Privacy within Aged Care Facilities

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Abstract

Nursing practice involves attention to the privacy of clients and their families in the provision of health services. Geriatric nursing is further challenged in providing privacy in health services provision as the nursing occurs in the 'home'. Privacy was investigated from the perspective of residents, staff, visiting service providers and management in geriatric settings. A case study approach was used with two cases: one a new facility and the other, the users of a new building within an existing facility. Semi-structured interviews were undertaken with all stakeholders. Privacy was found to be linked with feelings of freedom and empowerment. The design of the long term care facility provides a clear distinction between public and private places and opportunities to use both are needed for residents and their families. The design of the built environment is an important part of residents, staff, visiting service providers and management achieving privacy in public, physical and social levels.

INTRODUCTION

Nursing practice involves attention to the privacy of clients and their families in the provision of health services. Geriatric nursing is further challenged in providing privacy in health services provision as the nursing occurs in the 'home'. Relocation to a long term care facility where older people reside permanently and receive required services is a potentially stressful event in anyone's life because major life changes may be required. Among people of all ages, older adults are particularly vulnerable to changes in their living conditions because of their increased dependency upon environmental cues, such as familiar objects or sights to orientate themselves [1]. Many individuals experience great difficulty in establishing a sense of 'home' in alternative settings that lack the past known environmental cues which can have a devastating affect that threatens one's quality of life [2, 3] One of the most important aspects of relocation is the provision of privacy within the long term care facility [1,4]. Therefore, provision of privacy in facilitating feelings of home is essential in maintaining quality of life.

Privacy can be conceptualized in many ways. For the purpose of this research, privacy was defined as "having designated space and time which does not have to be shared by others except by choice" [5]. Older adults are greatly concerned about control over their privacy which connects with feelings of 'freedom' and 'empowerment' [5]. The management of privacy issues in aged care occurs at public, physical and social levels. Publicly aged care organizations are accredited according to their commitment to maximising clients' privacy and dignity [6]. Personal information is managed in line with relevant legislation; for example in Australia with the Privacy Act 1988 and the Privacy Amendment (Private Sector) Act 2000 in Australia [6]. At a personal or social level, privacy is managed by nursing staff on an everyday level through the relationship they develop with residents, space, time and touching the private places of their bodies [5,6]. For residents the sense of losing personal space and time is obvious. However, information privacy is not obvious but nevertheless an essential ingredient in the maintenance of people's dignity [5]. For example, staff discussing care giving routines in the dining room which may detract from eating being a social event with pleasant conversation [7].

Physical privacy in aged care centres on the construction, physically and socially, of the home and the room. The home is commonly considered a private space, although some rooms such as bedrooms, bathrooms and toilets are more private than others. In aged care policy and practice, physical privacy is most often considered in relation to the residential care. In the long term care facility, the room becomes the home and the private or owned space, primarily because of the dominance of the bed, but also because prized and intimate objects mark the individuality of the occupant [6]. Overall, "the boundary which distinguishes home from the outside world is one of the physical markers or privacy" [8 p. 783]. Physical care and communication can be most

important for privacy (9).

Privacy can be enhanced through structural changes in the building design (2). For example, residents sharing rooms with others and insufficient provision of private space were considered undesirable. Creating living rooms for smaller groups of residents as well as quiet places facilitates privacy in limited shared use spaces. Institutional appearances impede autonomy, privacy and other human needs (10). The characteristics of the building are weakly related to feeling at home. An ability to speak in private (telephone or physically direct) is highly important. Creating single rooms alone is not sufficient but contribute to decreasing disturbances caused by other residents, and found to be an important predictor of feeling at home (2).

Life in a long term care facility is very public. The patient admitted to the hospital for a one-week stay can put up with less than ideal surroundings but those surroundings become more meaningful for the long term care facility resident who will be calling the facility 'home' for the long-term. A "commitment toward creating a home-like environment, with design that meets the physical, emotional and psychosocial needs of residents, will go a long way toward enhancing residents' quality of life and making your facility more marketable"(11, p39).

Residents are conscious of privacy issues and would like to have more private space and time made available for them (5). However, the perceptions and views of residents in long term care facility about their privacy are less well known. Most studies focus on the opinions of staff and family members where perceptions can greatly differ (2). Further research is required on the evaluation of newly designed long term care facilities which aim to enhance privacy (8) using regular reviews in the form of a 'post-occupancy evaluation'. The creation of privacy for residents in aged care comes from both physical and social methods, and is vital in the resettling of residents into aged care. Further, the range of visiting service providers which may increase as services are outsourced will also seek to provide privacy for residents. Even less is known as to the views of visiting health service providers, those medical and health care providers that visit the facility to see their clients. The purpose of this study was to understand privacy from the perspective of the resident, staff, visiting service provider and management of aged care facilities.

METHODOLOGY

An interpretivist theoretical framework was used.

Interpretivism enabled exploration of the depth of feelings and perceptions from a philosophical standpoint (12, 13). Participants sharing their lived experience enabled exploration of privacy and its different meaning to different people. An interpretivist approach captured variations on the themes of privacy. For example, some participants considered the taking of medical histories at the bedside acceptable, others did not.

A case study approach was used. A case study is an integrated methodological approach that allows for theoretical insight and also reveals possibilities for future research (14). For this research of privacy in a long term care facility, the case study method emphases and grounds the research in time and place. By doing so, opportunities to structure and implement different policies and practices in future projects are highlighted. Punch (15 p.150) suggested that the aim of a case study approach is to "preserve and understand the wholeness and unity of the case." Detailed case studies revealed how residents in Case A and B related to their privacy, and how this place in turn influences and affects their life worlds. Case studies were chosen which served a diverse culturally linguistic group, predominately older Italians, who had migrated to Australia, and for whom English was not the first language. Privacy can be considered culturally based (16). For example, in the Chinese culture the importance of maintaining balance and harmony was found to shape participants' perceptions of what privacy meant to them (16). The case studies were chosen within one organisation to enable homogenous management practices across the case study sites. The design of the buildings was typical of Australian homes and residential settings.

TWO CASE STUDIES WERE CHOSEN

- New long term care facility of 80 beds (Case A)

- Existing long term care facility with 23 new beds (Case B)

Purposive sampling was used to select case study residents. Semi-structured interviews were used to determine the feelings and opinions of research participants on privacy (17,18). Interviews were conducted by one interviewer with case study residents, their families, staff, visiting service providers and management. All interviews were electronically recorded, transcribed and studied for recurrent themes leading to summative findings (19). The University of South Australia Human Research Ethics Committee gave

ethical approval for this project.

The fundamental process of analysis was guided by an inductive model presented by Neuendorf (20). All interviews were transcribed. Interview responses were read and re-read numerous times prior to preliminary analysis. Two researchers independently read the narrative-text analogues to uncover themes. Themes were then discussed between the researchers for consensual validation. Categories, patterns, and themes in the data were identified; similarities and differences were documented based on the researchers' personal understanding, professional knowledge, and the literature (21). Strategies used were analysis and interpretation, including thematic analysis (22). Responses from participants ranged from simple phrases (for example," I don't know"!!) to narrative passages of fifty words or more. The final display of data from both cases revealed three distinct silos of information: a) privacy in owned space, b) privacy in shared areas, and c) privacy in limited shared use areas.

Table 1 provides the details of the interviews completed and the number of participants. The number of participants was achieved by:

An invitation was extended to all management and service providers.

The residents were approached by the Director of Nursing if the resident was considered to be able to give informed consent and an ability to participate in the interview from the sample of all residents.

Residents' representatives were invited by the Director of Nursing to participate if the resident was considered unable to give informed consent or participate in the interview.

Figure 1

Table 1: Interview Respondents

| Case A	Number of participants
Residents	6
Resident representatives	6
Nursing management	1
Visiting service provider	4
Case B	
Residents	7
Resident representatives	6
Nursing management	1
Visiting service provider	4

RESULTS

CASE A

The facility at Case A was opened in January 2004 and is located on a corner site, orientated to the north. The facility is focused around a mid axis, with the kitchen, administration and meeting room in the centre, and the eight resident units linked with corridors to either side. Each of the units has a common room for meals and relaxation. The lake is embraced by the building, and creates a soothing view from every common room. Case A has a capacity of 80 beds, with eight houses of ten beds each. Unit A and B (of a total of eight units) are secured for those with dementia. Figure 1 provides a site map of Case A.

Figure 2

Figure 1: Observation Area Case A
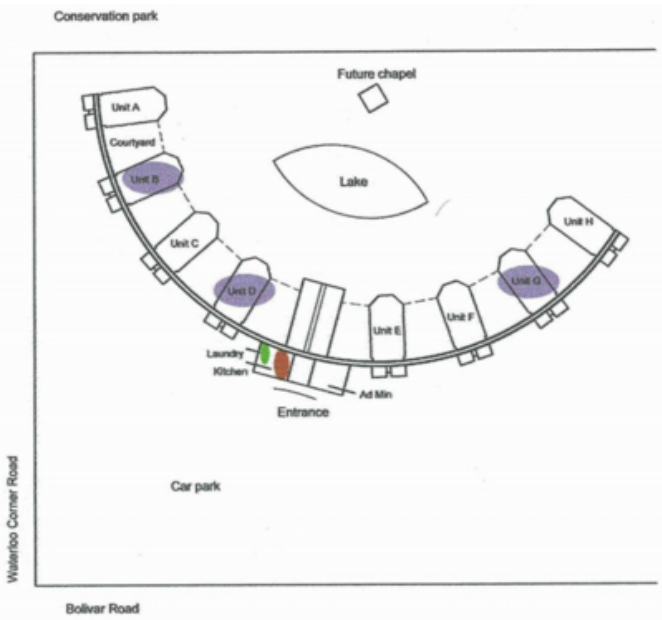
CASE B

The original building in Case B was opened in 1981, which is today called the Hostel. Case B consists of the common rooms and kitchen, and a four-bedded house. Around 1987 the first 20 beds of the long term facility were added, with another 15 beds in 1990. St Anthony's, building for long term care facility beds was built in 1996 along with the laundry. In 2003 the newest addition, St John's (Case B, new building) was completed, with another 23 beds.

Today 114 people are living at the site of which 38 are residents in the long term care facility, 28 are in the four-bedded houses, 25 are in St Anthony's and 23 in the new St John's building. A few of the residents are living in independent units. Residents can maintain their community supports if they are physically able to do so. Some still go

shopping and attend external hairdressing appointments. The research focused on St Johns, the newest building. The kitchen is located in the centre of the facility is adjacent to the administration and dining room. Figure 2 provides a site map of case B. Figure 2 is a diagram of St Johns. Residents live in the buildings that are situated at the periphery of Figure 2, St Anthony's. St Johns, Independent Living Units and the 'Nursing home'.

Figure 3

Figure 2: Observation Area Case B

Respondents were asked concerning the privacy provided by the long term care facility in the various settings available, including bedrooms, common use areas and use by visiting service providers. The three distinct themes that emerged from respondents views were grouped as: 1) privacy in owned space; 2) privacy in share areas; and 3) privacy in limited use shared areas.

PRIVACY IN OWNED SPACE

The vast majority of interviewees were widely positive regarding the privacy provided in the facility particularly in relation to the bedrooms; as single rooms with doors which can be shut (providing dressing privacy) with lockable cupboards, private ensuites with closing doors, and placement of the bed (you can not see the resident in bed when initially entered). Staff protocol includes knocking before entering.

Residents believed privacy from owned space (single bedrooms) has never felt to be isolating, rather a very successful and appreciated way of obtaining privacy. Residents appreciated that they could lock the door. Opportunity for a private telephone line into bedrooms if organised (at a cost) was appreciated and undertaken. If no telephone was in a resident's bedroom, they can use a

telephone in the kitchen; one resident stated this was 'private enough'.

All interviewees appreciated the privacy and benefits of having a single room. As one resident summarised,

"It is privacy you need more than anything else. Some of the places I have been to have two and three and four to a room. Well, that is not fair. When you are getting old you … like your privacy." Another commented "I would hate having to dress or undress or do anything else in front of people."

Resident representatives similarly saw the benefits. Ensuite bathrooms were appreciated, with additional appreciation expressed for the privacy they provide, and the simple lack of a "need to wait". Two residents indicated that they spent most of their day in their room. Bedroom activities included resting or napping, watching TV, reading, playing cards, doing crosswords, listening to music, knitting, using the computer, or caring for pot plants. The bedroom was considered a place where residents could go for peace and quiet, but a great many of them also used them for visiting with the family. The bedrooms provided privacy, and were large enough to cater for visitors.

Management respondents felt sound insulation between rooms contributed to privacy. Only one resident and one resident representative reported that nursing staff can be heard outside the bedrooms from within the bedrooms (one mentioning occurrences occasionally at night). Thick curtains and high courtyard fences also were perceived to add privacy.

PRIVACY IN SHARED AREAS

On the circumferential corridor, but adjacent to the entry of each unit, is a "quiet lounge" in both case A and B. Initially planned as an area where families could visit with residents in a little more privacy than the unit shared lounges, their use has been very limited. The shared areas are still considered "very nice places" and "a good idea" for private discussions, and useful when residents want peace and quiet without retreating to their bedroom. However, only two interviewees commented that they used them. Therefore, the share areas were considered by some "a waste of space". One resident had never seen anyone use them. Staff commented that many are still waiting for furniture; in fact, all were furnished at the time of opening, and some furniture had been moved (to unit lounges) and some stolen. Without furniture, the rooms lost function and aesthetic appeal. Within the unit

"there is a reasonable provision of space for people to be able to get away a little bit … you have got the central dining area, … the TV lounge and then you have got the subsidiary lounge on the other side of the dining area. … (also) …. You can have another person or two in your room and not totally feel on top of each other."

The quiet lounges in the present function did not appear to provide realised opportunities for privacy. However, residents' perceptions of the design of St John's in particular, comments included that the building was "fine – just nice", "designed well", "well laid out", and "roomy". The design was reported to both contribute to privacy, and yet provide "lots of areas to have lunch and sit about and watch TV". The future of the quiet lounges is consequently being considered. The quiet lounges may be superfluous for their original intended use as a quiet area for staff hand-overs, family conferences or use by visiting service providers. Alternatively, quiet lounges could be made more appealing to provide private areas. If no such need for private lounges exists, consideration to changes of use to "a library … a gym and a physio treatment area … a music room … and a relaxation room… the dolphin type music, lighting, and aromatherapy" could be made.

Management commented that the design and corridor placement also contributed to privacy, that the spread out corridors meant you did not see lots of people. Also, the meandering nature of hallways gives a type of privacy, management indicating that visitors seek directions rather than wandering the hallways lost. Management's opinion was also that the meandering corridors meant you did not see lots of people, adding to a sense of privacy. The corridors enabled incidental encounters enabling opportunities for interaction between staff and residents, with each able to choose the level of interaction that followed. For the residential wing designed for older people with challenging behaviours, special consideration to common areas being less suitable for family visits and therefore resident's rooms should be larger, and that sound insulation was even more important.

PRIVACY IN LIMITED SHARED USE AREAS

Case B has an allocated physicians' room. The room is used both by general practitioners and other visiting service providers, and is sometimes considered the place that providers use most in the facility. The physician's room is appreciated for its usefulness, its security (lockable, so appropriate for leaving a computer) and its privacy for consultations and telephone calls. As there is only one physicians' room, and many visiting service providers, the room is not always available. The existence of a physicians' room for treatments, with closing blinds, was a contributing factor to perceived privacy. Management reported that a locked cupboard was present for medications, and allocated spaces for case notes enabling confidentiality of information and privacy were also available. The nurse's stations were also places where residents may frequent when they are seeking company; in many cases, the residents reported they see the staff more than their relatives and consequently build relationships with them. The nursing staff feel these areas lack privacy and security due to accessibility by residents.

A number of issues were identified by staff as relating to the hand-over (shift report) period at the end/beginning of shifts. Staff approximated that the nurse's station only really has enough room for two people on chairs, and that up to eight staff can be present at hand-over .Therefore, hand-over is a time when lack of floor-space and bench-space was most obvious. Staff involved in hand-over can be standing in the circumferential corridor, and facing into the nurse's station over the section of raised bench. Staff also felt the subsequent handovers in the corridor did not sufficiently address resident confidentiality. As a positive aspect, standing staff could then use the raised bench space for paper-work rather than being limited to the low bench area within the nurse's station. Comment was later made by senior management that the currently under-used quiet rooms near the nurse's station could be used for hand-over, thereby eliminating many of the issues detailed above. No staff lockers are provided in the nurse's station or areas where nursing staff can secure personal belongings; the staff considered this omission to affect the security of their possessions.

Case A has no room for consultations with health care providers. Nurses commented if all consultations occurred in the 'physicians' or health care providers room, ', an activity of 'normalcy' – going to visit your physician – would perpetuate. Whilst saving the time of the health care provider required escorting residents back to their bedrooms to achieve privacy, use of a consultation room would also require staff on occasions to escort residents to their 'appointment'. Visiting health service providers indicated that, whilst not convenient, they were able to make private telephone calls. If a resident or visiting service provider use a staff member's portable telephone, the carer or nurse is isolated from communication with other staff members until

the telephone is returned. The common area or shared telephones are in plain sight and hearing of the kitchen area and do not provide privacy for the visiting service provider.

DISCUSSION AND CONCLUSION

Privacy in the public, physical and social levels can be achieved in aged care facilities. The primary source of privacy for the residents comes from their rooms which have become their home in a long term care facility, their owned space. Physical privacy and space were achieved for residents with single bedrooms with ensuite bathrooms, a telephone in the room and ability to lock the door provided autonomy in keeping with the literature (2). The single rooms were not seen as isolating rather as providing perceived control over the personal environment for residents, adding to a sense of well being. Staff protocol to knock before entering added to the feeling of privacy both public and physical. The placement of the bed, such that one can not see the resident when initially entering was also important and valued, contributing to privacy. The respect and personal dignity the single room with ensuite achieved for residents and their families contributed to feelings of freedom and empowerment. Achieving privacy for residents and their families contributed to their well being and health overall.

The design of the long term care facility contributes to privacy particularly but also facilitates physical and social privacy. Design features in the case studies adding to privacy, but not presently found in the literature, aimed to decrease possible disturbances by other residents (for example, sound proofing, meandering hallways). Design features considerably added to social privacy by reducing interference or interruptions from other residents, improving feelings of autonomy and feeling at home. The design by providing a clear distinction between the public and private places, and opportunities to use both according to the resident's and their families wishes underpins privacy. The proximity of residents' rooms in clusters of units was seen as important in forming friendships, and no comments were that clustering of rooms detracted from their privacy.

Social privacy was a feature of the management and staff's approach. Privacy in shared areas was achieved carefully with attention to avoiding conversations and interactions being overheard or observed. The design of the built environment contributed to social privacy by enabling opportunities for conversations in shared areas to occur.

Public privacy was achieved with the management of

personal information. Locations to secure information to maintain privacy were essential. The lack of a designated health care provider room in Case A was not reported by respondents as detracting from privacy, other means were used to achieve privacy. However, the lack of designated health provider room could be expected to detract from resident privacy. Staff privacy could be lost in the focus on residents in the design stages. For example, locations to secure belongings or have breaks with colleagues alone, such as a lunch room, were still needed.

The design of the built environment for a long term care facility is an important factor in providing privacy for residents and staff. The design can underpin the ability to provide privacy in public, physical and social levels. The privacy residents, management, staff and visiting service providers commented upon occurred in owned and shared spaces, each location or space requiring an attention to public, physical and social privacy. The built environment clearly provides physical privacy in a single room, yet also in the meandering corridors, opportunities to use to limited shared use areas and undertake communications, using the telephone, and not be overheard.

Nursing staff in long term care facilities can contribute to privacy of residents and fellow workers in their health service provision. The facilitation of physical privacy (for example while dressing a resident) and respecting their social privacy is linked to feelings of autonomy and empowerment (6, 23). It might be possible to further improve the autonomy of residents if nurses acted as advocates to support residents to make self determined decisions which are applied as informed consent. The implementation of informed consent with regard to nursing interventions would promote both autonomy and respect for privacy (23).

Nurses play a key role in respecting and facilitating resident privacy. However, the importance of nursing in the design of a long term facility can go unrecognised (24). A view of how the built environment can achieve privacy is also needed from the vantage point of all stakeholders, particularly the advanced practice nurse who has an in-depth knowledge of the needs of residents and nurses in long term care facilities. This in-depth knowledge should be sought when designing the built environment. Nurses should be more involved in the construction and/or remodelling of a facility to the benefit of the final design. Focus or consultation groups held with administrators, architects and engineers should include the providers, especially nurses, when considering the layout

of the facility. Nurses have a key sense of what is needed to provide the elements to enhance privacy. The way in which different people understand and enact privacy also requires further research in order to understand both its complexity and context. This research would ideally be led by advanced practice nurses.

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