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Quality of Life of Members of a Religious Community Living in Long-Term Care

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This qualitative study investigated perceptions of quality of life among a small sample of elderly nuns (N=15) and one priest identified as having a cognitive impairment and who were residents in a religious nursing home. By using in-depth semi-structured interviews, it compared their self-reports of quality of life with those provided by the nurse manager. Following data analysis, four key categories linked to the overarching theme of continuity emerged. These were (1) religion, (2) belonging, (3) autonomy, and (4) altruism. Findings showed that most nuns claimed they enjoyed a good quality of life; however, their perceptions of a “good life” were often at variance with those of the nurse manager, whose appraisal tended to be based on residents’ physical functioning, cognitive status, and age, and not on their religion, belonging, and altruism. This study generates new findings on the quality of life of members of religious orders with a cognitive impairment.

By international standards, Ireland has a relatively young population. There are approximately 625,500 people aged 65 and over in Ireland, yet this figure is set to more than double over the next thirty years.¹ Like other Western countries, only a small proportion (circa 4.6%) of older Irish people are residents in long-term care.² While the topic of their quality of life (QoL) has received some recent attention,³ less is known about the QoL of aging minorities, including nuns and priests who, because of chronic health conditions and disability, require long-term care. This study explores the

QoL of members of religious orders living in one particular religious-based nursing home operating exclusively for religious orders. Research into the needs of aging religious people is important because this is an international and multifaith issue.

Literature Review

Using key terms such as religion, QoL, nursing home, cognitive impairment, and dementia, an extensive literature search was undertaken. Search engines used included Sage, PubMed, Scopus, CINAHL, PsycINFO, and ProQuest. No articles of direct relevance to the topic were found. Accordingly, while a substantive body of literature exists on the topics of QoL and dementia⁴ and QoL and long-term care,⁵ published works about the QoL of members of religious orders with dementia or cognitive impairment living in long-term care facilities are lacking. The much-cited Nun study,⁶ which followed 678 Catholic nuns over a number of years, is one exception. While the latter showed how spirituality and faith appeared to influence these

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nuns' life expectancy and QoL, the main focus of the Nun study was not on QoL per se but rather on risk factors for Alzheimer's disease and the related dementias.

An existing body of literature on religion, spirituality, and dementia reveals how religion—through providing comfort, fostering strength, engendering hope, and relieving fears and anxieties—can confer positive coping mechanisms for both people with dementias and also their informal caregivers.⁷ Faith, with a strong belief in God, has been shown to enable people with early stage dementia to face difficulties and uncertainties.⁸ A conceptual distinction is made in this literature between the terms religiosity and spirituality. Religion has been defined as the process by which humans try to understand, experience, and communicate spiritual insights—a process that, it is argued, provides some aspect of institutionalization (e.g., sets of rules, rituals, language, and ways of interpretation).⁹ Spirituality, in contrast, is all-encompassing and is not necessarily formal religion. It is noted that as cognition declines, the spiritual aspect of the person may become the only way to experience meaningful exchanges. Other experts argue that while religion most often refers to a particular doctrinal framework (guiding belief systems), spirituality (which may or may not be linked with a particular religion) is more focused on a search for meaning in life. It is these meaningful exchanges that are said to bring hope and purpose amid the devastation of dementia.¹⁰ Propst and colleagues found that those who are more religious experience greater well-being and life satisfaction, especially if a religious perspective is introduced into their care.¹¹ They also revealed that, for some, the continuation of religious practice or some aspect of worship, through the course of their dementia, is important. This may include some of the principal values of the religious community, including submitting to authority.

In terms of proxy versus subjective QoL ratings, it is noted that people with dementia can be reliable informants of their own QoL and that proxy ratings (i.e., ratings done by others) generally differ from self-assessments.¹² People living with dementia tend to report their experiences in the here and now, whereas proxies usually report on both past and current situations.¹³ Proxy ratings may be biased by the proxy's own expectations and belief system, by the burden of care, and by a prior or current relation-

ship.¹⁴ When comparing both sources, patient/proxy agreement about the QoL in dementia has been shown to be only moderate.¹⁵ One study showed that self-ratings on QoL by residents with dementia was significantly higher than nursing staff ratings.¹⁶ The study concluded that if proxy ratings are used, primary nurses should perform them.

Research Methods

Nursing Home Selection

Fieldwork for this study took place in a Dublin nursing home operating exclusively for members of a Roman Catholic religious order. The facility was one of four nursing homes randomly selected for two other interrelated published studies. The first published study was on the topic of dementia prevalence in nursing homes,¹⁷ and the second was on the QoL of people with different levels of cognitive impairment living in nursing homes.¹⁸ In undertaking the data analysis for the QoL and dementia study,¹⁹ it became obvious that QoL data of those belonging to religious orders was so different that the analysis warranted a separate write up. In this article, we report findings on QoL of these people who are members of the same religious order.

At the time of research, this private nursing home (a large single-story bungalow) had been in existence for some 27 years and accommodated 28 residents. Most residents had lived in community/convent settings prior to moving into long-term care and hence had prior experience of communal living. Many had worked on missions and/or in orphanages, teaching and nursing the sick and disadvantaged. Several were well acquainted with each other prior to nursing home admission, through earlier years spent in various mission/charity locations. The nursing home employed 35 staff: 18 health care attendants, 7 nurses, 3 domestic staff, 3 kitchen staff, 2 administrative staff, and 2 directors/nurse managers. It subscribed to a person-centered philosophy of care, was committed to staff training, and had a multi-sensory garden, a chapel, and separate bedrooms for all but three of the terminally ill residents.

Data Collection Instruments

The Mini Mental State Exam

The Mini Mental State Exam (MMSE) was used,²⁰ and we followed Folstein's recommendations for

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cognitive impairment (CI) severity, namely (1) normal cognitive function = 27–30, (2) mild CI = 21–26, moderate CI = 11–20, and (3) severe CI = 0–10.

Interview schedules

An interview schedule containing fifteen simple open-ended questions was used to assess residents' QoL (see appendix 1). The questions asked were informed by the published literature on QoL and dementia.²¹ Examples of these questions include "What makes you happy?" "What makes you sad?" "What do you like most about living here?" "What do you like least about living here?" and "What helps you enjoy your days here?" In addition, a short interview schedule, which asked questions about residents' demographic profile, was designed for the nurse manager (NM). The NM was also asked to rate each resident's QoL using a Likert scale with the response categories of (1) very poor, (2) poor, (3) fair, (4) good, (5) very good, and (6) excellent. No interview was audio-taped but extensive notes were taken throughout the interviews.

Inclusion criteria for residents

To be eligible for this study, participants needed to (1) be a resident of this nursing home and (2) have a mild, moderate, or severe cognitive impairment as reflected in a MMSE score of less than 27.

Procedure

Sampling

All 28 residents of this Irish religious nursing home were invited to take part in the study, and the first 25 who agreed were initially included. Eight were later excluded because of blank interviews arising due to aphasia and to significant cognitive/communication problems. Among the remaining 17 and following screening for cognitive impairment, one nun was excluded based on her MMSE score, which indicated that she was still cognitively intact. The final sample consisted of fifteen nuns and one priest.

Data Analysis

Data was scrutinized using a thematic analysis approach. Thematic analysis generally involves different steps in which the researcher identifies, analyzes, and reports on patterns of meaning or themes important to the description of the phenomenon.²² The first step of the analysis involved familiarization with the data; it was performed by two different researchers who repeatedly and carefully read the 16 interview scripts and the NM data.

Subsequently, both researchers performed an initial coding of the data independently. At this stage, the researchers aimed to code the data, look for categories, and identify the key overarching theme

Table 1: Thematic Framework for Analysis

Overarching Theme	Categories	Codes
Continuity	Religion	<ul style="list-style-type: none"> • Fulfilling religious obligations (Mass, Holy Communion, etc.) • Access • Vocation and joining a religious order • Presence of God in life
	Belonging	<ul style="list-style-type: none"> • Getting on well, togetherness • Knowing each other • Part of the community • Feeling at home • Other relationships (family, friends, etc.)
	Autonomy	<ul style="list-style-type: none"> • Physical independence • Independence from others • Privacy • Choice • Respect of rights
	Altruism	<ul style="list-style-type: none"> • Compassion and acceptance • Helping others • Doing good

observed in the data, focusing on residents' experiences and on the elements that were contributing to residents' lives positively or negatively. The results of this initial coding process were compared and agreement reached on the overall thematic framework. All interviews were analyzed using this framework. Any new codes emerging from the analysis were incorporated into the framework. Table 1 shows the thematic framework (i.e., theme, categories, and codes).

Finally, emergent codes and categories from the respondents were compared against the NM data and with the international literature related to QoL in long-term care.

Results

Socio-Demographic Characteristics of the Sample

The mean age of participants was 88.6 years (range = 76 to 98 years). Mean length of stay in the nursing home was 3.3 years (range = 2 months to 12 years). Eleven (69%) had a secondary-level education and five (31%) had a third-level education. According to the NM, in twelve cases, admission was precipitated by dementia; and in another four cases, for medical reasons. Among the 16, and based on MMSE assessment, 5 had a mild cognitive impairment; 7, moderate; and 4 were severely impaired.

Continuity

The overarching theme identified in this study is "continuity," which explains how the study participants constructed meaning to their everyday QoL. The categories forming the basis for this overarching theme are (1) religion, (2) belonging, (3) autonomy, and (4) altruism. As the data to follow show, the four categories embodied in the theme of continuity connect back to the biographies, life stories, behaviors, and experiences these members of a religious order had prior to their nursing home admission. In earlier years, most had lived in communal settings and had pursued religious lives not entirely different to the lives they were now leading in the nursing home.

Religion

When asked to reflect on what was most important to them in their everyday lives in the nursing home and what made them happy, eight nuns identified religion. Most nuns stated that they looked forward to practicing their religion through attending Mass,

receiving Holy Communion, and reading the Bible along with their prayer books. Fulfilling their religious obligations was an integral component of their earlier years, and it was still something that continued to give their everyday life purpose and meaning.

"[What is important to my life now is] my Mass, time for my prayers, the rosary." (Nun, aged 87, MMSE = 23)

"My prayer life [is most important]. I look forward to going to Mass, receiving our Lord every morning. It is something I look forward to. If I don't get our Lord, I am hungry; it is the biggest part of my life. It is the main part of my day." (Nun, aged 82, MMSE = 25)

Another source of happiness for these nuns and the priest was having access to a chapel in the nursing home and being able to attend daily Mass. Those in poor health or with reduced mobility could follow Mass on television in their own rooms. The priest visited these nuns in their room to give them Holy Communion.

"Well, I feel happy every day, I suppose prayers in the chapel." (Nun, aged 88, MMSE = 2)

"I like living here because I get Mass here every morning." (Nun, aged 91, MMSE = 25)

Having a vocation linked to earlier lifestyle choices and the decision made by them to join a religious order was another important topic emerging in the interviews. Religion and joining a religious order was a salient aspect of their current lives and also something which helped them to cope with and enjoy their daily lives.

"My vocation, I joined the convent to give myself to God. When I got the Holy Habit, I was sent out to England ..." (Nun, aged 89, MMSE = 12)

Interviewer: *"What makes you happy?"*

Respondent: *"God." (Nun, aged 94, MMSE = 2)*

The omnipresence of God in the lives of these residents and the way in which religion provided a purpose and meaning to phenomena otherwise inexplicable was at times apparent in their words.

"When I see people doing wrong, I read the papers and see murders and ... God is there for everyone." (Nun, aged 82, MMSE = 25)

"At the moment, I am the only one of a family of 9. My youngest brother died a few years ago. The most

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important thing [now] is being prepared to die. [I] think, why did God have me for so long, the last of the family?" (Nun, aged 91, MMSE = 24)

Belonging

A sense of belonging to a community of like-minded people was another relevant category emerging from the data, and this feeling of belonging was an aspect of living which conferred happiness. Reference to happiness was often couched in terms of meaningful relationships arising from positive interactions with other residents who shared similar values and beliefs and enjoyed belonging to the same religious "community."

"[I like] living with other people who have the same idea of what life should be like for my status, the fact that I'm a member of a religious community and live with people who are anxious to live a religious life and to fulfil that." (Priest, aged 87, MMSE = 15)

This notion of being part of the same "community," a group of like-minded people already familiar to them, emerged in virtually every interview as being a particularly gratifying aspect of life in the nursing home.

"Everything that comes up regarding our community – being in the community. Well, I am part of the community." (Nun, aged 90, MMSE = 9)

Many respondents talked about the importance they attached to their relationships with the other nuns in the nursing home, often referring to them by their religious title "sisters"; it was as if the religious community was their family. Overall, their narratives reflected a very strong sense of interconnectivity, togetherness, and social inclusion.

"I enjoy living with the sisters from the (names the religious order)." (Nun, aged 85, MMSE = 18)

"I like the sisters to call in ... seeing the older sisters, seeing them happy, and having a chat with them." (Nun, aged 89, MMSE = 22)

"Yes, everybody is your friend." (Nun, aged 90, MMSE = 12).

Analysis of the QoL data also showed a sense of social connectedness and interdependence between one another, and while relationships with others, including family members and staff, were deemed important, they were far less salient than relationships with one another. As stated, respondents'

accounts reflected their being accustomed to living in communal settings with other nuns prior to their nursing home admission. Indeed, often the nuns had already known each other prior to moving to live in this nursing home.

"Oh yes, we are used to the sisters." (Nun, aged 90, MMSE = 23)

There also was a strong feeling of being "at home" in the nursing home, feeling connected to what was happening in the nursing home, and a sense of familiarity, safety, and security.

"It's home. Anything that happens, we hear about it." (Nun aged 89, MMSE = 22)

"It is the security of it really. It's home because it's security for us." (Nun, aged 85, MMSE = 18)

Autonomy: Independence and Right to Privacy

Based on data analysis, another topic which emerged and which was directly relevant to many of the residents was that of autonomy. Within this category, a relevant dimension related to continuing to be able to remain independent in daily life. This included (1) being free from physical pain and discomfort and (2) being able to continue to behave and act in a familiar way without requiring assistance from others. Several respondents seemed pleased, lucky, and grateful to God that, given their age and health decline, they were still reasonably independent and free from pain and discomfort.

"I am grateful God has given me the strength to dress and walk around." (Nun, aged 91, MMSE = 24)

"I am lucky, I have my senses, I am 85." (Nun, aged 85, MMSE = 12)

"I live like a normal life, hold onto my independence for as long as I can." (Nun, aged 85, MMSE = 18)

Conversely, a very small minority talked about their aging, health decline, reduced mobility, and restricted autonomy due to physical frailty.

"I can't get up and do what I like. The legs bad and can't walk." (Nun, aged 85, MMSE = 19)

"I can't go out without someone with me; they are always afraid I would fall." (Nun, aged 91, MMSE = 25)

"I would like to be able to do more for myself." (Nun, aged 90, MMSE = 23)

In one unusual case, a nun diagnosed with lymphoma, when asked what made her happy, stated that “after all that treatment my blood has improved.” She was the only participant who talked at length about her health complications. And when asked what saddened her, she referred to the discomfort and fear her symptoms caused: “still having a lot of air in my throat, and being frightened, feeling getting choked.”

Another relevant aspect relating to personal autonomy was that of privacy and choice but, interestingly, the concept of privacy had different meanings for different participants. For some, it meant the freedom to choose to be alone (generally to pray); for others, it meant choosing to be together with like-minded people in privacy, if one so desired.

“Oh, yes, I like privacy. I like the sisters to call in occasionally.” (Nun, aged 89, MMSE = 22)

And for others, what was most important was informational privacy; simply being in control of sensitive information about oneself. Another small minority understood privacy to mean geographical privacy, that is, having private bedrooms, a chapel, and a quiet garden—a phenomenon many were already familiar with, having lived in quiet convents prior to their nursing home admission.

“I like to be away from the main road.” (Nun, aged 98, MMSE = 21)

“Oh, God, yes, I love my own room.” (Nun, aged 82, MMSE = 25)

Another relevant aspect of QoL was the respect for dignity and privacy demonstrated by the nursing home staff. The fact that staff knocked on bedroom doors prior to entering was provided as an example of the staff respecting their privacy.

“Privacy in my room, staff always knock when coming in.” (Nun, aged 87, MMSE = 23)

“Oh, yes [privacy] in every way really, they [staff] are very good like that here.” (Nun, aged 85, MMSE = 19)

Interestingly, other relevant aspects of choice and independence—for example, being able to decide what to eat or when to go to bed, and, in general, following the rules imposed by the regime of life in a nursing home—did not emerge in the interviews.

This may be a result of the fact that the nuns and the priest were already accustomed to living in a convent or in a community where they had to respect rules and regulations and follow orders imposed on them by virtue of their being members of a religious order.

Altruism

The final category that emerged following data analysis refers to altruism: this sense of being charitable and reflecting on other people’s needs rather than one’s own, being compassionate and being committed to a value system—already very familiar to them because of their religious vows. Several nuns talked about how they cared for each other and tried to help one another on a daily basis.

“I do my best for everybody and help them if I can.” (Nun, aged 90, MMSE = 12)

“I can’t bear to see people less cared for.” (Nun, aged 93, MMSE = 2)

A sense of security about oneself, arising from living with like-minded well-intentioned people who could be trusted and from living in a supportive compassionate environment where people helped each other, was identified in much of the interview data. Although all had a cognitive impairment and many are likely to have dementia, data show how a few attempted to distance themselves from those they perceived to be more cognitively impaired. This distancing, however, was done in a humane compassionate way.

“Some are living in another world ... can’t even hold a conversation, but it’s okay, poor people.” (Nun, aged 87, MMSE = 23)

“Well, sometimes they [older nuns] are a bit funny, a bit strange, but I would know they are not responsible for what they are saying.” (Nun, aged 89, MMSE = 22)

In response to a question that asked what made them sad, one third claimed they were never sad. Those who admitted to feeling sad were never self-indulgent but rather tended to attribute sadness to external factors and especially to other people’s tragedies: “looking at younger people and what they are going through,” “the downturn of the economy,” “the tragedies of life,” “friends losing their memory,” and “seeing people around me die.” Only one

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nun claimed that her own health complications saddened her.

Perceptions of Quality of Life

One of the two NMs who was a staff member of the nursing home and did not belong to a religious order was asked her views on each resident's QoL. Interestingly, based on her perceptions, most residents (N=10) were rated by her as enjoying only a fair to poor QoL. Close analysis of data shows that these proxy ratings were largely dependent on her perceptions of residents' cognitive status and/or physical health, including mobility and independence, or on challenging behaviors and not on religion, belonging, and altruism. Interestingly, when residents were assessed by her as enjoying a good QoL, reference to their cognitive functioning, physical health, mobility, visitors, and sometimes their age was made.

However, as described in the preceding sections and in contrast to the NM's assessment, when the nuns and priest referred to their lives in the nursing home, a strong sense of their enjoying a very good QoL emerged. This was mainly defined as living a life which was congruent and well aligned with the life they had lived prior to their admission to the nursing home. It was a life they had chosen many years earlier and one which they felt they could continue to pursue, now that they were living in residential care. Their earlier vocations and their life-long commitment to a religious life and its implications had ramifications for their current lifestyle and their understandings of key aspects of QoL, such as religion, belonging, altruism, and independence. Being able to fulfil all their religious obligations and living with like-minded people whom they trusted were also key aspects of the nuns' and priest's accounts of QoL.

Table 2 provides examples of the respective meaning and understanding of QoL of the residents as described by the NM and by the residents themselves. As table 2 shows, the NM ratings were often discordant with the respondent's own self-rating. In fact, congruence between the NM's assessment and the participant's self-assessment was found in only a minority of cases.

Discussion

This religious-based nursing home is one of a small minority of nursing homes available exclusively to Catholic nuns and priests across Ireland. Due to a decline in vocations, these nursing homes are a fast dwindling feature of the Irish long-term care landscape. Our findings on the QoL of members of a religious order differ in part from the published literature on QoL, nursing home care, and dementia.²³ Key differences are that some well-established QoL domains for people with dementia in long-stay care, such as (1) the family, (2) freedom and choice, (3) self-esteem, and (4) feelings of usefulness were not salient aspects in the descriptions of QoL provided by these nuns and the priest. Instead, for them, what was most important was religion, including the omnipresence of God, Mass, prayer, the religious communities, and devout relationships between each other. Similarities include the fact that, as in other studies,²⁴ a sense of continuity with life, privacy, attachment and feelings of belonging, connectedness, independence, and, to a lesser degree, health (physical) were identified as sources of happiness.

It seems that religion, including an enduring faith in God, prayer, religious ritual and practice, and spirituality – as reflected in attributing meaning and explanation to behavior – may have protected these

Table 2: Nurse Manager's and Respondents' Perceptions of Quality of Life

Excerpt from the Interview with Nurse Manager	Excerpt from the Interview with Participant	Demographic Information
Poor due to the arthritis.	Very good, excellent, to tell you the truth.	Nun, aged 85, MMSE = 18
Not great, wandering and she doesn't know where she is.	I am always happy.	Nun, aged 89, MMSE = 12
Her QoL is fair, she goes to Mass but going out exhausts and upsets her.	I am quite happy, and I have no complaints.	Nun, aged 87, MMSE = 23
Severe [she has] osteoporosis and [her mobility] restricts her.	I can't get up and fix my own things, that's what makes me sad.	Nun, aged 85, MMSE = 19

nuns from everyday normal anxieties and fostered a sense of acceptance and resignation. "The community" not only provided stimulus for them but also allowed them to care for each other and tolerate each other's foibles: it enabled them to share aspirations, encouraged their silences, allowed them to celebrate accomplishments,²⁵ and, as their dependency needs increased, it seemed to nurture and support them. From the time they entered the convent, being members of such long-established congregations appeared to confer status, dignity, and connectedness. In fact, their strong faith and a belief in God's "holy will" may have protected them from negative emotions and from dwelling on their own health problems in that, unlike other studies on QoL and dementia, none spoke about their own memory/cognitive deficits and only a small minority (N=4) referred to their own physical health problems. Previous studies have shown the influence of "aging in place" (familiarity/continuity),²⁶ and other research has shown the influence of religion on QoL.²⁷ In this study, continuity with life and religion emerged as important contributors to QoL. While this was not a quantitative study in which a regression analysis would have enabled us to disentangle one variable from another, we deemed it appropriate to interpret "religion" to be a component of the overarching theme of "continuity" since all of these residents had led a religious life prior to their admission to long-term care. However, as researchers, we acknowledge the possible shortcomings in this narrow interpretation.

Regarding proxy versus self-ratings of QoL, our results are in accordance with the literature and show only a very modest to weak agreement between the residents' and the NM's ratings.²⁸ Interestingly, the NM's assessment was largely based on her perceptions of residents' health (cognitive and physical) and not on God, religion, faith, and a belief in the greater good. Nor did the NM's appraisal consider the joy these nuns derived from their devout relationships with each other. Accordingly, while a sense of familiarity and convergence with their previous lifestyle and principles was a finding in the nuns' accounts of their QoL, concerns about health, aging, challenging behaviors, and dependency were the main issues resonating in the NM's interview.

Best practice in dementia care suggests that the life of people in long-stay care should resemble, as much as possible, the life they would choose to live at home.²⁹

For these nuns and this priest, life in a nursing home operating exclusively for religious orders was not entirely different from the lives they once led that were devoted to religion and prayer. Most were used to being confined to single bedrooms. Most were also used to moving around between convents—a fact which might explain why some, particularly those with a more severe cognitive impairment, believed they were still on retreat. Indeed, the majority knew each other prior to nursing home admission; they cherished the fact that they were living with like-minded people who shared the same values and beliefs, and this comradeship yielded comfort and gratification.

In a previously published paper on QoL and long-term care, based on a larger sample (N=61),³⁰ the category of attachment emerged as an important aspect of QoL. It was shown that some nursing home residents, particularly those with severe dementia, felt lonely and isolated, craved human contact, and wanted "to go home." In this earlier published work, home was part of these residents' identities and biographies and a place where they were in control. For these older people with dementia, living in a nursing home disconnected them significantly from their former lives and homes. In contrast, for the religious respondents in this study, data showed no emerging evidence of a similar disconnect or of these nuns craving home, since for these religious people, home was "the community." In fact, life in a religious nursing home was probably not that much different from the life they had led in convent settings.

The notion of "themed nursing homes" or clustering like-minded people (who share a similar history, experiences, lifestyle, and social standing) to live together in long-stay dementia care facilities is one model of long-term care now well established in the Netherlands. In the context of dementia care and personhood, there is scope to further develop such a model. This nursing home, which operated exclusively for members of a particular religious order, provides a good example of how person-centered care can be delivered in a purpose-built environment, complete with private bedrooms, separate rooms for separate functions including a chapel, and person-centered religious activities such as Mass and prayer available around the clock. Indeed, had care staff been more aware of the dominating impact religion had on the everyday life of these people, more

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attention could have been paid to this aspect of living to further promote their QoL.

This study has several limitations. First, the sample is small (N=16) and was recruited from only one nursing home. Therefore our findings must be interpreted cautiously and cannot be generalized. Secondly, due to aphasia and other severe cognitive problems, the views of those nuns with a very severe dementia were not included. Accordingly, it cannot be ascertained whether our exceptionally positive QoL results would have been found in people more severely cognitively impaired. A third limitation is that, while these nuns' extremely positive experiences can be interpreted against the backdrop of both their vocations and religious life and the similarities found between previous and current lifestyles and biographies, it could also be argued that, for them, voicing complaints about life in long-term care may have been difficult. Indeed, religion may have militated against their speaking out, lest by doing so, their commentaries would be perceived as unkind, ungrateful to God and to staff, and, at the extreme, even sinful. A final limitation of the study is that only the NM's views on the residents' QoL were sought. If nurse practitioners' views had been sought, a more valid and reliable assessment of QoL would probably have been obtained, since nurse practitioners are more likely to be in close contact with residents than would a NM and, therefore, may have a more accurate appraisal of residents' overall mood and well-being compared with a NM, whose workload tends to be more administrative.

Conclusion

This study has generated new findings on the quality of life of one priest and fifteen nuns who have a cognitive impairment and are residents of one religious-based nursing home in Ireland. Overall, results show that the participants in this study enjoyed an extremely good QoL which was largely attributed to their religion, to remaining socially engaged, to being enabled to help others, to living with like-minded well-intentioned people, and to their not experiencing much physical discomfort. The overarching theme of "continuity," their sharing a similar ideology—values, beliefs, thoughts, and ideas—and commitment to a religious life, and their enjoying similar physical space both in the past and in the present, may further help to explain how

they experienced and constructed meaning to their everyday QoL. They were also surrounded by familiar activities, that is, prayer, Mass, receiving Holy Communion, and other religious devotion—all of which meaningfully connected their earlier years to their current everyday existence.

In conclusion, our results concur with findings from other studies and suggest that religion was a powerful force impacting positively on the QoL of these nuns and the priest. Religion provided a purpose and meaning to life in the face of adversity. It appeared to have a powerful protective effect and contributed very significantly to their QoL. Accordingly, while most people living in long-stay care are unlikely to share the same strong religious beliefs as this fairly unique sample, nonetheless, there are some universal religious/spiritual tasks particular to old age, such as connection, respect, appreciation, altruism, compassion, reciprocity, and hope,³¹ which are not lost by dementia but, rather, may be more difficult for the individual to achieve and experience. The challenge for practitioners and family caregivers is to competently identify these aspects of QoL and respond to them by providing care that includes a spiritual and, when necessary, religious component. With advanced dementia, as memory and cognition decline, one's religious/spiritual well-being may, in fact, become a much more important aspect of one's life. Our findings would lead us to recommend that religiosity/spirituality should be included in all future dementia-specific QoL scales.

Appendix 1:

Interview Schedule for Residents with Cognitive Impairment

1. Can you tell me briefly what is it like for you living here in (name of nursing home)?
2. What is important to your life now?
3. What makes you happy?
4. What helps you enjoy your days here?
5. What makes you sad?
6. Do you see (name of nursing home) as "home"?
7. What helps you to see this nursing home as home?
8. What prevents you from seeing (name of nursing home) as your home?
9. Do you have your own private room and is privacy important to you?

10. Do you like the way staff in (name of nursing home) treats you?
11. Do you like the way other residents in (name of nursing home) treat you?
12. Do you like the activities that (name of nursing home) organizes for you?
13. What do you like most about living here?
14. What do you like the least about living here?
15. Is there anything that could be done to improve your life in (name of nursing home)?

Acknowledgments

The authors would like to thank the nuns and priest who participated in this study and the nurse manager who kindly agreed to be interviewed. We would also like to thank the nursing home staff for supporting the study. Special thanks are extended to Dr. Maria Pierce, Senior Research Fellow with the Living with Dementia programme, for reading and commenting on an earlier draft of this manuscript. This work was supported by a grant from the Atlantic Philanthropies to which we are grateful. ❖

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