical of the population or particularly knowledgeable about the issues of institutional elder care in nursing homes. In consideration of this, all selected participants had spent part of their careers working on all three nursing home wards. Purposive sampling represents a strategy in which researchers hand-pick the cases or types of cases that best contribute to the information needs of the study[56].

The data generated was analysed by a procedure of conventional content analysis according to instructions by Hsieh and Shannon[57]. This type of design is usually appropriate when existing theory or research literature on a phenomenon is limited[58]. The transcribed interviews were read several times to obtain an overall sense of the context, as one would read a novel. The initial coding started by extracting labels or expressions from the transcribed content. As this process continued, similar labels or expressions were coded to the final coding scheme. Then the codes were sorted into categories (main themes) based on how different codes were related and linked. These emergent categories were used to organize and group codes into meaningful clusters[59,60]. For ease of understanding, codes and categories were formed through logical induction by seeking general terms that might be familiar to the broader public, and by using the terms found during the literature review process in connection with the institutional elder care phenomenon.

Trustworthiness of the qualitative part of the study

Trustworthiness of the study was approached through consideration of its credibility, dependability, confirmability and transferability[61]. Credibility was sought through critical judgement, in that all the authors took active part in the data analysis. Additionally, the first author personally conducted all the interviews. A further step assuring credibility was the involvement of an external researcher from the field of gerontology and institutional elder care during the process of content analysis. Categories formed by the researchers were confirmed by the external researcher, who also analysed all the interviews at full

length. Both researchers and the external researcher were unanimous about the formation and content of the categories as discussed by Padgett[62]. The confirmability of the study was addressed by comparing the results obtained with earlier studies and knowledge. Transferability was sought by representing the field of elder care through general concepts, so that a sufficient level of abstraction for the institutional elder care phenomenon could be guaranteed. Dependability was addressed by selecting a sample of nursing staff with extensive working experience in nursing homes.

Ethical considerations

Approval for the study was obtained locally from the ethics committee of each nursing home supporting the study. The participants were informed about the nature of the study and what participation would entail for them, by receiving a printed information sheet[63]. By returning the questionnaire, the participants gave their consent for the data to be used for research purposes. Anonymity was protected throughout the study, since no names were displayed, and it was not possible to determine the exact person who had completed a questionnaire. Concerning the interview recording, all the participants were informed about the nature of the study and received an information sheet about the research process. At the start of the interview, the participants were asked once more for permission to make a voice recording, and they were informed of their right to stop and erase the recorded data by withdrawal from the study at any time. Any private issues that were recorded and not considered in the study have been erased. Participation in the study was voluntary.

Results

The 1st phase: survey

The instrument measuring willingness to meet needs had a predefined number of items in connection to physical care (eating, dressing, toileting, moving etc.), and psychosocial care (safety, peace, personal touching, conversation, sexuality etc.), as shown in Table 2. Items in each subcategory were calculated into sum variables. On the scale from 1 to 5, the mean value of 4.4±0.5 shows that the staff was best at meeting the physical needs of the older person. The mean value of psychosocial needs was 3.9±0.4, and the difference between the two was statistically significant ($p<0.001$). A strong positive correlation between physical and psychosocial care was calculated ($r=0.65$; $p<0.001$), which meant that staff who assisted in physical needs well also assisted in psychosocial needs more. There were no significant differences in mean values by education or ward. Neither did correlations with nursing experience show any significance.

Results by individual items in Table 2 show that staff members were primarily available to help residents with eating and drinking and to accompany them to the toilet. Residents could also contact their relatives at any time. The most problematic items were found to be meeting sexual needs, taking time to listen to residents and allowing residents to do their own hygiene.

The adequacy of knowledge about and skills to meet needs had a predefined number of items in connection to physical and psychosocial needs, as shown in Table 3. Items in each subcategory were calculated into sum variables. On the scale from 1 to 4, the mean value of physical care knowledge was 3.8±0.2, and the mean value for psychosocial care knowledge was 3.4±0.5. The difference was again statistically significant ($p<0.001$). As with the assessment of willingness to meet the older person's needs, a strong positive correlation between knowledge of physical and psychosocial care was calculated ($r=0.64$; $p<0.001$). Staff members who expressed more knowledge about physical care also expressed greater knowledge of psychosocial care. Registered nurses showed more knowledge of psychosocial care ($p=0.040$). Also, a week correlation between nursing experience and knowledge of psychosocial care was calculated ($r=0.2$, $p=0.017$). There were no significant differences by wards between mean values.

The mean values for individual items of the second instrument show best results for knowledge about helping residents with personal hygiene, followed by the ability to dress the resident appropriately in order to maintain his/her normal body temperature (Table 3). The third best score concerned help in connection with excretion. On the negative side, there were three items where highest grade of 4 was given by fewer than 50.0% of respondents. Those items were expression of sexual needs (28.7%), giving advice to solve personal problems (36.4%) and recognition of pain (47.3%).

The 2nd phase: Interviews

The interviews were intended to complement the quantitative data by providing a more complete account of staffs' views on the perceived needs of their elderly residents and their ability to meet these, therefore nursing staff were asked to describe their views on the quality of institutional elder care, considering both the physical and the psychosocial aspects. Attention was also paid to the quality of life of the residents, from the nursing staff own perspective. Content analysis of the interview data resulted in three main themes being identified: the resident-oriented approach, working conditions and satisfying needs (Table 4).

The nursing staff emphasised the importance of communication skills, since communication represents a large part of daily work, and staff members must be able to share information with other colleagues, residents and their families. When working with older persons, one staff member adverted the following: »Work with the elderly is very specific; you need sensitivity and warmth, expressed in a nonverbal manner, virtues difficult to learn.« Slovenian nursing homes are obligated to accept seriously ill residents at advanced ages, who are often transferred directly from hospitals. To continue offering adapted hospi-

TABLE 4
CODES EXTRACTED AND CATEGORIES FORMED DESCRIBING QUALITY OF ELDER CARE FROM THE NURSING STAFF POINT OF VIEW

Level I category	Level II category	Codes (words, expressions)
Resident-oriented approach	Sound communication	Nonverbal virtues, warmth, need to explain treatment, communication with relatives
	Highly-educated nursing staff	Coping with age and illness, more knowledge about treatment, ability to orient oneself
	Privacy	Adequate dwellings, legislation, protecting privacy
	Home-like atmosphere	Adjustment, considering habits, family-like atmosphere
Working conditions	Adequate staff ratios	Inadequate staff regulations, need for more devotion, less administration, job satisfaction
	Good organization of work	Good organisation of work, rationality, teamwork
	Opportunity for self-care	Self-care, more time
Satisfying needs	Resident satisfaction	Experiencing satisfaction, fulfilling wishes
	Observation ability	Empathy, observation, recognition of problems
	Stimulated autonomy	Stimulation, meaningful activities, gatherings
	Physical care	Nursing standards, long-life physical therapy, guarantee of safety

tal care, high-educated nursing staff is needed. Privacy, too, was highlighted as an important part of the quality of life, as one staff member explained: »There is an urgent need for better accommodation options, with more space and with single or twin-beds only, to improve quality of life.« Moving to a nursing home is like moving to a new home, for older people usually the final destination in their life. An important task of the nursing staff should include the provision of dwelling conditions similar to those in the residents' homes. As one staff member said, »We should adjust to residents and consider their habits and not the opposite.«

Several staff members expressed the need for adequate numbers of personnel. The present staff regulations are reflected in a surplus of residents or too many responsibilities per employee. The legislation mandates minimum staffing levels, which are, according to the nursing staff, too low, and administrators, for reasons of cost, satisfy only the minimum requirements: »For quality of care, we need more personnel; sadly, this is regulated by legislation; we can't do much about it.« According to staff descriptions, their level of satisfaction with the organisation of work and working conditions is reflected in how they treat the residents. One staff member said: »The present organisation of work does not leave any room for unforeseen incidents; if these occur we work under stress and are less attentive.« Some staff members also considered the importance of self-care: »Time is needed to stimulate residents in performing self-care to preserve their identity.« Time shortage was quite often mentioned, but its application was most evident in the matters of self-care and in the nursing staffs' inability to enjoy closer interaction with the residents.

Perhaps the most frequently emphasised quality goal was described as resident satisfaction. Basically, the quality indicators have been met if residents are satisfied with their quality of life and the quality of care provision. Additionally, some staff members said that residents express most satisfaction if their treatment is done in the way they like or desire. Residents were also satisfied if attention was paid to their suggestions: »To satisfy residents' needs, we should offer things they want and not work by procedure.« Sadly, there are also many residents who can not express their feelings and their satisfaction or dissatisfaction. Therefore, abilities related to empathy, such foreseeing physical and psychological problems, anticipating and making decisions on time, were rated as advantageous. The ability to recognise physical and psychological problems, for example, by observing changes in behaviour patterns, may be helpful for a successful career in this occupation. One staff member added: »In my experience, to satisfy residents' needs, empathy is needed more than education.« Staff also reported that they felt obligated to stimulate resident autonomy to motivate them and in that manner give them the chance to preserve their physical capabilities: »Residents must be stimulated so that they still feel capable of achieving something and are not written off.« Another staff member said: »We should find ways to occupy capable residents, find ways to stimulate them and praise them." The majority of staff emphasised that adequate nursing care should include nursing interventions according to set standards, long-term physical therapy and a guarantee of safety.

We can briefly summarise the quantitative and qualitative results as follows: staff members reported being better at and knowledgeable about satisfying the physical needs of nursing home residents. Satisfying psychosocial needs was seen as a part of quality elder care, but staff members expressed their inability to fulfil these expectations because of time shortage due to inadequate staff

regulations. Both quantitative and qualitative results put physical needs before psychosocial needs; in the quantitative data, this yielded statistically significant difference. In confirmation of this, nearly all the interviews began by addressing the importance of adequate physical care; psychosocial needs were addressed secondly. Quality elder care was seen as being resident-oriented; a home-like environment should be created for residents, and nursing interventions should be made when needed and not by schedule or in a task-orientated manner. Some discrepancies were found, as the qualitative results show that the communication with residents and providing the opportunity for self-care were seen as vital parts of quality elder care; however, the quantitative results show that, in practice, less attention was given to those needs.

Discussion

Slovenia has joined the European Union, and in the process of adapting to its laws has implemented many directives and achieved comparable living conditions in nursing home settings. According to international policy, quality care in nursing homes should comprise both physical and psychosocial care[21-23], but this ideal could not be corroborated by previous studies[20,31]. Similarly, in this study we can draw the same conclusion. The nursing staff acknowledged the importance of psychosocial care in meeting the quality goals of elder care, but in nursing practice the emphasis was clearly on physical care. Furthermore, the nursing staff reported being better able to meet residents' physical needs than their psychosocial needs. These results regarding nursing staff skills correspond to previous results using the same instruments[20].

Some shortcomings were identified that may need further attention for improvement and may be critical for the future prospects of elder care in Slovenia. For example, the most serious concern found in this study was that only 11.5% members of the nursing staff always took the time to listen to residents' problems. This may be a warning, because nursing staff members depend on sound communication to understand and meet the needs of their clients[37,64,65]. If their social needs are to be considered, residents should have opportunities to discuss and exchange ideas with the nursing staff and thereby to obtain personal psychosocial support[66,67]. In the interviews, nursing staff highlighted the need to explain treatment to residents and to banish their negative thoughts. Nursing staff should also be capable of advising residents on legal issues and of protecting them from financial exploitation. Although this issue was not addressed as critical, things may change rapidly under conditions of economic turmoil. Previous studies have shown that staff members would rather avoid this to prevent conflict with relatives[68,69]. Eventually, improvement in communication represents in every respect an important goal in the implementation of resident-oriented care[70].

Another dissatisfactory result in this study was that the nursing staff paid insufficient attention to the autonomy of residents' self-care. Self-care activities take time and patience; residents should ideally be allowed to attempt activities with the minimum of assistance, and they should be verbally supported by the staff members[2,71,72]. Allowing residents to undertake independent self-care could be combined with activities connected to psychosocial care, since this time could be used for communication, conversation and company. In such a manner, self-care could provide an opportunity for forging bonds, getting to know each other and at the same time monitoring the health status of residents. Promotion of self-care may reduce the physical care efforts of the nursing staff, while residents get the chance to remain autonomous for a longer period of time[73,74]. On the other hand, some studies took the opposite tack, highlighting falls as a major reason for not pursuing the practice of self-care[75-77]; moreover, concerns were expressed that all required tasks may not be completed if residents are allowed to perform self-care[78]. Staff members in this study avoided statements about meaningful activities, which are also important for fostering autonomy, probably because of the additional responsibility they involve and the increased risk of injuries to residents.

Psychosocial care combines many activities that are, unlike physical care, non-standardised and without financial specification. The problem exists that psychosocial care is assumed, but is neither scheduled, rewarded nor compensated[79]. Therefore, in current nursing practice, these activities only take place if spare time is available, which, of course, is seldom the case. A very important role in psychosocial care provision is played by family members who are in a position to replace or help nursing staff and the residents if the nursing home administration is able to stimulate and recognise their involvement. Results in this study show that nursing staff do not have perfect relations with families, a situation which is unfortunately similar to other studies[80,81]. Thus, some previous studies had already warned that long-term care facilities alone, without the support of family involvement, may fail to meet the physical and emotional needs of the elderly population[82-85].

Suggestions for further research, education and long-term care orientation in Slovenia

The solutions for improving psychosocial care should not represent large obstacles; basically, nursing staff should provide these in their daily nursing practice, yet how best to do this may constitute an interesting topic for further research. Such research should also include nursing home residents, in order to establish their opinions on this topic. According to our results, it is difficult to provide exact guidelines for improvement because our interest lay primarily in investigating the perceived balance between physical and psychosocial needs. Nursing staff provided some suggestions about what changes would be needed to improve both the quality of residents' lives and their own job satisfaction: sound communication, opportunity for self-care and higher staff-resident ratios. The relative reluctance of nursing staff to participate in psychosocial

care in this research was connected to overexertion in physical care provision. Perhaps there may be room to reduce the amount of physical care by fostering residents' self-care in consideration of strategies to minimise injury risks.

Provision of psychosocial care is very much a specific need of institutional long-term care; therefore, education or training in specific skills should be addressed by nursing homes because nursing staff could be said to take on the role of the residents' family. In addition, nursing home administrators should consider how to strengthen the provision of psychosocial care to best meet residents' expectations as well as financial costs that may increase. Currently, in Slovenia, older people in poor health have no other option than to seek custody in nursing homes; the waiting list is larger than the overall capacity, and these institutions do not have to fight for customers on the open market. Nevertheless, home care is growing, and in due time in the future conditions may change. Nursing home administrators must realise that conducted deficiencies in this study and other international publications, along with negative public opinion, could represent excellent promotion for recruiting home care customers.

Conclusion

The relevant conclusion for nursing practice based on this study is that nursing staff should be concerned with residents' social contact level in case where family and friends remain absent. Nursing home residents need a person to help them banish negative thoughts and to cheer them up. Lack of personal contact and isolation may result in deteriorating health, which various studies have related to poor psychosocial care. Conversation, as the most often recognised aspect of psychosocial care, should be promoted, since improvements in this area would not be costly, and each nursing staff member may decide individually how best to include more conversation in the daily routines of elder care provision. Conversational exchange on a frequent basis may also help with early identification of health problems or with keeping informed about potential disruptions in the family or among residents themselves.

Nursing home administrators should try to strengthen psychosocial care in such a manner as to improve residents' quality of life. Unfortunately, owing to the present situation in elder care provision, priorities are placed on physical care. The current trend in international research towards an emphasis on relevant shortcomings may not serve as good promotion for those considering nursing homes as their new home in the last stage of life. In the long term it is vital for older people not to consider the choice of nursing home accommodation as being pushed away by their family and local community.

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