Spirituality in Selected Nepalese Residential Care Facilities: A Process of Connecting

Sital Gautam

A thesis submitted to Auckland University of Technology

In fulfilment of the requirements of the degree

Doctor of Philosophy (PhD)

2020

School of Clinical Sciences, Nursing Department

Auckland University of Technology

Abstract

Background: Moving to a Residential Care Facility (RCF) is recognised as being a significant life event for older adults that has potential to negatively impact their spirituality. Although much is known about the process of adjusting to residential life, little is known about how older adults maintain their spirituality in a RCF.

Aim: The study sought to provide a theoretical explanation of how older adults maintain spirituality in RCFs in Nepal. The specific objective was to explore how nurses/caregivers perceive and respond to residents' spiritual needs.

Methods: A total of 24 participants (17 residents, 3 nurses, and 4 caregivers) were recruited from two RCFs in Nepal using theoretical sampling. Semi-structured interviews in Nepali language, and observation during interviews, were undertaken. Using Corbin and Strauss' variant of grounded theory, data were analysed until the point of theoretical saturation was achieved.

Findings: This study identified that maintaining spirituality in a RCF involves *a process of connecting*, which is complicated, ongoing, and dynamic. The process of connecting comprised of three main categories or sub-processes; namely, making sense, seeking connections, and maintaining connections.

Making sense explained how residents made meaning of their new identities-as-residents before seeking and maintaining connections in the RCF. Making sense comprised phases of isolating, exploring, evaluating, and compromising, which eventually led to the consequence—internalisation of the new identity. When residents internalised their new identity as a person lacking connection, they started seeking connections in the RCF. Seeking connections described how residents pursued different sources of connections before deciding whether or not to maintain those connections in the RCF. Seeking connections included the strategies of identifying sources, developing connections, and appraising responses, which eventually led residents to build new connections in the RCF. After building new connections, residents started employing strategies to maintain those newly built connections; namely, sustaining connections with co-residents, preserving connections with nurses/caregivers, and continuing connections with inner-self and higher being/s. Each of these process were operated by different conditions, such as

facility structure, arrangement, rules, regulations, co-residents' language, gender, religious affiliation and attitudes, attitudes and practices of nurses/caregivers, decreasing physical abilities or increasing illness of residents, illness or death of co-residents, and retirement or resignation of nurses/caregivers. The process of connecting was ongoing, involving continually choosing particular strategies—making sense, seeking connections, or maintaining connections—in response to the shifting conditions in the RCF.

In addition, this study identified that nurses/caregivers were aware of most of the spiritual needs of residents; yet, only a few were involved in providing spiritual care. Therefore, most spiritual needs of residents remained unattended. The process of spiritual care provision included strategies such as preparing internally, interacting with residents, integrating care, and being involved in spiritual practices of residents. Furthermore, this study revealed that the increased gap between spiritual needs and spiritual care leads to spiritual distress in residents.

Conclusion: In the future, the focus of care for residents in RCFs must expand beyond the physical dimensions of their health and consider spiritual needs as well.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Abbreviation	Full text
AUT	Auckland University of Technology
AUTEC	Auckland University of Technology Ethics Committee
GT	Grounded Theory
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
NASCF	National Senior Citizen Federation
NGO	Non-Government Organisation
NHRC	Nepal Health Research Council
QOL	Quality of Life
RCF	Residential Care Facility
RN	Registered Nurse
SI	Symbolic Interactionism
SPRB	Spirituality, Religiousness, and Personal Beliefs
WHO	World Health Organization

Glossary

Nepali terms/idioms	Meaning
Aarati	Worshipping
Aausi Purnima	Holy day
Ago tapnu mudako, kura sunnu budhako	Burn the log to be warm and listen to older adults to be knowledgeable
Ama, Ama haru	Older women, female residents
Ananda	Extreme happiness
Arti	Advice, moral lessons, counselling
Ashram	Old age home or RCF
Ba	Father
Baba	Religious figure of respect
Baini	Sister
Bal chhaunjel sabai ko afno	When you are strong, everyone owns you
Batti	Cotton threads used for worshipping
Bhagwat	Hindu scripture/book
Bhajans	Songs with religious themes or spiritual ideas
Bheti	Cash as an act of religious devotion
Brahmin	A type of caste, spiritual advisor
Briddhashram	Old age home or RCF
Budo bhayo aja ghar birano	When you become old, even your own home becomes unfamiliar
Buwa	Older men, male residents
Chaurasi	Ceremonial worship done after turning 84 years old
Chhora chhori le yaad garenan	My children did not think about me

Chhori	Daughter
Daan	Donation
Dharma	Religion, moral behaviour, ethics, code of conduct, duty, or spiritual practices
Dhungi	Ornament
Dikchhya	Moral values
Geeta	Hindu scripture/spiritual book
Gotra	Clan
Guru	Spiritual advisor
Hait	No way
Hajur	Respected
Jhumka	Ornament
Lato/lati	Male and female co-resident having cognitive impairment
Matridevo Bhava, and Pitridevo bhawa	Father and mother should be considered as God
Moksha	Spiritual peace and freedom from the endless cycle of rebirth and death
Murali	One form of religious teachings
Namaste	Hello
Nani, nani haru	Little one/s
Newari	A type of Nepali language
Om Shanti	Religious group
Pranami	Religious group
Pravachan	Recitation of religious scripture or texts
Podini	A type of caste
Puran	Hindu scripture
Ramayan	Hindu scripture
Rudri	A vedic chanting
Sai Ram	Type of a religious group

Sari	Traditional dress
Shiva	Higher being
Ta yesto	Anything wrong
Thal thapera khana parya cha	Living by begging for food
Thalase	Bed-ridden
Tika	The mixture of vermillion powder, yogurt, and rice
Tilari	Ornament
Tirtha	Pilgrimage

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Student ID: 16937149

Dated: 26/02/2020

Acknowledgments

Completion of a thesis is not an individual endeavour. Many people have guided, supported, and encouraged me throughout the duration of this study. I acknowledge the effort and contributions of all those people who helped me gain what I could never achieve through my solitary effort.

I am deeply indebted to my supervisors—Professor Stephen Neville and Dr Jed Montayre—for their expert guidance and persistent support. My supervisors have provided extensive knowledge, detailed feedback, insightful suggestions, and encouragement throughout the duration of this study. I am privileged to have had the opportunity to work with such dedicated and patient supervisors, who made my PhD journey remarkable. I would also like to extend my deepest gratitude to Dr Barbara McKenzie-Green. Her expertise in Grounded Theory (GT) methodology and profound belief in my abilities were instrumental in completing this work. My sincere appreciation also goes to my field advisor, Professor Sarala Joshi, for her time and guidance during the period of data collection and analysis in Nepal. The contributions to my work from all of these people are beyond praise.

I would like to thank the Auckland University of Technology (AUT) for awarding me a Vice-Chancellor's Doctoral Scholarship that allowed me to pursue my passion, as well as study full time. In addition, the AUT GT group provided a great amount of help in understanding the complexities of the methodology. This group generously shared their knowledge of the GT methodology, and experience of using different variants of GT. I very much appreciate the AUT GT group for allowing me to present my theory, providing feedback, discussing concepts, and giving me the courage to keep moving forward. Furthermore, I am extremely grateful for the substantial understanding gained by attending Professor Jane Mills and Professor Melanie Birks: GT Masterclass in Melbourne. My thanks to AUT and my supervisors for the excellent opportunity to interact with these influential GT scholars.

Many thanks to Professor Sarala Shrestha, Professor Sarala Joshi, Krishna Murari Gautam, and Anju Poudel for being my source of inspiration to undertake a doctoral degree. To all my friends, thank you for your moral support throughout the study

period. I also acknowledge the help of Julie Balloch, as well as the officers of both RCFs in making the administrative work timely and smooth. In addition, the professional assistance of Dr Shoba Nayar with editing and formatting the final document is much appreciated. Equal appreciation goes to my host family in New Zealand who made my stay pleasant.

The completion of this thesis would not have been possible without the support and nurturing of my family who were there for me when I needed them the most. To my husband, mother, father, mother-in-law, and father-in-law—I cannot thank you enough for taking care of my son, Adarsha Paudel, when I was immersed in my thesis. I owe you a lot for the sacrifices that you all have made on my behalf.

Most importantly, my vote of thanks goes to older adults, nurses, and caregivers who shared with me the details of their residential and professional lives, and beyond. Listening to your stories, I have developed enormous admiration for your courage and resilience. This theory, *a process of connecting*, would not have been developed without your contribution.

Ethical approval for this study was provided by:
The Nepal Health Research Council (NHRC) on 28th November 2017. Approval number 460/2017.
Auckland University of Technology Ethics Committee (AUTEC) on 11th December 2017. Approval number 17/413.

Chapter One: Introduction

1.1 Introduction

Nepal is experiencing a significant demographic and socio-cultural transition. The latest trend of admitting older adults to a Residential Care Facility (RCF) to live is one consequence of the increasing older adult population, and changing family support systems in the Nepalese society. Currently, the total number of RCFs operating in Nepal is 141 across 64 districts; together, they accommodate 1577 residents (National Human Rights Commission-Nepal, 2019). In the context of Nepal, ageing is considered a spiritual process. Maintaining spirituality holds a vital place in the life of Nepalese older adults; yet, how Nepalese older adults maintain spirituality in RCFs has not been explored. The care of Nepalese older adults living in RCFs is oriented towards physical needs, with spiritual needs being neglected. This study argues that the spiritual care of older adults living in RCFs is crucial.

This chapter begins with an overview of how I became interested in researching this topic. I begin with my professional experiences when engaging with older adults of Nepal, personal experiences of witnessing the deteriorating family support system in the country, and my motivation for undertaking the research. Following this introduction, I provide a brief overview of ageing in the context of Nepal. This section includes detailed information about the demographic shift, change in the traditional support system for older adults, and the emergence of residential living in Nepal. Next, I will outline the government initiatives designed to safeguard older adults and how it led to the privatisation of RCFs in Nepal. The issues created by the privatisation of RCFs in Nepal and concerns older Nepalese adults have about living in RCFs will be described. The final sections set out the research question, aims, rationale, and significance of the study. The chapter concludes with explaining the key terminologies used in the study and an overview of the thesis structure.

1.2 Background to the Thesis

The main impetus for the initiation of this thesis came from my personal and professional experiences. I am a Nepalese citizen, born and raised in Nepal. Professionally, I am a Registered Nurse (RN) with a specialty in adult health nursing. As a lecturer, I taught gerontology and guided students clinically for almost five

years. I had a particular interest in issues related to older adults, mainly psychological and social vulnerabilities related to ageing. Therefore, I joined Geriatric Centre Nepal, now called Ageing Nepal, as a volunteer. Ageing Nepal is a Non-Government Organisation (NGO) working for emerging psycho-social issues of older adults throughout Nepal. During my training in nursing, and career as a nurse and volunteer, I had the opportunity to read about, observe, interact, work with, and care for older adults in a variety of settings. Along with my professional experiences, I witnessed increased migration of young adults, changing family dynamics, increased issues of care of older adults, and the trend towards residential living in Nepalese society. I grew up hearing stories about "bad" children who sent their parents to RCFs.

In 2011, the nursing course that I was teaching required me to take students on an observation visit to one of the RCFs. We visited a RCF in Kathmandu, Nepal, where students had the opportunity to interact with the residents and observe the care being provided. It was surprising that the RCF staff were only taking care of the physical needs of the residents. I was aware that recognising and addressing the psychological, social, and spiritual needs of older adults are equally important. I became curious about what happens to residents' psychological, social, and spiritual needs in RCFs. Initially, I decided to study Quality of Life (QOL) of Nepalese older adults living in RCFs as it incorporates physical, psychological, social, and spiritual aspects of life. I prepared my initial proposal on this topic and applied for a PhD. In the process of searching for the relevant literature, I found that previous research conducted in RCFs in Nepal was mostly related to depression, health status, or QOL of residents (Bhandari, 2014; Dhungana et al., 2004; Kafle et al., 2017; Mishra & Chalise, 2018; Shrestha & Zarit, 2012). The findings of those studies revealed that spirituality is a vital aspect in the life of residents in Nepal. However, how older adults maintain spirituality in RCFs was unclear, and the researchers recommended that there is a dire need to understand spirituality among residents.

After discussion with my supervisors, we decided to explore what is known in the literature about how older adults maintain spirituality in RCFs. This initial exploration identified a significant gap in the literature on this topic. The findings of our initial review were published in the International Journal of Older People Nursing (Appendix A). I consulted with Ageing Nepal about the relevance of

studying how older adults maintain spirituality in RCFs in Nepal. My motivation increased when the founder of Ageing Nepal encouraged me to pursue this project and showed that it is one of the priority areas proposed to the government of Nepal. Therefore, to fill the knowledge gap, I decided to initiate this study to understand how residents maintain their spirituality in RCFs in Nepal.

1.3 Ageing in the Context of Nepal

The world is going through a significant demographic shift. The trends of decreasing fertility rates, improving public health interventions, and increasing life expectancy have led to a global increase in the numbers of older people. In 2019, globally, there were 703 million people aged 65 years and over. This population is projected to reach 1.5 billion by 2050 (United Nations, 2019). Furthermore, the rate of growth of older people in many developing countries is faster than that of developed nations (United Nations, 2019; World Health Organization [WHO], 2011, 2015). Along with many other South-East Asian countries, Nepal has also experienced lower fertility and mortality rates (Amin et al., 2017; Dhakal, 2012; Ministry of Health-Nepal et al., 2017). In almost two decades, the average life expectancy in Nepal has increased from approximately 56 years to 68 years (Amin et al., 2017; Central Bureau of Statistics, 2012; Parker et al., 2014). Adults aged 60 years and over are referred to as senior citizens or older adults as per the Senior Citizen Act of Nepal (Nepal Law Commission, 2006). As of 2011, there were 2.15 million older adults in Nepal. This age group constitutes nearly 8% of the country's total population, which is 28 million (Central Bureau of Statistics, 2012). The population aged 60 years or above is growing at a rate of about 3.59% (Karki, 2017). The new population census report of Nepal is scheduled for release in 2021, and the projections maintain that the total population of older adults in Nepal will reach 2.6 million and 3.5 million by 2021 and 2031 respectively (Central Bureau of Statistics, 2014; Karki, 2017). These figures mirror the trend of age-structural transition throughout the world.

Nepal is not only witnessing a major demographic transition, but also a socio-cultural evolution. Hinduism is the main religion in Nepal, followed by almost 81.34% of the Nepalese population (Central Bureau of Statistics, 2014). According to the Hindu culture, children have filial responsibilities towards ageing parents. Adult sons are considered responsible for caring for their ageing parents, and living with a married

daughter is uncommon due to cultural taboos (Chalise et al., 2010). In most cases, three generations live together under one roof, where younger adults are expected to provide physical, psychological, social, and financial support to older adults. Older adults are expected to guide the younger generations. The knowledge and experiences of older adults are considered highly valuable in Nepalese society, as illustrated by a famous Nepali proverb—*Ago tapnu mudako, kura sunnu budhako,* which means burn the log to be warm and listen to older adults to be knowledgeable. Additionally, there are different religious and cultural ceremonies of honouring older adults when they reach a particular milestone, such as 74, 84, and 90 years (Parker et al., 2014). Furthermore, children are taught values such as *Matridevo Bhava, and Pitridevo Bhawa,* which means father and mother should be considered as God (Malakar & Chalise, 2019). However, in recent years, younger generations' commitment to traditional filial responsibilities has diminished. Nowadays, the moral obligation of caring for older adults is perceived as a burden by many younger generations (Chalise & Brightman, 2006; Yadav et al., 2018). Traditional extended families are increasingly being replaced by nuclear families who have one head of the household, his or her spouse, and children (Libois & Somville, 2018). Filial piety, a long-established tradition of treating older adults with utmost respect, is fading (Kshetri et al., 2012; Yadav et al., 2018). As social and cultural values are eroded in Nepalese society, social security issues for older adults are emerging. For instance, police reports, newspapers, and research reports in Nepal have identified increasing incidences of abandonment, neglect, physical, psychological, financial, and sexual abuse of older adults (Bhattarai, 2014; HelpAge International, 2018). The reported prevalence of older adults' abuse in the Nepalese community is shocking, ranging from 47.4-61.7% (Chalise, 2017; Geriatric Center Nepal & National Human Rights Commission-Nepal, 2010; Rai et al., 2018; Yadav & Paudel, 2016; Yadav et al., 2018). Moreover, HelpAge International (2018) has noted that many cases of older adults' abuse in the Nepalese community go unreported. The traditional family support system is shifting for Nepalese older adults.

The disruption in the traditional intergenerational ties in Nepal is accompanied by the trend of youth migration and increased female literacy rate, which has mutually influenced the care of older adults. Problems with unemployment and the lack of educational opportunities have forced thousands of younger generations to migrate to

urban areas and foreign countries in search of work and better opportunities (Dhital & Chalise, 2015; Thapa et al., 2019). The majority (97%) of Nepali migrants are male, and it is estimated that almost one male out of four households has emigrated abroad, leaving women, children, and older adults behind to take care of the household (World Bank Group, 2018). The role of a daughter-in-law, which used to be the primary caregiver for older adults, has changed. The improvement in female literacy rates has led to increased employment opportunities for this group (Acharya, 2004; Williams, 2009). Moreover, due to male outmigration in Nepal, there is increasing pressure for women to be involved in income generating activities in order to survive financially (Asian Development Bank, 1999; World Bank Group, 2018). The migration of younger generations and expanding roles of women have made the living arrangements for older adults and their long term care challenging for every household in Nepalese society. As a result, increasing numbers of families in Nepal are now choosing residential living for older adults (Acharya, 2008; Malakar & Chalise, 2019). The establishment of RCFs is one of the government initiatives to ensure the social security of Nepalese older adults, the rest of which will be explained in the following section.

1.4 Government Initiatives for Social Security of Older Adults

A marked increase in the population of older adults and change in the socio-cultural context is a relatively recent phenomenon for Nepal. The primary focus of government policies, programmes, research, and funding bodies remains focused on family planning, maternal and child health, and disease control (Geriatric Center Nepal, 2010; Ministry of Health-Nepal, 2017). Consequently, there are few policies, programmes, research, and funding bodies explicitly targeted at the social security of older adults. Although previous policies had included the older population, the first separate policy for older adults in Nepal was developed in the country's "Ninth-five-year plan (1997-2002)" (Dhakal, 2012). This initiative was per the Madrid International Plan of Action on Ageing, 2002, which prioritised the social protection of older adults (United Nations, 2002). However, most Nepalese policies that have been developed for older adults are limited to the financial aspects of their health care. For instance, there are policies for providing free medicine and treatment to poverty affected older adults, free health services for heart or kidney patients aged 75 years and over, as well as establishing geriatric wards in public hospitals, and

discounting public transportation fares (Ministry of Women Children and Social Welfare-Nepal, 2005). These policies are general and do not reflect the changing socio-cultural trend affecting the social security of older adults in the country.

One of the policies targeting the social security of older adults in Nepal is the provision of financial assistance. The government provides an old-age allowance of 3000 NRs (approx. 41.26 NZ$) per month for everyone who is 70 years or above (Kathmandu Post, 2019). The government provides an additional widows' allowance of 2000 NRs (approx. 27.10 NZ$) per month for older adults. In the case of retired public workers who are 75 years and above, the government adds 10% to their pension (Geriatric Center Nepal, 2010; Limbu, 2012). Despite the government's commitment to safeguarding the financial and social security of older adults, evidence highlights many issues regarding these policies. Firstly, the allocated amount of these government allowances has been reported as inadequate with negligible impact on the life of older adults. Secondly, the coverage of these government allowances is limited and has not reached the hands of all older adults. Only 7% of Nepalese older adults benefit from the pension system, and 74% from the old age allowance programme (Shrestha & Dahal, 2007). Older adults have also reported dissatisfaction regarding this government allowances policy (Kc et al., 2014; Malakar & Chalise, 2019). Furthermore, the age threshold set by the government in most of the policies is unsuitable, given the fact that 60 years and above is considered old age in Nepal and the average life expectancy of Nepalese is 68 years. As a result, the intended outcome of the old age allowance policy to safeguard the social security of older adults has not been achieved.

Another government policy to ensure the social security of older adults was articulated in the "Ninth five-year plan," one of the periodic plans of Nepal extending from the years 1997-2002. The Ninth five-year plan stated that "one elderly home will be established in each development region and such home will have the provision of entertainment, library and religious speeches deliverance" (Government of Nepal, 2016c, p. 689). The Ninth five-year plan also encouraged the participation of NGOs and private sectors for the execution of the programme. However, the implementation of this plan was inhibited by the lack of financial and trained human resources, and institutional capabilities (Government of Nepal, 2005).

Then, in 2005, the government of Nepal developed a national plan of action for senior citizens to re-direct the attention to the social issues created by the changing demographics and socio-cultural context of the country, as demonstrated in the following statement in the policy.

> Contemporary structural changes have been observed gradually with [the] pace of the development. Joint family culture is under extinction. There is [a] decreasing trend in the respect, service, and facilities expected from the family. It is [a] big challenge for us to maintain and preserve the social customs and norms to prevent downing further. (Government of Nepal, 2005, p. 2)

Through the National plan of action for senior citizens, as shown in the above text, the government of Nepal called for the establishment of RCFs in all five regions, the development of minimum criteria for forming and operating RCFs, senior citizen counselling services, welfare fund, day-care centres, private sectors' involvement, respecting and maintaining the dignity of older adults (Government of Nepal, 2005). Furthermore, provision was made for the formation of laws, acts, and regulations regarding the rights and welfare of older adults. Consequently, in 2006, the government of Nepal established the Senior Citizen Act.

Formulation of the Senior Citizen Act was a major legislative step taken for the protection and social security of older adults in Nepal. The Senior Citizen Act, section 4, sub-section 1 has delineated that the care of older adults is the duty of family members (Nepal Law Commission, 2006). However, the Senior Citizen Act has not made it mandatory for the family members to take care of older adults. As a result, the obligation is limited to the paper. As an amendment to the Act, a new law is being proposed to the government that children must give 5-10% of their income to their older parents and will be penalised if they fail to do so (News18, 2019). The Senior Citizen Act, section 20, sub-section 1 has also given the freedom to anyone interested to establish and operate a RCF in Nepal. The Senior Citizen Act has used the term "care centre" to denote RCF, and defined it as a "home, shelter or other structure of similar nature established and operated under this Act for the maintenance and care of senior citizens with or without collecting fees" (Nepal Law Commission, 2006, p. 2). The maintenance and care have been defined as "making

provisions of food, clothes, housing, movement, social services and entertainment to and for senior citizens and of their involvement in religious activities" (Nepal Law Commission, 2006, p. 2). To monitor and regulate the activities of RCFs, and to provide funding for the RCFs, the Senior Citizen Act established the Senior Citizen Welfare Committee and Fund, under the Ministry of Women, Children, and Social Welfare.

In 2008, the government of Nepal formulated Senior Citizen Rules, which has set the standards for the infrastructure and facilities inside RCFs. For instance, Rule-12, schedule-2 has delineated that for 10 residents, rooms should be at least 40 square feet, the building should be older adults-friendly, have separate rooms for male and female, at least two toilets and bathrooms, kitchen, dining hall, study room/TV room, first aid room, waiting room, library/reading room, space for sports activities, pure drinking water, and sufficient ventilation and light (Nepal Law Commission, 2008). Regarding human resources, there should be a cook, waiter, cleaner, "necessary staff, and necessary medical person for health check-up and care of senior citizens" (Nepal Law Commission, 2008, p. 14). Furthermore, regular training and education sessions should be arranged for the staff (Nepal Law Commission, 2008). Rules state that funding of 1 caregiver for 10 residents in a RCF will be covered by the government grant. Likewise, each RCF should arrange an annual pilgrimage, sightseeing twice a year, and the cremation of residents according to their wishes (Government of Nepal, 2016a; Nepal Law Commission, 2008). All these government initiatives have been introduced to ensure the social security of Nepalese older adults, and, as discussed above, led to the privatisation of RCFs across the country.

1.5 Privatisation of RCFs in Nepal: Current State of Private RCFs, Issues, and Contributing Factors

With the demographic and socio-cultural transition, the demand for RCFs started escalating in the country. Pashupati *Briddhashram*, established in 1920, was, and is still, the only RCF run by the government providing free facilities, prioritising the destitute, and has occupancy for 230 older adults. One government RCF was not sufficient to meet the growing demand for care. As a result, the private sector or non-government or charity organisations started setting up private RCFs in Nepal to cater to the increasing demand. In a short period, the country witnessed a rapid increase in

the number of private RCFs. In 2010, there were around 70 RCFs in Nepal, which accommodated approximately 1,500 residents (Geriatric Center Nepal, 2010). Currently, the total number of RCFs operating in Nepal is 141 across 64 districts, with 1577 (612 men, 965 women) residents. A further 22 RCFs are currently being constructed in Nepal (Asia Pacific Forum of National Human Rights Institutions, 2018; National Human Rights Commission-Nepal, 2019). The demand for RCFs in Nepal is growing as evidenced by escalating numbers of RCFs being built, and associated increases in occupancy rates.

Different types of RCFs exist in Nepal; namely, government, private, and NGO-based. The government RCF is operated by the government of Nepal and provides free services to the residents. The socio-economic status of the residents living in the government RCF is comprised of a mix of destitute older adults and those from a well-off family; the majority being destitute. In the case of private RCFs, some receive a grant from the government however, the grant is not enough for operating the institutions (National Human Rights Commission-Nepal, 2019). Private RCFs also accommodate both destitute and older adults from well-off families. Private RCFs can provide free services to the very poor, and charge those who can pay. Only a few RCFs aim to make a profit and as such charge significant amounts to those who can pay for their services. Furthermore, few RCFs are NGO-based, which means they are non-profit institutions oriented towards the common benefit of the local community.

The increasing number of private RCFs in Nepal have accommodated a significant number of older adults and benefited society. However, many problems prevail in private RCFs in Nepal. Most of the private RCFs in Nepal lack financial resources, infrastructure, and trained staff; therefore, run with minimum services and poor quality of care (Bhandari, 2014; Dhungana et al., 2004; Geriatric Center Nepal, 2010). Even though residents are getting their physical needs fulfilled in RCFs, either through government grant or institute or private donations, most are being denied the right to dignified care including their psychological, social, environmental, and spiritual aspects of health and wellbeing (Acharya, 2008). The majority of RCFs in Nepal are running without organising productive, social, and spiritual activities for residents (Bhandari, 2014; Dhungana et al., 2004). The approach to the care of older

adults in RCFs is welfare-based rather than rights-based (Government of Nepal, 2016b). Welfare-based care focuses only on fulfilling the basic needs of residents; whereas rights-based care is concerned with providing dignified care. Recently, the National Human Right Commission of Nepal surveyed all the RCFs in the country. The purpose of the survey was to verify if RCFs have been preserving the human rights of the residents, and following the Senior Citizen Act and Senior Citizen Rules. The report indicated that most of the RCFs are not following the law, and the universal rights of the residents to independence, participation, care, self-fulfilment, and dignity are not being met (National Human Rights Commission-Nepal, 2019; United Nations Human Rights, 1991). Central to the rights-based care approach is the idea of resident-centred care, which is missing in most of the RCFs in Nepal.

There are a number of factors responsible for existing challenges in RCFs in Nepal. Firstly, the concept of residential living is relatively new—both for the government, private sector, and NGOs and for care providers and recipients of care. Although the government has formulated policies for RCFs, gaps in these policies are prominent. For instance, the Senior Citizen Act, 2006 has stated that RCFs should make provisions for movement, social services, entertainment, and religious activities (Nepal Law Commission, 2006). However, the minimum standards to open a RCF (see section 1.4, p. 8) have not specifically addressed these aspects of care, which means most of the RCFs are running just as a place of providing shelter, food, and medicine to residents (Khanal & Gautam, 2011; Nepal Law Commission, 2008). Secondly, workforce planning is missing in most RCFs in Nepal. The Senior Citizen Rules of Nepal have not outlined the number of staff needed in RCF, and the necessary educational qualifications and skills. The Senior Citizen Rules of Nepal have not delineated staff regulations or standard caregiving protocols. Furthermore, the Senior Citizen Rules of Nepal is silent about the requirement of regular health assessments and the establishment of recording systems in RCFs. As a result, workforce recruitment, regulations, categorisation of residents, their care, and health care management systems in RCFs have been haphazard. Most of the RCFs are running without adequate staff, not to mention “specialized geriatric human resources” (National Human Rights Commission-Nepal, 2019, p. 6). The prominent policy gaps related to RCF establishment and workforce regulations are major factors that have shaped the current state of RCFs in Nepal.

Another factor that has led to diverse problems in RCFs in Nepal is the lack of culturally congruent care. The model of care in most RCFs is bio-medical with doctors, nurses, and caregivers mostly focusing on the fulfilment of the residents' physical needs. Key Nepalese policymakers and activists have criticised the bio-medical model used in the care of older adults as outdated. As an alternative, advocates for older adults have recommended replacing the bio-medical model with a bio-psychosocial and culturally appropriate model of care (Parker et al., 2014). An additional factor responsible for the current state of RCFs in Nepal is the lack of an efficient funding management system.

The government's increasing financial investment in this sector is commendable. However, effective implementation of the financial management system of RCFs in Nepal is lacking in many areas. Despite the formation of the Senior Citizen Welfare Fund, the distribution of the government's grant is not uniform across all RCFs; therefore, a number of RCFs do not receive government funding (National Human Rights Commission-Nepal, 2019). This means that most of the private RCFs are running solely based on either charity, international, private, local club donations or payment from the resident's family (National Human Rights Commission-Nepal, 2019). The lack of systematic funding has forced most of the private RCFs in Nepal to run with basic or minimum amenities. Further, the survey conducted by the National Human Rights Commission of Nepal indicates that most of the RCFs, which have been receiving the government fund, have not utilised the grant appropriately (National Human Rights Commission-Nepal, 2018). Although the Senior Citizen Welfare Committee and monitoring system is established, timely documentation, monitoring, and regulations of financial resources used in private RCFs have been ineffective (Geriatric Center Nepal, 2010; National Human Rights Commission-Nepal, 2019). The lack of effective distribution and use of financial resources has affected the quality of services offered in RCFs in Nepal.

One more factor accountable for prevailing problems in RCFs in Nepal is the lack of research in this area. There is a significant gap in the evidence on how the existing plans and policies related to residential living are being implemented in RCFs in Nepal. Key academics, activists, or NGOs working in the field of older adults have agreed and have been highlighting that generally older adults, let alone those living

in RCFs, have been neglected in research, policies, and budget distribution in Nepal (Limbu, 2012). The absence of adequate research involving RCFs has hindered the continuous development or reformation of policies related to residential living in Nepal. In the absence of adequate research, the caregiving practice in RCFs in Nepal is experience-based rather than evidence-based.

Recently, NGOs such as Ageing Nepal and the National Senior Citizen Federation (NASCF), both established in 2011, have been actively investigating the issues of ageing in Nepal. These organisations have lobbied and collaborated with the government and international organisations for the rights of Nepalese older adults, including residents in RCFs. Furthermore, these organisations have advocated for shaping Nepalese policies according to older adults' needs. Moreover, social anthropologists, medical gerontologists, ageing activists, and the general public have been vocal in public forums regarding the privatisation of RCFs, the rights of residents, and dissatisfaction with the quality of care in most of the RCFs as evidenced by the recent articles published in local newspapers (Kathmandu Post, 2018; The Himalayan Times, 2017a, 2017b). This evidence clearly shows there are significant issues for Nepalese older adults living in RCFs which must be brought to the government's notice.

This section has shown that residential living is not a well-established form of living arrangement for Nepalese older adults, and is a recently emerging concept. Furthermore, the section has elucidated the existing organisational issues in most RCFs in Nepal. The following section will primarily focus on the concerns of the older adults who are living in RCFs in Nepal.

1.6 Concerns of Nepalese Older Adults Living in RCFs

The concerns of the older adults living in RCFs in Nepal are unique because of the distinct socio-cultural context of residential living. Firstly, residential living is not a well-planned form of living arrangement in Nepal. Most of the older adults are abused, abandoned, or forced by the family to move to a RCF against their will (Asia Pacific Forum of National Human Rights Institutions, 2018; National Human Rights Commission-Nepal, 2019; Rai et al., 2018). Thus, in most cases, it is not older adults but family or relatives who decide where older adults should spend the rest of their life. Officially, this is against the Senior Citizen Act which states that "no one shall

detach the senior citizen from the family or compel the senior citizen to get detached from the family" (Nepal Law Commission, 2006, p. 3). Current practices demonstrate the unawareness, powerlessness, insecurity, and vulnerability of Nepalese older adults. Secondly, residential living is not a well-accepted form of living arrangement in Nepalese society. Residential living is considered as an alternative for only the destitute or neglected group of older adults (Dhakal, 2012). Consequently, most of the Nepalese older adults enter the RCF unprepared.

Adjustment to residential living is challenging for Nepalese older adults. Most Nepalese residents lack support from their family, friends, relatives, and have poor interpersonal relationships with fellow residents (Dhungana et al., 2004). Consequently, almost 77.8% of the Nepalese residents report loneliness (Chalise, 2014). Similarly, the prevalence of depression among residents in Nepal ranges from 47-72% (Acharya, 2008; Chalise, 2014; Kafle et al., 2017; Khanal & Gautam, 2011; Ranjan, Bhattarai, & Dutta, 2014; Timilsina, Sherpa, & Dhakal, 2014). The major factors associated with depression among Nepalese residents include the lack of social connections, desired activities, financial security, disappointment with the staff, and environment of RCFs (Timilsina et al., 2014). Furthermore, more than half of the residents in Nepal suffer from chronic health problems—almost 15.5% are malnourished, and 61% are at risk of being malnourished (Acharya, 2008; Ranjan et al., 2014; Singh & Shrestha, 2016). Nepalese residents face a diverse array of problems while living in RCFs. Additional to these problems, the socio-cultural aspects of ageing is also threatened when Nepalese older adults move into a RCF.

Nepalese older adults are inclined towards deep-rooted socio-cultural norms and traditions. Ageing for Nepalese older adults is not just a physical and psychological process, but a social and spiritual process (Pandya, 2016). Age-specific socio-cultural roles, guidelines, or rituals exist for Nepalese older adults, which are considered as *dharma*—meaning religion, moral behaviour, ethics, code of conduct, duty, or spiritual practices (Dimock et al., 2019). For instance, ideally, older adults should "live and die integrated within the family and the village society" (Regmi, 1993, p. 34). Similarly, older adults should give back to younger generations and society, offer devotions to a higher being/s, gain knowledge about and remain involved in traditional spiritual practices, and donate on days of spiritual importance (Gautam et al., 2007; Shrestha & Zarit, 2012). These rituals are believed to be crucial in

achieving the ultimate life goal, which is gaining *moksha,* meaning spiritual peace and freedom from the endless cycle of rebirth and death (Mishra, 2013). What stands out in all these socio-cultural principles for Nepalese older adults is the obligation to remain connected with the family, society, and higher being/s; and find meaning, and purpose in life, which is collectively termed as spirituality (Buck, 2006; Manning, 2012). Maintaining spirituality is vital for Nepalese residents.

Overall, the unique socio-cultural context of residential living in Nepal, as described above, positions Nepalese residents in complex circumstances with multi-layered physical, psychological, social, religious, and existential needs. However, the major focus of care in most RCFs is on the physical needs of residents. Only a few RCFs provide opportunities to participate in educational, social, spiritual, vocational, and experience-exchanging activities or excursions through which residents will have a chance to develop networks with people (Dhungana et al., 2004; National Human Rights Commission-Nepal, 2019). Similarly, the provision of counselling, psychological, and spiritual support are missing in most RCFs in Nepal (Acharya, 2008). The psychological, social, existential, and religious needs, collectively termed as spiritual needs of residents (Erichsen & Bussing, 2013; Man-Ging et al., 2015), are being neglected in RCFs in Nepal. Unattended spiritual needs can have a negative impact on residents' spirituality (Gautam et al., 2019). However, few studies in Nepal, have explored the spiritual aspects of residential life (Bhandari, 2014; Shrestha, 2010). The focus of the current study is on understanding how residents maintain their spirituality in RCFs in Nepal. An ultimate aim of the study is to give voice to a group of older adults to identify their spiritual needs. Findings from the study have the potential to contribute to developing resident-centred spiritual care in Nepalese RCFs.

1.7 Research Question

How do older adults maintain spirituality in residential care facilities in Nepal?

1.8 Aims/Objectives:

The primary aim of the study is to provide a theoretical explanation of how older adults maintain spirituality in RCFs in Nepal. Specifically, the study investigates how nurses/caregivers perceive and respond to residents' spiritual needs.

1.9 Rationale and Significance of the Study

The demographic and socio-cultural transition in Nepal suggests that increasing numbers of older adults will be living in RCFs in years to come. The high prevalence of depression and loneliness among Nepalese residents, lack of support systems, and the neglect of the spiritual aspects of health in policies, research, and practice, as discussed above, make it essential that RCFs develop effective ways of involving residents in meeting their spiritual needs. However, the government of Nepal lacks specific strategies to influence the effective spiritual care of residents in RCFs (Geriatric Center Nepal, 2010). Therefore, it is essential to follow what the existing international guidelines and studies recommend about the spiritual care of older adults living in RCFs.

The guidelines developed by international organisations and the findings of international studies recommend including spiritual aspects in the care of older adults living in RCFs. In 2015, the WHO issued a report on ageing and health, suggesting that a holistic approach is the most effective way of providing care to older adults (WHO, 2015). New Zealand's Healthy Ageing Strategy also recommends using a holistic approach while caring for older adults (Ministry of Health-New Zealand, 2016). Here, a holistic approach means caring for the mind, body, and spirit of older adults (Jasemi et al., 2017). Similarly, Joint Commission for Accreditation of Health Organizations, and Meaningful Ageing Australia has highlighted the significance of assessing and taking care of the spiritual needs of older adults in all health care settings (Meaningful Ageing Australia, 2016; O'Brien, 2011). Specifically, in the case of RCFs, it is recommended that nurses and caregivers should provide spiritual care, which means taking into account the importance of residents' spiritual needs (Meaningful Ageing Australia, 2016). It is established that spiritual needs of older adults are equally important as their physical needs, irrespective of where they live. This is especially important in a country like Nepal, where numbers of older adults living in RCFs are rapidly increasing, but their spiritual needs and care have not been investigated. Since nurses and caregivers play a significant role in the lives of older adults in residential care, it is imperative to understand the meaning they give to the spiritual needs and care of residents.

This study is the first to investigate spirituality in older adults living in RCFs in Nepal, as well as nurses' and caregivers' perspectives on spirituality. Therefore, this study will potentially lead to changes in practice and policy by generating knowledge, raising awareness, and giving voice to older adults. The findings of this study will be beneficial for nurses and caregivers to identify areas of improvement in current practice and design effective interventions according to identified needs; thus, improving the effectiveness of service delivery. Similarly, it could inform policymakers in developing policies to improve the provision of spiritual care to older adults living in RCFs. Furthermore, the findings of the study could help in the development of aged care guidelines for migrant communities living in RCFs in other countries.

1.10 The Key Terminologies Used in the Study

The key terminologies used throughout this study are:

Spirituality: The connection with the inner-self, people, and higher being/s. It includes both religious and moral dimensions.

Maintaining spirituality: The process of keeping in existence or continuing spirituality.

Spiritual practices: Denote the strategies used to maintain spirituality while living in a RCF. The strategies can be cognitive or behavioural. The approach of spiritual practices can be individual or group.

Spiritual needs: Refers to any needs of residents beyond physical needs. Spiritual needs can include psychological, social, religious, or existential needs.

Spiritual care: Any care provided by nurses/caregivers to fulfil spiritual needs of residents. In this study, nurses refer to the registered nursing staff, and caregivers are unregulated staff working in RCFs.

Spiritual programmes: Refer to preaching, prayer, singing hymns, reciting Hindu scriptures, spiritual trips, meditation, or yoga.

1.11 Structure of the Thesis

Chapter one, the introduction, highlights the unique socio-cultural context of ageing in Nepal, which has shaped the exclusive concept of residential living and, in turn, the distinct issues of older adults living in RCFs in Nepal. The chapter also clarifies the aims, rationale, and significance of conducting this study.

Chapter two, the literature review, presents a critical review of the existing literature on spirituality in older adults. The existing arguments, theoretical, and methodological input on the topic of spirituality in older adults is critiqued. Research gaps in the existing body of knowledge are accentuated.

Chapter three, the methodology, elucidates the GT methodology used to address the research question. This chapter includes the details of GT, comprising its origin, evolution, fundamental GT tenets, choice of GT variant, philosophical underpinning, and relevance of the chosen GT variant to the current study. The positioning of the researcher within the research is explicated.

Chapter four explains the research setting, sampling technique, recruitment, data collection, and data analysis. Ethical considerations and steps used to improve trustworthiness are explained.

Chapters five to nine, the findings chapters, illustrate and explain the theory—*A process of connecting*. In chapter five, a theoretical overview of the process of connecting is provided. Chapters six, seven, and eight delineate the process of making sense, seeking connections, and maintaining connections, respectively; along with conditions influencing each process and its consequences. Chapter nine explains the process of spiritual care provision, influencing conditions, and its consequences.

Chapter ten, the discussion, presents the key findings of the study in the context of existing theories and critiques its' contributions to the existing body of evidence. The strengths and limitations of the study are outlined. Recommendations are provided.

1.12 Summary

This chapter has set the foundation of the thesis by uncovering how I was drawn to the topic. My experience as a nurse, lecturer, volunteer, and member of the changing Nepalese society, and how it motivated me to conduct this study, has been explained.

In addition, this chapter has introduced the unique socio-cultural context of ageing in Nepal. In this chapter I have established that even though the concept of residential living might be developed, expected, and accepted in western countries, the case of Nepal is different. I have also described the key policies related to RCFs in Nepal and how they have influenced the recent privatisation of RCFs. In addition, the issues surrounding residential living linking it to policy limitations and issues of older adults living in RCFs have been explained. The research aim has been outlined, as well as the rationale and importance of conducting this study. Finally, the key terminologies and structure of the thesis were introduced. The following chapter presents the review of the literature on spirituality.

Chapter Two: Literature Review

2.1 Introduction

The previous chapter presented the focus of this study, which was to explore how residents maintain their spirituality in RCFs in Nepal. I introduced the distinct socio-cultural context of ageing in Nepal; an emerging concept of residential living in Nepal; and subsequent spiritual issues of Nepalese residents. The previous chapter also provided a brief background on why maintaining spirituality is important to Nepalese older adults. As mentioned in the introduction chapter, spirituality has not gained enough attention in the scholarly literature in the Nepalese context. Therefore, this chapter provides a review of primarily western literature regarding the concept of spirituality within which to situate the current study.

The literature review is a disputed topic in a GT study. Therefore, I begin by briefly introducing the existing arguments regarding the literature review in a GT study and where I position my approach to the literature review in this study. Next, I provide a brief overview of the search strategies used in reviewing the literature. The historical milieu of the term spirituality and its evolution is presented before moving into the actual findings of the reviewed studies which introduce the traditional and contemporary view of spirituality used in the literature. The reviewed literature is organised in terms of meaning attributed to the term spirituality; the intersection between spirituality and ageing; the impact of maintaining spirituality on the wellbeing of older adults; and integrating spirituality to the care of older adults. The chapter concludes with a summary of the reviewed literature.

2.2 The Timing of Literature Review in a GT Study

The timing of the literature review in GT research is one of the most discussed areas. Different variants of GT exist, each with diverse views about timing of the literature review. In the original GT texts, Glaser and Strauss (1967) mentioned that the researcher using GT methodology should delay the literature review until the core categories surface from the data. The main idea behind this recommendation was to prevent the researcher from imposing their received knowledge or ideas from existing theories, forcing the data, and contaminating the theory development (Glaser, 1978, 1992, 1998; Glaser & Holton, 2004). Bearing in mind the educational

background, training, and professional experiences with which the researcher enters the field of research, it is unrealistic to be unfamiliar with the concepts and literature around the topic of interest. Furthermore, the university requirements regarding the proposal, scholarship, and ethics applications make it essential that the researcher is aware of what is happening around the topic of interest. Unlike the original texts, the advanced work of Strauss and Corbin (1998), Corbin and Strauss (2008), and Charmaz (2014) have accepted that the idea of delaying literature review is impractical. I agree with Corbin and Strauss that a review of the literature is essential to understand the extent of current knowledge, justify the need for the study, and enhance theoretical sensitivity. Theoretical sensitivity will be addressed in further depth in chapter three. Therefore, I reviewed the literature prior to commencing the study. I also worked with the literature in a way which was congruent with my choice of the Corbin and Strauss' variant of GT, which supports referring to the literature during data collection, analysis, and discussion of the findings. The literature reviewed after the analytic development of major categories in this study will be covered while discussing the findings derived from the study (see chapter ten).

2.3 Search Strategy

The literature review began in March 2017. A general review around the concept of spirituality was carried out, which aided with recognising key search terms for the actual review. Electronic databases such as CINAHL Plus with Full Text via EBSCO, Scopus, PubMed, PsycINFO, Web of Science, and ProQuest Social Science Database were accessed. In addition, some articles were identified from the reference lists of retrieved research reports. The search terms used were spiritual* (spirituality, spiritual wellbeing, spiritual health, spiritual needs, spiritual wellness, spiritual coping, spiritual care, spiritual experiences, spiritual practices); relig* (religiosity, religion, religiousness, religious needs, religious coping, religious practices, religious experiences); pastoral* (pastoral care, pastoral counselling); old* (older adults, older people, old people, old age); senior; geriatric; aged; ageing; advanced age; elderly; elderly people; residential* (residential care, residential homes, residential aged care, RCFs); care home; old age home; nursing home; rest home; long term care; aged

care; assisted living; and accommodations. Truncations were used so as not to miss potential words being used in the research articles.

The inclusion criteria were primary research with spirituality as a key measure, peer reviewed full-text journal articles published in English, and studies that included older adults aged 60 years and over. All studies published from 2006 were included in the review since it was the year when the WHO established spirituality as a component of QOL of every individual. In response to the development of the scale WHO QOL SPRB (Spirituality, Religiousness, and Personal Beliefs), an increasing number of research studies on spirituality as a component of wellbeing were published. Before 2006, spirituality was mainly covered in review or commentary articles rather than empirical research. Yet, some seminal earlier work on spirituality has been included in the literature review. All studies undertaken with older adults using quantitative, qualitative, and mixed methodologies were included in the review. Similarly, studies conducted in all settings, such as the community, hospitals, and RCFs were included to gain a broad understanding of spirituality and ageing. RCF denotes any type of institutional setting providing long term care to residents; the level of care ranging from basic to specialised; and including, but not limited to, assisted living facilities, residential aged care facilities, nursing home, care homes, specific state residences, assisted accommodation homes, old age home, senior centres, and rest homes.

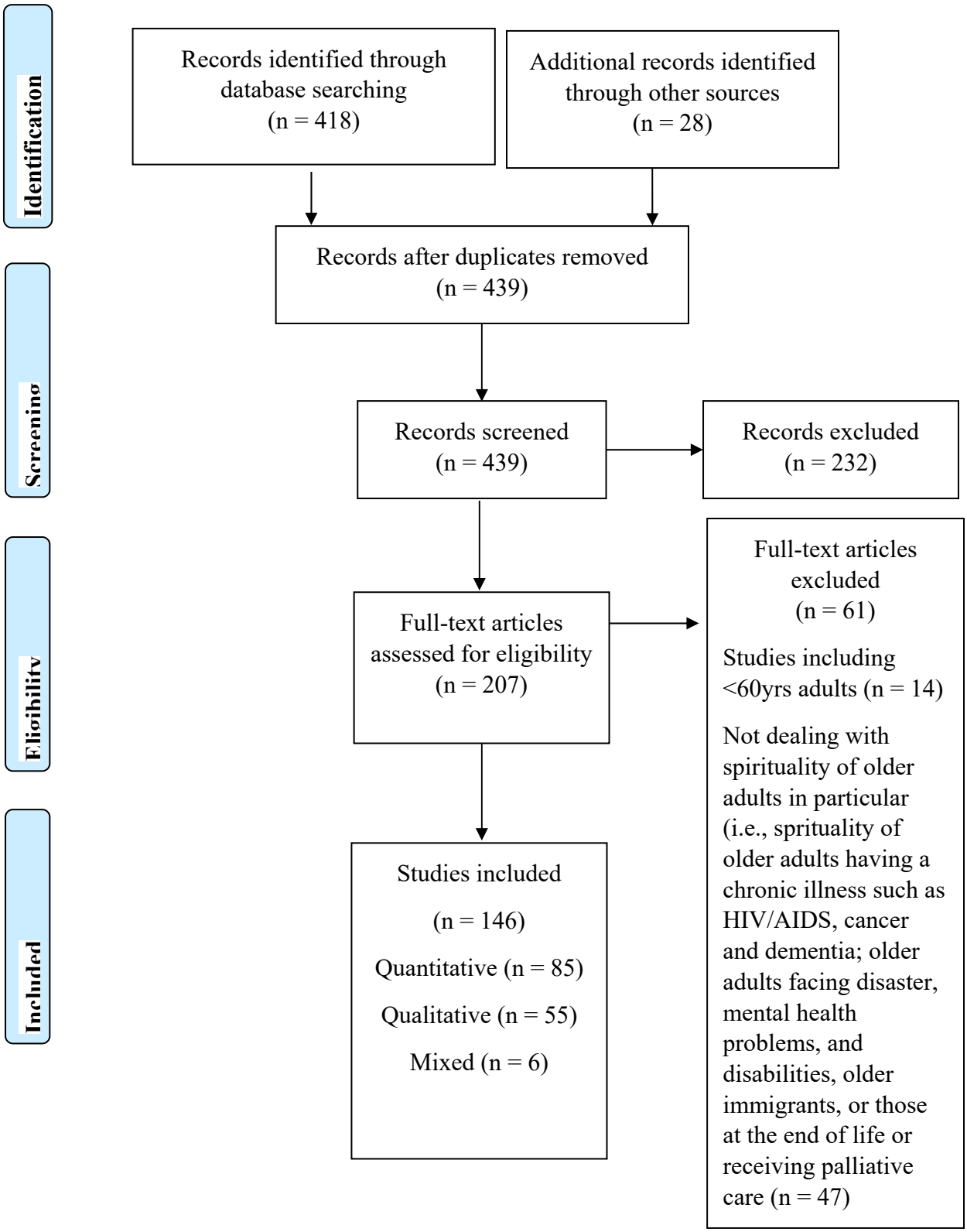
The exclusion criteria were studies that focused specifically on the spirituality of older adults having a chronic illness such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), cancer and dementia; older adults facing disaster, mental health problems, and disabilities. These studies were excluded because the focus was on a medical condition or disaster rather than solely on spirituality. Also, studies concentrating particularly on spirituality of older immigrants or those at the end of life or receiving palliative care were excluded, since spirituality of older adults in general was not the concern of these studies.

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (Figure 2.1, p. 23) shows the number of articles retrieved, discarded, and retained for analysis (Moher et al., 2009). A search for relevant literature using various combinations of aforementioned key words retrieved a total of 446 articles.

Only 146 studies (quantitative, 85; qualitative, 55; mixed, 6) were eligible for the review after screening articles using the PRISMA framework. The chosen articles were read multiple times. The study focus, details of methodology, and key findings related to spirituality were documented to identify common concepts among the chosen studies. Once the relevant concepts were assembled, a conceptual map was formed, and similar concepts were grouped together. In addition, government or organisational reports, conference proceedings, and books were also included in the review, mainly when elucidating the concept of spirituality and integration of spirituality in the care of older adults.

Figure 2.1

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flowchart



2.4 The Historical Milieu of the Term Spirituality and its Evolution

The meaning of the term spirituality has evolved over time. The term spirituality was coined in the 5th century, but entered the common language at the end of the 15th century (Jones, 1997; Sheldrake, 2007). The origin of the word spirituality lies with the Latin word *spiritualitas* (spiritual) derived from the Greek word *pneuma* (spirit). A spiritual person referred to one "who lived under the influence of the Spirit of God" (Sheldrake, 2007, p. 3). In this sense, spirituality denoted living a life oriented towards higher being/s. This definition of spirituality reflects the traditional view of spirituality inspired by religion, evidenced in the sacred texts of different religions such as Judaism, Christianity, Buddhism, Hinduism, and Islam (Eckersley, 2007; Setta & Shemie, 2015). It is beyond the scope of this chapter to include the details of how different religions described spirituality in a theological context. The main concern is to assess the state of knowledge around spirituality in the realm of health-related literature. Yet, the concept of traditional spirituality revolved mainly around the idea of connecting with the divine power. Although support for the traditional view of spirituality embedded within the notion of the divine still exists, the conceptualisation of the term spirituality has broadened (Hodge, 2018).

In response to the secular movements in the 20th century, the traditional meaning of spirituality shifted, contemporary interpretation emerged, and "spiritual but not religious" became a widely held view among people (de Souza, 2016, p. 2). The contemporary understanding of spirituality is more widespread, flexible, and not necessarily within the traditional religious sphere. One of the main problems with the contemporary stream of thought is that there is no conceptual demarcation of spirituality (Hodge, 2018). Accordingly, several researchers have put forward varying definitions of spirituality, with few similarities between them. Before interpreting the findings of existing research, it is also crucial to understand some current theoretical discourses on spirituality and ageing, which will be discussed in the section below.

2.5 The Intersection Between Spirituality and Ageing: Theoretical Approaches

A great deal of academic work is focused on understanding the intersection between spirituality and ageing. Two main theoretical approaches underlying the study of spirituality and ageing can be termed as a developmental approach or situational approach to spirituality. Taking a development approach means spirituality is primarily viewed as part of the psychological development in old age. According to the developmental approach, there are spiritual tasks which older adults must fulfil in old age. For instance, MacKinlay's (2002) GT study with 24 nursing home residents aged 65 years and older in Australia, has theorised that older adults have eight spiritual tasks to fulfil. These spiritual tasks are to find ultimate meaning in life, an appropriate way to respond, transcend disabilities, loss, find wisdom, relationships with higher being/s and others and hope (MacKinlay, 2002). Additionally Dalby (2006) reviewed 13 articles on spirituality and ageing, and concluded that tasks of old age are to maintain "integrity, humanistic concern, changing relationships with others and concern for younger generations, relationship with a transcendent being or power, self-transcendence, and coming to terms with death" (p. 11). Likewise, some studies claim that older adults tend to have spiritual connections with higher being/s, people, a deep sense of faith, abstract thinking, and increasing consciousness of self (Hedberg et al., 2009; Manning, 2013). The developmental approach in understanding the link between spirituality and ageing is consistent with Erikson's (1997) theory of psychosocial development and Tornstam's (2005) theory of gerotranscendence. According to Erikson's theory of psychosocial development, transcendence is a ninth developmental stage in "very old age," referring to older adults in 80s and beyond. In ninth developmental stage of life, older adults start to search for their "existential identity," which mirrors searching for meaning in life (Erikson & Erikson, 1997). Similarly, Tornstam's theory of gerotranscendence supports that as people age, there is a shift from the materialistic to a transcendent view of the world (McCarthy & Bockweg, 2013; Tornstam, 2005). In his theory, Tornstam (2005) stated that the development of gerotranscendence in old age is characterised by:

> a feeling of cosmic communion with the spirit of the universe, a redefinition of time, space, life, and death, and a redefinition of the self and relationships

> to others. The individual becomes, for example, less preoccupied with self and at the same time more selective in his/her choice of social and other activities. There is an increased feeling of affinity with past generations, a decreased interest in superfluous social interaction and the positive solitude becomes more important. (p. 144)

Tornstam's theory positions gerotranscendence as a natural phenomenon in old age. This developmental approach to studying spirituality and ageing suggests that every older adult goes through this developmental phase no matter what, and has to complete these spiritual tasks associated with old age to achieve integrity or life satisfaction.

Conversely, taking a situational approach argues that inclination towards spirituality is not necessarily associated with old age, and can develop as early as younger adulthood. According to the situational approach, spirituality is a compensatory mechanism to deal with adversities in life, which can develop at any age. Likewise, this approach argues that spiritual tasks are not universal to all older adults. Consistent with this argument, in a self-report survey conducted with 133 community-dwelling French older adults aged 60-95 years, Velasco-Gonzalez and Rioux (2014) found that age and health status does not predict spirituality. Instead, the researchers concluded that only those older adults who are dissatisfied with their life rely on spirituality to cope with their sufferings (Velasco-Gonzalez & Rioux, 2014). Similarly, researchers have claimed that increasing age can bring profound challenges in life such as deteriorating health, social relations, and loss of significant others; and spirituality is a compensatory mechanism to deal with these adversities of life (Momtaz et al., 2010; Shaw et al., 2016; Sun, 2012; Yoon, 2006). It is, therefore, speculated that as age increases, people become more spiritual (Krause & Hayward, 2014; Lowis et al., 2009; Stefanaki et al., 2014). However, it cannot be assumed that spiritual tasks are universal to all older adults (Manning, 2012, 2013). Some older adults might not consider fulfilling all these spiritual tasks, but still achieve integrity in life (Seifert, 2002). Likewise, some older adults might have totally different spiritual tasks depending on their gender, religion, culture, ethnicity, distinct life events, or circumstances (Dalby, 2006; Sadler & Biggs, 2006). What these

discussions point out is that the researcher should consider older adults' spirituality from both a developmental and situational theoretical lens.

2.6 Meaning Attributed to the Term Spirituality

Spirituality is a commonly-used notion in theology, philosophy, sociology, nursing, medicine, and psychology. The last two decades have seen a significant increase in the publication of health related literature on spirituality in older adults. Despite being commonly used, there is no consensus among researchers regarding the definitions of spirituality. The most influential leaders in the field argue that spirituality remains a poorly defined term because of its subjective nature (Koenig, 2012; Pargament, 1997). Spirituality can mean different things to different individuals. As a result, widely varying definitions of spirituality have emerged in the literature, and a generally accepted definition of spirituality is still lacking. Since the definition of spirituality varies among researchers, it is important to understand how the term is being used in different disciplines.

Diverse academic disciplines use the term spirituality differently. From a sociological point of view, spirituality is described as an "aspect of what it is to be human, to search for a sense of meaning, purpose, and moral guidance for relating with self, others and ultimate reality" (Canda & Furman, 1999, p. 37). This definition of spirituality reflects the fundamental nature of spirituality, which can be applied to all individuals living within the society; yet, it is somewhat vague and does not consider the subjective nature of spirituality. In the context of psychology, spirituality is defined as a process of searching for the sacred (Pargament & Mahoney, 2012). Here, the term sacred denotes either higher being/s, higher power, divine, ultimate reality, relationships with people, nature, or universe (Pargament & Mahoney, 2012). This definition of spirituality allows for a subjective interpretation of the term sacred. For instance, individuals who do not identify with any religion might understand the term sacred differently compared to those who have a religious belief. Yet, in both the sociology and psychology definitions, how to address spirituality in health care is not made explicit. To answer the question of how spirituality should be defined in the realm of health care, two conferences on spirituality were held in 2012 and 2013, respectively. Forty-one international leaders, including physicians, nurses, psychologists, social workers, theologians, spiritual

care professionals, donors, researchers, and policy makers participated in these conferences (Puchalski et al., 2014). Eventually, all agreed on the following definition of spirituality:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices. (Puchalski et al., 2014, p. 646)

The above-mentioned definition of spirituality, approved by a large group of health care leaders, can be considered as one of the most comprehensive definitions in the context of health care. Eminent in this definition is its practicality, since it has delineated how spirituality is expressed; that is, through individuals' "belief, values, traditions, and practices" (Puchalski et al., 2014, p. 646), which clearly indicates the areas that health care workers should focus in order to address health care recipients' spirituality.

Although disciplines use spirituality differently, the core meaning attributed to the term is common to all disciplines. For instance, it is evident in all the definitions, mentioned above, that spirituality is an integral aspect of human life. Similarly, all definitions established that spirituality means to search for or seek either meaning or purpose in life. Likewise, it is evident in all the definitions that spirituality denotes connecting with what is significant in life. Taken together, spirituality means a fundamental component of human life, where an individual seeks for ultimate meaning or purpose or connections in life, irrespective of religious or secular belief.

In literature, the term spirituality is also confused with religion. While some researchers have treated these two constructs separately (Adhikari, 2013; Corsentino et al., 2009; Yoon & Lee, 2007), others have used them interchangeably due to the interconnection between the two terms (Manning, 2012; Molzahn, 2007; Skarupski et al., 2010). Yet, these terms have distinct meanings. Religion involves a shared social system of belief and rituals practiced by a certain group; whereas spirituality is searching for the meaning of life, which is not necessarily based on religion (Gautam et al., 2019). Although the argument about religion versus spirituality still exists,

most studies included in this review have agreed that spirituality is an umbrella term that can include or go beyond religion (Dunn, 2008; Sessanna et al., 2007). Spirituality is a broader term than religion, and inclusive of religious or secular or existential concerns of human life. In the present study, the term spirituality has been used solely to cover the comprehensive nature of the construct.

2.6.1. Older adults' perspectives on spirituality

The interpretation of the term spirituality can also vary among older adults from different religious, socio-cultural, or ethnic backgrounds. For instance, in a mixed methodology study conducted in Brazil, 12 community-dwelling Brazilian older adults aged 60 years and over described spirituality and religion as two different constructs. For these Brazilian older adults, spirituality meant the relationship with sacred, transcendence, and support system; and religion denoted affiliation, culture, and moral codes (Chaves & Gil, 2015). However, when Tongprateep (2000) interviewed 12 Thai older adults aged 60 years and over to explore spirituality using a phenomenological approach, findings revealed that spirituality and religion are interconnected concepts for the group. Thai older adults described spirituality as spiritual beliefs; religious practices; and the law of karma, afterlife, merit-making, moral behaviour, appreciation, care, and meditation (Tongprateep, 2000). Similarly, evidence shows that there is marked variation in the way American, Australian, Maltese, Tongan, Samoan, New Zealanders, Indian, and Nepalese older adults interpret the term spirituality (Baldacchino et al., 2014; Eames et al., 2010; Harvey & Cook, 2010; Ihara & Vakalahi, 2011; Pandya, 2016; Shrestha, 2010). Likewise, older adults from a similar religious or socio-cultural background but different ethnicity can also perceive spirituality differently. For instance, in a qualitative exploratory study, Cohen et al. (2008) explored the perspectives of 29 community-dwelling Jewish, African American, and Caucasian protestant older adults on spirituality. The study established that Jewish, African American, and Caucasian protestant older adults held different views about spirituality (Cohen et al., 2008). Older adults belonging to different religious, socio-cultural, or ethnic groups tend to look at spirituality from a different lens, and interpret it differently.

Despite differences in interpreting the term spirituality, it is interesting to note that most of the older adults who participated in the studies presented above agreed on

some broad facets of spirituality. Firstly, most of the older adults recognised spirituality as maintaining relationships with self, others, higher being/s, and nature. Secondly, there was a consensus among most of the older adults that remaining connected is central to maintaining spirituality, and a source of meaningful living. Next, most of the older adults used religion and spirituality interchangeably and found it very difficult to describe these two constructs separately. Yet, most of the older adults described spirituality in terms of and beyond religion, and approved spirituality as a more inclusive term (Baldacchino et al., 2014; Cohen et al., 2008; Eames et al., 2010; Harvey & Cook, 2010; Ihara & Vakalahi, 2011; Krause, 2008; Lee & Sharpe, 2007; Pandya, 2016; Shrestha, 2010). Research on spirituality should acknowledge and embrace these various worldviews by facilitating older adults themselves to describe what spirituality means for them.

2.7 Dimensions of Spirituality

Spirituality is a multi-dimensional construct. While researchers in the field of spirituality agree on the multi-dimensional nature of spirituality, there is no consensus in the literature regarding what constitutes dimensions of spirituality. According to Seicol (2005), spirituality has three dimensions—finding meaning, purpose, and value in life. Meaning in life is derived from personal experiences, actions, and accomplishments. Finding purpose in life is concerned with future aims or expectations, and finding values denote the searching for worth as human beings (Seicol, 2005). Spirituality is, therefore, concerned with the past, present, and future dimensions of life. Another dimension of spirituality is connectedness, which has been described as connecting with self, others, higher being/s, divine, higher power, nature as well as the universe (Baldacchino et al., 2014; Eames et al., 2010; Harvey & Cook, 2010; Ihara & Vakalahi, 2011). Dimensions of spirituality also include religious affiliation, organisational participation, religious practices and beliefs, and religious commitment (Ingersoll-dayton et al., 2002). Likewise, transcendence and psychosocial identity have also been referred to as dimensions of spirituality (Monod et al., 2010b).

It is difficult to demarcate the dimensions of spirituality, mainly due to two reasons. Firstly, spirituality is subjective (Pargament & Mahoney, 2012). Spirituality can incorporate wide varieties of dimensions. Secondly, dimensions of spirituality are

closely interlinked (Hedberg et al., 2009; Hupkens et al., 2016; Moore et al., 2006; Register & Scharer, 2010; Thomas & Cohen, 2006; Welsh et al., 2012). As a result, it is often challenging to demarcate where one dimension ends, and the other begins. Although many dimensions have been used in the literature to delineate the complex nature of spirituality, two most common dimensions are a search for meaning in life and connectedness (Krause & Bastida, 2009; Zibad et al., 2017). Thus it can be seen that spirituality is a multi-layered construct.

In contrast to other literature discussed so far, using concept analysis, Zibad et al. (2016) provided a new and broader outlook on dimensions of spirituality in the context of health. The researchers concluded that spiritual health includes four dimensions; namely, cognitive, functional, affectionate, and consequential. The cognitive dimension involved the awareness of higher power, religion; meaning, purpose, an ultimate goal of life; and belief in self-actions and life after death. The functional dimension comprised actions such as assessing self, retaining relationships with higher being/s, others, and pureness. Likewise, an affectionate dimension encompassed emotions towards self, higher being/s, and others. Finally, the consequential dimension included the benefits of maintaining spirituality (Zibad et al., 2016). These dimensions of spiritual health emerged from a review article and a qualitative thematic analysis conducted among 12 community-dwelling Iranian older adults aged 60 years and over (Zibad et al., 2017). The strength of this research is that it provides a comprehensive understanding of the dimensions of spirituality. While conducting a research on spirituality, the researcher has to address its cognitive dimension (i.e., belief involved in maintaining spirituality); functional dimension (i.e., actions taken to maintain spirituality); affectionate dimension (i.e., emotions involved in maintaining spirituality); and the consequential dimension of the phenomena (i.e., impact of maintaining spirituality) (Zibad et al., 2017). The dimensions of spirituality, discussed above, echo the complex nature of spirituality.

2.7.1. Older adults' views related to the dimensions of spirituality

When conducting the literature search, six qualitative studies exploring older adults' perceptions regarding the dimensions of spirituality were accessed and analysed. Three studies focused on the dimension of meaning in life (Moore et al., 2006; Thomas & Cohen, 2006; Welsh et al., 2012), two on purpose in life (Hedberg et al.,

2009; Hedberg et al., 2013), and one on connectedness (Register & Scharer, 2010). Moore et al. (2006) expanded the idea of what makes life meaningful for 11 Canadian older adults aged 66-92 years living in the community and RCFs using a narrative inquiry. The older adults linked meaningful living to being lively, appreciating every situation, and finding meaning in stressful circumstances, and accepting life as it. Recognising the inner-self, self-power, self-confidence, involving in self-talk, and connecting with people, and higher being/s were also reported as aspects of meaningful living. This study makes a significant contribution to research on maintaining spirituality by demonstrating that older adults strategise cognitively to maintain a meaningful living in both community and RCFs. The study covered some aspects of maintaining spirituality; yet, meaningful living is only one of the dimensions of spirituality and the study did not analyse the overall aspect of maintaining spirituality. Researchers also recommended future research needs to address the role of spirituality in meaningful living in old age (Moore et al., 2006). Further, the study mixed the perceptions of older adults from both community and RCFs. Likewise, Thomas and Cohen (2006) recruited 24 African American older adults from senior centres in the United States of America (USA). Researchers allowed older adults to complete a life journal signifying their major turning points in life, how it impacted their relationship with a higher being/s, and the lessons learned from that event. The study showed how multiple turning points in the life of older adults added new meaning to spirituality or changed the meaning associated with it. The study adds to the literature that spiritual meaning-making is a dynamic construct. The main focus of the study was, however, on how significant life events changed the spirituality of older adults based on life stories, rather than how they maintain spirituality in RCFs.

A phenomenological study undertaken by Welsh et al. (2012) described how 11 older adults aged 64-92 years perceived meaningful living in RCFs in Canada. Residents described meaningful living as connecting, surviving regardless of diminishing abilities, engaging in activities, and pursuing protection. Findings of this study are noteworthy since it revealed that RCFs negatively impact on residents' source of connection, sense of self, privacy, and autonomy. In this context, the spiritual belief was the primary source of comfort and peace for residents. This study offers

probably the most selective analysis of the concept of meaningful living among residents. However, only a single dimension of spirituality was addressed.

Two studies explored the dimension of purpose in life (Hedberg et al., 2009; Hedberg et al., 2013). In these two studies, conducted in Sweden, 23 community-dwelling older men and 30 women aged 85 years or above were asked about purposeful living (Hedberg et al., 2009; Hedberg et al., 2013). Content analysis revealed that most of the female participants maintained a purposeful living by having a positive outlook in life, connecting with a higher being/s, and being involved in meaningful activities. The strategies used by female older adults to maintain a positive outlook in life were being appreciative, connected, content, and autonomous. Similarly, connection with higher being/s was maintained by having faith in a higher being/s and feeling safe. Likewise, meaningful activities were maintained by enjoying a hobby, doing domestic work, and continuing friendships. However, some female older adults did not experience purposeful living in the community and labelled it as "simply existing," which meant "hanging on, feeling lonely, and feeling uncertain" (Hedberg et al., 2009, p. 131). In contrast, the male participants described purposeful living in terms of past achievements, health, difficulties encountered, how they moved forward and adapted in life. These two studies highlight how male and female older adults' perspectives on maintaining spirituality can differ. Still, the study encompassed the perspectives of community-dwelling older adults, and the findings do not represent the context of RCFs.

A GT study conducted by Register and Scharer (2010) extended the dimension of connection in older adults. The purpose of the study was identifying the process involved in connectedness in 12 community-dwelling older adults aged 65 years or above in the USA. The four processes involved were having a motive, relationships with friends and family, something to aim for, and a sense of continuity. Register and Scharer (2010) mentioned how spirituality is integrated into all these four processes of connectedness, yet, has not treated the concept of spirituality in detail. As a result, it has not adequately addressed the question of how older adults maintain spirituality in RCFs.

2.8 Quantitative Evidence: Impact of Maintaining Spirituality on the Wellbeing of Older Adults

Understanding spirituality and its influence on the life of older adults has been the central part of literature over the past two decades. Much of the current literature on spirituality pays attention to the impact of maintaining spirituality on the physical, psychological, and social wellbeing of older adults. The vast majority of previous research in this area has utilised quantitative approaches, and is based on community-dwelling or hospitalised older adults of western countries such as the USA, England, and Australia. There is a dearth of research investigating the impact of maintaining spirituality on the wellbeing of older adults living in RCFs. Therefore, studies conducted in both community and hospital settings have been included in the review to gain a broader understanding. Nevertheless, the findings of these studies have been interpreted cautiously with due consideration to the study settings. The first section will begin with the findings reported by quantitative studies included in the review, followed by an overall critique. Since vast quantitative studies are available on the topic, an overall critique of those studies has been provided in the second section.

Maintaining spirituality is related to the physical wellbeing of older adults. Studies have shown that older adults who are inclined towards spirituality or more involved in spiritual practices are more likely to follow healthy lifestyles, behaviours, and perceive better health, diminished symptoms, and severity of illness (Klemmack et al., 2007; Lucchetti et al., 2011; Skarupski et al., 2010; Yohannes et al., 2008; You et al., 2009). The above mentioned studies were either community-based or undertaken among older adults admitted to intermediate care or those from outpatient rehabilitation setting. Similarly, it is reported that maintaining spirituality enhances older adults' ability to care for self during illness (Callaghan, 2006). An educational intervention study directed towards maintaining spirituality has also supported its positive impact on older adults' self-reported physical wellbeing (Lee et al., 2012a). In that study, a 12-week educational programme on the ways of strengthening body-mind-spirit aspects of health was conducted among 32 community-dwelling Korean older adults. Regarding spirituality, information on how to maintain "meaning, relations, forgiveness, and happiness" in old age was provided (Lee et al., 2012a, p.

476). Pre- and post-surveys of self-rated physical, mental, and spiritual dimensions of health were conducted. A spiritual dimension of health was measured on the basis of the 11 questions regarding frequency of their involvement in spiritual practices such as evaluating meaning in life or importance of faith. Compared to the control group, the older adults who participated in the programmes reported significant improvement in physical as well as spiritual dimensions of health (Lee et al., 2012a). These studies suggest a beneficial impact of maintaining spirituality on the physical wellbeing of the older adults whether they are institutionalised or living in a community.

Several lines of evidence acclaim that maintaining spirituality is associated with older adults' psychological wellbeing. Studies agree that maintaining spirituality is a resource for older adults because it provides the meaning of existence and motivation for a living (Francis et al., 2010; June et al., 2009; Krause, 2008; von Humboldt & Leal, 2017). For instance, June et al. (2009) recruited 37 American and 35 African American community-dwelling older adults aged 60 years and over to investigate the relationship between their spirituality, social support, and the reasons for living. Spirituality was measured using the Brief Multidimensional Measure of Religiousness/Spirituality instrument containing 40-items and 12 subscales. In a five-point Likert scale, participants selected the response regarding "daily spiritual experiences, meaning, values/beliefs, forgiveness, private religious practices, religious and spiritual coping, religious support, religious/spiritual history, commitment, organisational religiousness, religious preference, and overall self-ranking" (June et al., 2009, p. 755). The result showed that older adults with high spirituality reported more reasons for living (June et al., 2009). Maintaining spirituality has also shown to create a sense of coherence and control among older adults (Chokkanathan, 2013; Krause & Bastida, 2011; Krause & Hayward, 2014; Krok, 2016; Stefanaki et al., 2014); therefore, promoting their coping mechanism and anger management (Lowis et al., 2009; Mefford et al., 2014). Similarly, maintaining spirituality has shown to decrease the negative psychological impact of the frailty (Kirby et al., 2004), and widowhood (Kim et al., 2011; Momtaz et al., 2010). Evidence suggests that maintaining spirituality helps older adults cope with adversities associated with old age.

Enhanced spirituality is linked to various positive emotions in older adults. For instance, it enhances older adults' optimism (Dunn, 2008; Krause & Bastida, 2011), self-worth (Krause & Hayward, 2012), self-identity (Wink et al., 2007), resilience (Vahia et al., 2011), self-strength (Kim et al., 2011), forgiveness (Krause & Ellison, 2003; Lee, 2007), humility (Krause & Hayward, 2014), and happiness (Pandya, 2016). Moreover, maintaining spirituality has been linked to successful ageing (Tomás et al., 2016), and life satisfaction in older adults (Jang et al., 2006; Pandya, 2016; Skarupski et al., 2013). Likewise, a longitudinal study conducted over a four year period among 324 community-dwelling Australian older adults aged 75-96 years, also supports that maintaining spirituality lead to life satisfaction in older adults, and this relationship was mediated by the effect of an increased sense of coherence and positive and meaningful reappraisal of life events (Cowlishaw et al., 2013). Thus, maintaining spirituality can promote a positive outlook of ageing in older adults.

It is equally imperative to consider findings of studies which have shown that maintaining spirituality decreases the negative health outcomes in older adults. For instance, maintaining spirituality plays the role of a buffer to decrease anxiety, loneliness, and fear of death in older adults (Han & Richardson, 2010; Iovu et al., 2015; Law & Sbarra, 2009; Lee, 2011; Lowis et al., 2011). Similarly, a growing body of evidence suggests an inverse relationship between spirituality and depression (Coleman et al., 2011; Gautam et al., 2007; Hughes & Peake, 2002; Lee, 2007; Lee et al., 2012b; Lucchetti et al., 2011; McGowan et al., 2016; Moon & Kim, 2013; Skarupski et al., 2010; Timilsina et al., 2014; Yoon, 2006; Yoon & Lee, 2007; You et al., 2009). Moreover, maintaining spirituality has shown to decrease the cognitive decline in older adults (Fung & Lam 2013; Lucchetti et al., 2011). The inverse relationship of maintaining spirituality with cognitive decline, as well as depression, has also been validated by three longitudinal studies (Corsentino et al., 2009; Reyes-Ortiz et al., 2008; Sun, 2012). These three studies included 2,938, 2759, and 1000 community-dwelling American older adults aged 65 years and older, and followed them over 3, 11, and 4 years, respectively. The findings of these three studies show that maintaining spirituality reduces decline in cognitive functioning and depressive symptoms among older adults (Corsentino et al., 2009; Reyes-Ortiz et al., 2008; Sun, 2012). Even in cases of older adults who are already diagnosed with mental health

disorders, maintaining spirituality helped them to find meaning in life (Bamonti et al., 2016) and reduced their suicidal ideation and emotional distress (Chen et al., 2007). It is important to note that most of the above-mentioned studies have dealt with a single aspect of the psychological wellbeing of older adults. However, the positive impact of maintaining spirituality is consistently reported by studies which have treated overall psychological wellbeing of older adults as one outcome variable (Fry, 2000; Kim et al., 2011; Klemmack et al., 2007). Maintaining spirituality enhances the overall psychological wellbeing of older adults.

Maintaining spirituality also lowers suicidal and overall mortality risk among older adults. Enhanced spirituality gives older adults more reasons to live and, hence, reduces the suicidal risk (June et al., 2009). According to June et al. (2009), maintaining spirituality reduces the suicidal risk among older adults either through the spiritual belief that suicide is not acceptable or social support gained by maintaining spirituality. The argument put forward by June et al. (2009) is complemented by a longitudinal study (McDougle et al., 2016). McDougle et al. (2016) studied how religious and secular coping strategies impact the mortality of 3,146 community-dwelling American adults aged 69-72 years over 17 years. The result of this self-report study confirmed that social approaches to religious and secular coping, such as attending religious services and volunteering, is associated with lower mortality risk among older adults. Mortality status was determined using National Death Index records. Given the volume of evidence, maintaining spirituality can be one of the cost-effective ways of reducing adverse health outcomes of older adults irrespective of the place they live.

There is a link between maintaining spirituality and the social wellbeing of older adults. Various studies have reported that maintaining spirituality increases social networks, opportunities for social interactions, promotes emotional and social ways of coping; in turn, leading to the pathway of social wellbeing in old age (Chokkanathan, 2013; Krok, 2016; Stefanaki et al., 2014; Ysseldyk et al., 2013). Similarly, in a study conducted among 159 community-dwelling Asian-American older adults aged 65 years and over, Ryu and Lee (2016) found that maintaining spirituality is a social capital for older adults since it increases social relations, resources, social status, sense of belongingness, and chance to practice leadership,

which is crucial for the social wellbeing of older adults. Maintaining spirituality can combat the common problems of loneliness or isolation in old age by enhancing their social life.

In contrast to the positive impact of maintaining spirituality, discussed so far, there are few studies which have shown that some spiritual belief, practices, or coping mechanism can be negative and detrimental to older adults' life. For instance, in a study conducted in the Netherlands, researchers recruited 60 highly spiritual community-dwelling Dutch older adults aged 68-93 years to explore their image of higher being/s (Braam et al., 2008). Here, the term highly spiritual meant older adults were actively and frequently involved in spiritual practices such as visiting church or praying. What is interesting is that despite being highly spiritual, some older adults reported discontentment towards higher being/s, which was significantly associated with hopelessness, repentance, and depression (Braam et al., 2008). Likewise, another study conducted with 1092 community-dwelling Singaporean older adults aged 60 years and over found that those having more spiritual inclination have more mental health problems, and are less likely to seek treatment than their counterparts (Ng et al., 2011). The researchers pointed out that some negative spiritual belief, practices, or coping mechanism might be responsible for this finding (Ng et al., 2011). Yet, the researchers did not specify those negative spiritual belief, practices, or coping mechanisms.

A four-year longitudinal study conducted with 3,537 community-dwelling Taiwanese older adults aged 60 years and over clarified that certain spiritual practices such as "going to temple/church" reduced depression yet, "praying for calmness and for help with difficult decisions" lead to more depressive symptoms in the long run (Hsu, 2014, p. 454). In the same vein, when 1500 community-dwelling older adults aged 66 years and over with bereavement were studied longitudinally over a seven years period in the USA, the depression worsened in those who had "spiritual doubt" compared to their counterparts (Hayward & Krause, 2014). Here, spiritual doubt referred to "perceived conflict with alternative sets of beliefs about the world, perception of evil or undeserved suffering that conflicts with belief in a just ordering of the universe, and conflict with members of the religious community" (Hayward & Krause, 2014, p. 218). Murphy et al. (2016) added those older adults who experience

"spiritual struggle" such as feeling of being penalised, or left out, by the higher being/s are more likely to use negative spiritual coping mechanisms such as withdrawing from participation in individual or social, spiritual practices, leading to increased severity of illness, depression, and mortality. Few other studies report similar findings regarding the detrimental effect of negative spiritual belief, practices, or coping mechanisms on older adults' QOL, and overall wellbeing (Cohen & Hall, 2009; Roff et al., 2007; Vitorino et al., 2016). Some spiritual belief, practices, or coping mechanisms can have a negative influence on older adults.

Taken together, the literature regarding the impact of spirituality, reviewed so far, has used a quantitative approach to measure spirituality. Most of the existing quantitative studies suggest an important role of maintaining spirituality on the physical, psychological, and social wellbeing of older adults. Yet, some studies also identified that maintaining spirituality does not necessarily mean older adults are following a positive spiritual belief, practices, or coping mechanisms. Also, when older adults embrace negative spiritual beliefs, practices, or coping mechanisms, its impact can be detrimental. Assessing how older adults maintain their spirituality is a significant area in research since the information gained can help both researchers and health care workers to identify, and address, these harmful spiritual practices, beliefs, or coping mechanisms.

2.8.1. A way forward for future research

The mainstream view of spirituality is based on quantitative evidence. The findings of much-published quantitative research on spirituality should be interpreted with caution because of several issues. The first issue is that terminologies, definitions, and measurement tools used to delineate the concept of spirituality vary widely in existing quantitative research. For instance, some studies primarily focused on religion, intrinsic religiosity, extrinsic religiosity, religiousness, religious belief, faith, practices, participation, involvement, attendance, and coping. However, other studies mainly concentrated on spiritual practices, experiences, meaning, purpose, health, distress, wellbeing, coping, or connectedness. All these concepts embody aspects or dimensions of spirituality; yet, the crucial issue here is the lack of a comprehensive representation of spirituality, which is a complex and multi-dimensional construct.

Likewise, in the absence of an agreed definition of spirituality, its assessment has also been challenged. Researchers have used a wide variety of tools, such as the Spirituality Assessment Scale (O'Brien, 2004), Ellison & Palutzian Spiritual Well-Being Index (Ellison, 1983; Paloutzian & Ellison, 1982), Multi-dimensional Measurement of Religiousness/Spirituality (Fetzer Institute/National Institute on Aging Working Group, 1999), Religious Meaning System questionnaire (Krok, 2016), and Duke University Religion Index (Koenig & Büssing, 2010). In the literature, there seems to be no agreement among researchers regarding what constitutes a comprehensive tool for assessing spirituality. Moreover, some of the studies have used only one or two item questionnaires to measure spirituality (Corsentino et al., 2009; Gautam et al., 2007). Considering the complex nature of spirituality, the validity of such measures is questionable. Similarly, when spirituality is measured quantitatively using a tool, it overlooks the views of older adults themselves. It is widely agreed that spirituality is a highly subjective phenomenon; therefore, allowing older adults themselves to describe it using their own dimensions would be the preeminent way forward (Chokkanathan, 2013; Harvey & Cook, 2010; Lee, 2007; Molzahn, 2007; Skarupski et al., 2010; Tan et al., 2011; Zibad et al., 2017). A qualitative approach to studying spirituality would foreground the unique voice of older adults and add new meaning to the existing body of knowledge.

The second issue is that when spirituality is measured quantitatively in a cross-sectional study, as conducted in most existing studies, the underlying assumption is that spirituality is a stable construct. Yet, a growing body of research supports that older adults' perspective and inclination toward spirituality can change over time. For instance, studies carried out with older adults of the UK, USA, and New Zealand found that the individual's viewpoint on spirituality is subject to change, depending on shifting interpersonal, socio-cultural circumstances (Eames et al., 2010; Eisenhandler, 2005; Ingersoll-dayton et al., 2002; Manning, 2012, 2013; Sadler et al., 2013). Changing situations in older adults' life can either add new meaning to spirituality or totally change the meaning associated with it (Thomas & Cohen, 2006). This changing nature of older adults' spirituality over time has been validated by a nationwide longitudinal survey led in the USA (Krause, 2008), and a review article on the spiritual development process in ageing (Dalby, 2006). Furthermore, McFadden (2009) recommended that future researchers take account of the changing

nature of older adults' spirituality. In other words, the process underlying spirituality should be the focus of future research.

Another issue in existing quantitative studies is that most of them have recruited older adults from the community or mixed settings such as community, RCFs, and hospital. Among those studies, some have included chronically or terminally ill older adults, while others have excluded them. Little is known about spirituality of older adults living in RCFs. The context of older adults living in a RCF can be different compared to those living in the community or hospital. Older adults living in RCFs may have long term conditions but not require acute care. Furthermore, access to resources for maintaining spirituality might be different for older adults living in a RCF versus community (Gautam et al., 2019). Therefore, it cannot be presumed that the findings discussed so far relate to older adults living in RCFs.

The next issue in existing quantitative studies is that most of them have recruited older adults from Western countries. Older adults living in other countries can have a different viewpoint on spirituality. Harvey and Cook (2010) pointed out that the elements of religion, culture, and ethnicity are interwoven in spirituality in such a way that it is difficult to separate them into different entities. Also, spirituality is not just a developmental process but a social-cultural process; therefore, influenced by older adults' religious, social, cultural, and ethnic upbringings (Sadler et al., 2013). The ways of expressing or practising spirituality can vary according to the contexts of older adults, and researchers should consider these variations (Harvey & Cook, 2010; Klemmack et al., 2007; Krause et al., 2010; Yoon, 2006). When researchers do not incorporate the participants' context while studying spirituality, the study does not fully reflect the true concerns of the participants. For instance, the quantitative measurement of spirituality in a Western context is mostly based on the frequency of attendance in a spiritual organisation, spiritual activities, or group prayer. This view overlooks the intrinsic nature of spirituality. Spirituality is not always revealed extrinsically (Skarupski et al., 2013). In the case of Korean older adults, spirituality might not be reflected by worship or spiritual community participation and is expressed more privately (You et al., 2009). Consistently, a quantitative study conducted among 152 community-dwelling Korean older adults aged 65 years and over using a Western-based instruments, such as Organisational Religiosity, Daily

Spiritual Experiences Scale, gained no evidence to support the notion that spiritual community participation lowers depression and increases general health perception (You et al., 2009). This finding is contrary to vast Western evidence, which suggest that spiritual community participation is associated with a better health perception and lower depression, as indicated earlier. Researchers argued that the reason for this unexpected finding might be the different ways of expressing or practicing spirituality in a Western versus Asian context. Researchers concluded that measuring spirituality using Western quantitative tools is unfit in the Asian context (You et al., 2009). Context is vital when assessing spirituality.

In another quantitative study, Dorji et al. (2017) studied the relationship between spirituality and QOL in 337 community-dwelling Bhutanese older adults aged 60 years and over. Spirituality was measured using four item questionnaire. The study found no association between maintaining spirituality and QOL. This finding is contrary to other evidence which suggest that maintaining spirituality is associated with QOL of older adults in Iran, Brazil, Korea, Philippines and Thailand (Ali et al., 2015; Chaves & Gil, 2015; Lucchetti et al., 2011; Moon & Kim, 2013; Soriano et al., 2016; Tan et al., 2011). Dorji et al. (2017) mentioned spirituality as not being associated with QOL in Bhutanese older adults; an unexpected finding. The researchers added spirituality is "highly visible in the everyday lives of Bhutanese people" (Dorji et al., 2017, p. 35). Most importantly, researchers concluded that the reason for the unexpected finding might be the use of a quantitative approach which was highly focused on the extrinsic nature of spirituality, and might not fully represent the spirituality of Bhutanese older adults (Dorji et al., 2017). Another study on the link between spirituality and QOL in 426 community-dwelling Canadians older adults revealed a similar view. The researcher concluded that measuring spirituality using a generalised tool might not be context-congruent (Molzahn, 2007). The evidence so far substantiates the need for context-congruent measurement of spirituality.

Gender differences need be considered along with socio-cultural variation when studying the spirituality of older adults. This is exemplified in the USA study conducted by Wink et al. (2007), which found that the protective effect of maintaining spirituality is only significant for older female adults. Another example

is the study conducted in the USA which reported that maintaining spirituality is associated with reduced depression only in older female adults, and the relationship is inverse for their male counterparts (Norton et al., 2006). Likewise, evidence holds that higher spiritual coping is associated with decreased depression in older men but not in older women in the USA (Jun et al., 2015). Although the details of those differences or reasons for it were not explained adequately, these findings suggest that spiritual beliefs, practices, or coping mechanisms can vary among older adults of different genders. What this means for future research is that incorporating the perspective of older adults of all genders is vital.

In summary, the way forward for future research on spirituality is to understand the process underlying spirituality. Likewise, there is a need to embrace the unique voice of older adults from different religious, social, cultural, ethnic backgrounds, as well as older adults of all genders. The following section discusses the qualitative findings related to maintaining spirituality from the perspective of older adults themselves.

2.9 Qualitative Evidence: Impact of Maintaining Spirituality on the Wellbeing of Older Adults

Most of the qualitative research in the field of spirituality in older adults has focused on how maintaining spirituality influences health, wellness, QOL, coping, resilience, and depression. Some qualitative research in this field has focused on understanding the concept of spirituality, and the developmental processes associated with it, some of which has also been mentioned in earlier sections to clarify the concept, and underlying theoretical approaches used in the literature (Hedberg et al., 2009; Hedberg et al., 2013; Ingersoll-dayton et al., 2002; MacKinlay, 2002; Moore et al., 2006; Sadler et al., 2013; Thomas & Cohen, 2006; Welsh et al., 2012). The findings of the qualitative component of a few mixed methodology studies have also been included in this section. Most qualitative research on spirituality has been conducted with community dwelling older adults. Some have included older adults from the mixed settings, including community, RCFs, and hospitals. Only two studies have been exclusively focused on the perspective of older adults living in RCFs (Baldacchino et al., 2014; Welsh et al., 2012). Some qualitative studies on spirituality were based on older women's perspectives, and the view of older men were missing (Knestrick & Lohri-Posey, 2005; Manning, 2012; Shih et al., 2010; Shrestha, 2010;

Shrestha & Zarit, 2012; Yehya & Dutta, 2010). Two qualitative studies conducted in the context of RCFs in Nepal were obtained from online thesis reports (Bhandari, 2014; Shrestha, 2010). The next section begins with the qualitative findings related to the impact of maintaining spirituality on the wellbeing of older adults.

Most of the qualitative research to date has tended to focus on the role of spirituality in illness management of older adults. It is well established, from a variety of studies, that maintaining spirituality helps older adults to mediate the physical symptoms associated with illness, cope with chronic ailments, or hospitalisation (Black, 2012; Harris et al., 2013; Harvey, 2006, 2008, 2009; Harvey & Silverman, 2007; Yehya & Dutta, 2010). Kotrotsiou-Barbouta et al. (2006) using context analysis, interviewed 25 hospitalised older adults (13 Male, 12 Female) aged 67-83 years in Greece about spirituality. Their findings showed that maintaining spirituality positively influenced the wellbeing of older adults. These older adult participants perceived spirituality as a subjective experience, prayer as an expression of spirituality, and health care professionals as a support system. This study highlighted that older adults value the role of health care professionals in maintaining their spirituality. Studies conducted with chronically ill Irish, American, and Filipino older adults have also reported the central role of maintaining spirituality in their physical and psychological wellbeing (de Guzman et al., 2009; Harris et al., 2013; Harvey & Cook, 2010; Mundle, 2015). The findings of these studies suggest that maintaining spirituality is fundamental in moving towards health during illness or hospitalisation.

The positive relationship between maintaining spirituality and wellbeing was also consistent in older adults who were not requiring hospital-based care. In a GT study exploring wellness in 20 community-dwelling Samoan and Tongan older adults (10 Male, 10 Female) aged 60 years and over, Ihara and Vakalahi (2011) identified that maintaining spirituality was key to their wellness. For the older adults of Samoa and Tonga, wellness meant a balance between bio-psychosocial and spiritual health, which is why these older adults gave value to maintaining spirituality. Samoan and Tongan older adults perceived that spiritual connection with self, higher being/s, family, community, land, and the spiritual world is a source of physical, psychosocial, and spiritual strength, which led to wellness. These older adults viewed praying, reading the holy script, attending church as a medium of spiritual

connection with a higher being/s, and forming social relationships (Ihara & Vakalahi, 2011). Similarly, Mackenzie et al. (2000) used phenomenology to explore the link between spirituality and wellbeing of 41 older adults living in retirement communities in the USA. The study concluded that older adults' relationship with a higher power and the personal spiritual support gained from this is central to the link between spirituality, physical, and psychological wellbeing. The spiritual connection with higher power led to the feeling of being continuously protected, helped, guided, and healed among older adults. Maintaining spirituality has been reported to be important for the overall wellbeing of older adults, irrespective of their illness state.

Research studies have also reported that maintaining spirituality can help older adults to develop resilience. Using GT, Manning (2013) explored the link between spirituality and resilience of six community-dwelling women in the USA aged 80 years and older. Findings revealed that maintaining spirituality helped older women to appreciate, accept, and gather strength in dealing with and recovering from adversities over the life course. The researcher claimed that spirituality was a pathway to resilience, and had a protective effect in the wellbeing of older women since it helped to re-evaluate adverse events in a positive light (Manning, 2013). Likewise, Ravanipour et al. (2013) analysed qualitative data from 26 community-dwelling Iranian older adults aged 60 years and over. Findings revealed that spiritual power in older adults increased to compensate for the decreasing physical power in old age, which was ultimately linked to their wellbeing, contentment, self-worth, and harmony, despite adversities. Qualitative studies of Australian, British, American, and Taiwanese older adults also supported the notion that maintaining spirituality was a guide to establish meaning, hope, strength, belongingness, continuity, which helped them cope with bereavement, loss, or adversities (Damianakis & Marziali, 2012; Knestrick & Lohri-Posey, 2005; Malone & Dadswell, 2018; Shaw et al., 2016; Shih et al., 2010; Wilkinson & Coleman, 2010). Maintaining spirituality can be a way to transcend the adversities in old age. Additionally, the concept of spiritual coping in RCFs has been explored previously.

A descriptive sequential explanatory study on spiritual coping, conducted by Baldacchino et al. (2014), was unique in the sense that it exclusively focused on older adults living in RCFs. Baldacchino et al. (2014) conducted face to face

interviews with 42 Australian and Maltese older adults (9 Male, 33 Female) aged 65 years and above, in one phase; and three focus group interviews with 23 participants (9 Male, 14 Female) in the next phase of the study. The study revealed that the connection with self, higher power, other people and nature was vital for their self-esteem, to accept, develop a sense of belongingness, adapt, and find meaning and purpose when institutionalised. However, Baldacchino et al. pointed out that some spiritual coping mechanisms, such as "perceived punishment from God" can inhibit "acceptance and adaptation" to a RCF (p. 845). Therefore, understanding how older adults are maintaining spirituality in RCFs is vital.

In summary, previous qualitative research regarding the impact of maintaining spirituality on the wellbeing of older adults has established that maintaining spirituality helped older adults to become resilient and transcend illness or other adversities associated with old age. Furthermore, maintaining spirituality was vital for the overall wellbeing of older adults, irrespective of their illness state or place in which they live. Finally, existing qualitative research also warns that some spiritual coping mechanisms adopted by older adults can negatively impact on their wellbeing.

2.10 Integration of Spirituality in the Care of Older Adults

The literature reviewed in the previous sections has shown that maintaining spirituality is an integral aspect of being human, more important in old age, and has the potential to impact on the wellbeing of older adults. This section moves beyond the literature reviewed in the previous section; namely, exploring directions for integrating spirituality, to the care provided to older adults. Firstly, the international guidelines regarding incorporating spirituality in the care of older adults will be briefly discussed. In the section that follows, I will explore the principal findings of the current studies regarding the role of nurses and caregivers in the process of maintaining spirituality of older adults.

Several international guidelines recommend including spirituality in the care of older adults. In 2006, the WHO established spirituality as one of the major domains of QOL, developing the WHOQOL SPRB instrument from a multinational study including 18 countries across the USA, Middle East, Europe, and Asia (WHOQOL SRPB Group, 2006). The tool included the aspects of spiritual connection, meaning

in life, awe, wholeness and integration, spiritual strength, inner peace, hope and optimism, and faith. Although the tool was developed incorporating the viewpoint of participants aged 16-90 years, the study concluded that spirituality, religion, and personal beliefs could have a significant impact on the QOL—mostly in those having poor health or heading towards the end of the life. This ground-breaking study acknowledged the importance of maintaining spirituality in QOL and its role in the provision of holistic care in health care settings (WHOQOL SRPB Group, 2006). Similarly, the Joint Commission for Accreditation of Health Organizations, the regulatory body responsible for maintenance of quality care in all health care organisations in the USA, has acclaimed maintaining spirituality is vital while caring for patients irrespective of their age group (O'Brien, 2011). Likewise, recently the inclusion of spirituality in care of older adults has been recommended in national aged care guidelines prepared by Australia and healthy ageing strategies developed by New Zealand (Meaningful Ageing Australia, 2016; Ministry of Health-New Zealand, 2016). What is established from these international guidelines is that integrating spirituality into the care of older adults is central. However, the question remains of how to integrate spirituality into caregiving practices. Only a few studies in the literature have explored the practical aspects of incorporating spirituality into the needs assessment and care provision of older adults. The terms commonly used in the literature are spiritual needs or spiritual care of older adults. However, there is no agreed conceptualisation of spiritual needs or care in the literature.

2.10.1. Spiritual needs

Five studies which primarily explored spiritual needs of older adults were identified (Erichsen & Bussing, 2013; Hodge et al., 2016; Hodge et al., 2013; Man-Ging et al., 2015; Monod et al., 2010a). One study focused on the conceptualisation of spiritual needs incorporating the viewpoints of health care workers (Monod et al., 2010a). Over two years, one physician, four nurses, and three chaplains from five different geriatric hospitals in Switzerland met, discussed, and conceptualised spiritual needs of hospitalised older adults. This group identified spiritual needs as a need for stability, connection, worth, power, and identity. This study was influential in many ways. Firstly, the study conceptualised spiritual needs from the perspective of health care providers. Further, this study has partially addressed the idea of integrating spirituality in the bio-psychosocial model of care by developing a Spiritual Distress

Assessment Tool to help health care workers identify the unmet spiritual needs of older adults. The researchers have also clarified that the use of the tool is contingent on the health care workers' training and experience (Monod et al., 2010a). However, the study makes no attempt to explain how these unmet spiritual needs can be addressed, and who is responsible for it. In other words, the spiritual care aspects have not been dealt with in detail. Furthermore, it cannot be assumed that the older adults, nurses, and caregivers in RCFs will have similar viewpoints about spiritual needs.

In contrast to Monod et al. (2010a), other studies assessed spiritual needs using quantitative approaches (Erichsen & Bussing, 2013; Man-Ging et al., 2015). In these studies, the spiritual needs of older adults were assessed using 29 items Spiritual Needs Questionnaire (SpNQ) with four domains: religious, existential, inner peace, and giving needs. The religious needs included the need for prayer, religious rituals, spiritual books, and devotion to a higher power. Existential needs denoted the need to reflect on past events, find meaning in life, adversity, and to talk about their afterlife concerns. Inner peace needs included the need for interaction with nature, people, to share fear, affection, and attain inner peace. Finally, giving needs indicated the need to contribute something to others in terms of support or knowledge gained from experiences (Erichsen & Bussing, 2013; Man-Ging et al., 2015). The study conducted by Man-Ging et al. (2015) revealed that religious and existential needs are the most important spiritual needs for 100 older adults (24 Male, 76 Female) aged 65 years and over living in nine RCFs in Germany, followed by inner peace and giving needs. In contrast to this finding, another study conducted with 100 older adults (18 Male, 82 Female) aged 65 years and over living in 12 RCFs in Germany found that need for generativity and inner peace was higher than religious and existential needs (Erichsen & Bussing, 2013). These rather contradictory results in two studies may be attributed to the subjective nature of spiritual needs, which is why older adults expressed it differently using diverse dimensions. These two cross-sectional studies contributed to the idea that the spiritual needs of older adults constitute religious, existential, peace, and giving needs. Moreover, the findings of the two studies suggest that spiritual needs are important for older adults living in RCFs. However, by assessing spiritual needs based on the predetermined responses to the questionnaire, these two studies overlook the viewpoint of older adults. The issue

remains how do older adults, nurses, and caregivers express spiritual needs, especially in the context of a RCF.

Other quantitative studies focused on understanding the link between addressing spiritual needs and satisfaction with health care services in hospitalised older adults in the USA (Hodge et al., 2016; Hodge et al., 2013). The findings showed that addressing spiritual needs is positively associated with satisfaction, and health care workers facilitate this link. However, this result was based on a single item Likert scale assessing the degree to which the spiritual needs of older adults has been addressed by the staff. The studies discussed so far do not explain what constitutes spiritual needs in RCFs from the older adults', nurses', or caregivers' perspective. Furthermore, the information on how to incorporate spiritual needs into the care of older adults in RCFs is missing in the studies discussed so far. Little is known how spiritual needs of older adults are addressed in a RCF, who is responsible, and how care should be directed to meet spiritual needs.

2.10.2. Spiritual care

Several qualitative and quantitative studies were conducted to explore the concept of spiritual care of older adults. In a descriptive cross-sectional survey, Wallace and O'Shea (2007) used the Spirituality and Spiritual Care Rating Scale to assess the provision of spiritual care in 26 older adults (7 Male, 19 Female) aged 65 years and over living in RCFs in the USA. Older adults in RCFs considered the role of nurses highly significant in fulfilling spiritual needs and providing spiritual care. The study revealed that the most important spiritual care for the older adults in RCFs were nurses organising a visit with religious people, providing company, giving time, listening and paying attention to their concerns, displaying respect to their spiritual needs, and compassion. Nurses permitting interactions with nature or music time were the least important spiritual care aspects for older adults. These findings must be interpreted with caution because the study is based on a spiritual care rating scale in the Western context, two faith-based RCFs in the USA, and focused only on older adults with chronic illness. Moreover, using self-report surveys do not fully incorporate the voice of older adults, nurses, and caregivers, since they are limited in their ability to fully respond.

Older adults and health care providers can hold differing views about spiritual care. To better understand the concept of spiritual care from the perspective of older adults, Rykkje et al. (2013) carried out a qualitative inquiry among 17 older adults (6 Male, 11 Female) aged 70 years and over living in RCFs and community settings in Norway using a Gadamerian hermeneutics approach. In this seminal study, they reported that older adults delineate spiritual care as having an opportunity to participate in meaningful events such as social, nature, or religion-oriented activities. Also, older adults perceived that spiritual care is about being treated as a whole person with various needs other than physical needs. Likewise, receiving compassionate, respectful treatment and religious support during hard times and at the end of life was also perceived as spiritual care. Most importantly, older adults living in both community and RCFs expected nurses to provide spiritual care. The findings from this study suggested that spiritual care is concerned with fulfilling the spiritual needs of older adults while providing nursing care for them. However, information on how nurses view spiritual care and incorporate it in their practice was missing.

Health care providers' perspective on spiritual care formed the central focus of a study by Blank et al. (2018) in New Zealand. Nurses, chaplains, caregivers, managers, and coordinator of four RCFs described spiritual care as conducting an initial assessment on older adults to collect information about their spiritual needs, enabling religious consultation, participation, family relationship, conducting counselling, and arranging end of life care. These studies highlight the crucial difference in what older adults versus nurses/caregivers perceive as spiritual care. While older adults especially valued nurses as responsible for providing spiritual care, the nurses and caregivers considered their role mainly as facilitators to arrange consultation with religious workers. This discrepancy in the concept of spiritual care among health care providers and the recipient might be attributed to the lack of awareness, education, training, confidence, time, staff, and terminological confusion surrounding religion and spirituality among health care workers (Blank et al., 2018). The differences in viewpoints can lead to unmet spiritual needs or gaps in the spiritual care provision. While conducting a study on spirituality in a RCF, it is important to bear in mind the perspective of older adults, nurses, and caregivers on

spirituality, spiritual needs, or care, differences in viewpoint, and how it impacts the process of maintaining spirituality.

The difference in viewpoints of older adults, nurses, and caregivers on spiritual care is further exemplified in two other studies (Carron & Cumbie, 2011; Wilkes et al., 2011). Carron and Cumbie (2011) conducted a GT study and interviewed five older adults and three family nurse practitioners to better understand spiritual care in a primary health care setting in the USA. Older adults perceived spiritual care as a need for compassion, support, respect, acknowledgment, and personal relationship with nurses. Nurses viewed spiritual care as listening to older adults, conversing with them, and being there for them whenever required. Nurses also perceived that facilitating older adults' support systems such as family, friends, and facilitating them to be involved in spiritual practices are components of spiritual care. However, nurses had problems incorporating spiritual care in practice since they were concerned about upsetting older adults by going too far or creating an uncomfortable environment in a conversation. One thing that was distinctly visible in the findings was that nurses were confused about the meaning of spiritual care and linking it to religion; whereas older adults perceived it as something beyond religion. This confusion in understanding what spiritual care constitutes is consistent in the literature discussed so far. Future research needs to let participants describe the term spiritual needs or spiritual care. Carron and Cumbie (2011) also developed a model, and suggested that providing spiritual care encompasses establishing a nurse-patient relationship, assessing spiritual concerns of older adults, and providing support to fulfil those concerns. However, researchers have suggested that future studies should assess the applicability of this model in settings other than primary health care.

Another study by Wilkes et al. (2011) has shown that older adults living in RCFs and pastoral care workers in Australia perceive spiritual care as establishing a trusting relationship, and pursuing emotional, spiritual, and practical support from that relationship while living in a RCF. Wilkes et al.'s findings were based on interviews with 18 experienced pastoral care workers. However, nurses' and caregivers' perspectives on spiritual care might differ. There is dispute in the literature regarding who is responsible for providing spiritual care to older adults. Some studies have established that pastoral care workers are in an ideal position to provide spiritual care to older adults and they can support the role of health care professionals in providing

holistic care (Wilkes et al., 2011). However, other studies suggest that nurses and caregivers can play a major role in providing spiritual care since older adults consider their relationship with nurses and caregivers as a resource in maintaining spirituality in health care settings (Rykkje et al., 2013). Future research should consider this dispute.

Unlike the studies discussed so far, one article explored the concept of both spiritual needs and care of homebound frail older adults with eight outreach nurses in Canada (Egan & Brisson, 2006). Nurses articulated spiritual needs of older adults in terms of spiritual distress, which denoted the feeling of resentment, neglect, isolation, fear, guilt, and identity concerns. Nurses also reported the spiritual needs of older adults as the need for connection with higher being/s, a meaningful life, and relationship with people. Nurses who were working with homebound frail older adults identified spiritual care as attending to older adults' spiritual distress, providing empathetic care, and arranging referrals as needed (Egan & Brisson, 2006). While the studies discussed previously have shown that older adults were more concerned with the religious or existential aspects of spiritual needs, nurses in this study highlighted the psychological components of spiritual needs such as the need for identity, value, and personal contribution; more than religious, existential, and the social dimensions of spirituality. These findings denote that maintaining spirituality can be challenging if the perception of spiritual needs and care vary among nurses and older adults.

Existing studies have provided information about what constitutes spiritual needs or spiritual care of older adults living in a RCF. Yet, integrated understanding of spiritual practices, needs, and care from the perspective of older adults living in RCFs and nurses and caregivers working there is lacking. For instance, except for three studies (Blank et al., 2018; Carron & Cumbie, 2011; Monod et al., 2010a), all other studies included either the perspective of older adults or nurses or other health care professionals. Similarly, with the exception of Egan and Brisson (2006), other studies focused on either spiritual needs or care. Finally, most of the studies focused on the spiritual needs, concerns, and care of older adults have been conducted in Western countries such as the USA, and Germany, and have utilised a quantitative methodology.

2.11. Evidence on Spirituality of Nepalese Older Adults

In the context of Nepal, only two studies have emphasised the voice of older adults on the topic of spirituality (Bhandari, 2014; Shrestha, 2010). Shrestha (2010) used a mixed methodology to study the QOL of 41 older women aged 60 years and over living in the community and a RCF in Nepal. The study revealed that irrespective of where older adults lived, the main factors essential for their QOL were sustenance (food and shelter), family support, physical health, functionality, religious/ spiritual devotion, end of life rituals and Karmic debt (worry about what will they face afterlife to repay the debt they had incurred during their stay at the RCF). Qualitative data from six older women indicated spiritual faith as a foremost source of comfort in a RCF; however, the focus of the study was on QOL, rather than spirituality. Researcher suggested that how spiritual coping mechanisms are used is still unclear and needs further exploration (Shrestha & Zarit, 2012). Furthermore, the study reflects the perspectives of older women, and a more comprehensive study on spirituality could include older adults of all genders.

In another qualitative study, Bhandari (2014) explored the experiences of six older adults (2 Male, 4 Female) aged 65 years and over residing in RCFs in Nepal using a Gadamerian hermeneutics approach. For these Nepalese residents, positive experiences constituted opportunities to establish social relationships with fellow residents and staff, and involvement in meaningful daily activities such as visiting temples, exercising, doing religious work, relaxing, and weaving sacred cotton threads. Furthermore, being valued and respected, and being positive and optimistic were considered equally necessary for positive experiences in a RCF by these Nepalese residents. This response belonged to those residents who were homeless and maltreated in the family before coming to the RCF. These two studies conducted in Nepal have established that maintaining spirituality, cultural norms, and tradition is crucial in the life of Nepalese older adults living in a RCF. However, these studies does not address the question of how older adults maintain their spirituality in RCFs in Nepal.

2.12. Summary

This chapter has placed the current research in the context of existing discourses in the field of GT methodology, spirituality, and ageing. The first section has explained how I utilised literature review in a way congruent with Corbin and Strauss' variant of GT. Next, the details of search strategies, inclusion, and exclusion criteria of articles were outlined; and the evolved meaning attributed to the term spirituality was highlighted. This chapter has also explained the key disputes on definitions and dimensions of spirituality, and how it has shaped the understanding of the term spirituality in the vast body of literature. The issues surrounding the theoretical approaches to understanding the intersection between spirituality and ageing have been described. It has been argued that spirituality is a fundamental aspect of being human. Spirituality is a subjective, multidimensional, dynamic construct and a vital resource in old age. Moreover, it is argued that how older adults maintain spirituality necessitates attention since they also tend to use ineffective spiritual coping mechanisms. Furthermore, that older adults value the role of health care professionals, mainly nurses, and caregivers, in maintaining spirituality has been demonstrated. Finally, it is claimed that the role of nurses and caregivers can be influential in promoting older adults' positive spiritual practices which, in turn, enhance their overall wellbeing. This review of the literature provided little information on the research question: how do older adults maintain spirituality in RCFs in Nepal? Specifically, there is a dearth of information regarding spiritual needs of Nepalese older adults, and how nurses and caregivers working in RCFs respond to those needs. The following chapter presents the methodology used to answer the research question.

Chapter Three: Methodology

3.1. Introduction

The introduction chapter acknowledged the background information which led to the research question of the study: How do older adults maintain spirituality in RCFs in Nepal? The literature review chapter established that existing literature provides little information about this research question. The next step was deciding the relevant methodology to answer the research question, which is the focus of the current chapter. This chapter begins by presenting evolving paradigms in research, along with different philosophical assumptions within the field of research. What follows is an explanation on how I reached the choice of qualitative research and eventually GT. Then, the origin of GT methodology is specified.

The next section elucidates how GT evolved into different variants, and what are the key differences between different variants, along with their critiques. What follows is the fundamental GT tenets shared between different variants. Next, the choice of Corbin and Strauss' variant is explained, along with its philosophical underpinning of pragmatism and Symbolic Interactionism (SI). The subsequent section will explicate the relevance of Corbin and Strauss' variant in the current study. The chapter concludes by presenting my position within the research.

3.2. Methodology

There are different ways a phenomenon of interest can be approached. In a broad sense, methodology reflects the approach taken by the researcher to study a particular research topic (Silverman, 2013). Crotty (1998) described the term methodology as "the strategy, plan of action, process or design" (p. 3). Similarly, Creswell (2007) framed methodology as the researcher's overall conceptualisation of the research process. In other words, methodology denotes how the researcher will undertake research in order to answer the specific research question. The term methodology is also confused with methods. However, methodology refers to "a set of principles and ideas that inform the design of a research study"; whereas methods are "the practical procedures used to generate and analyse data" (Birks & Mills, 2011, p. 4). In choosing a methodology, Denzin and Lincoln (2003) suggested the researcher ask, "How do we know the world, or gain knowledge of it" (p. 33)? If there was a

standard answer to this question, we would not see researchers using different methodologies to study the same phenomenon. Researchers have diverse views about nature of reality (ontology), ways of knowing (epistemology), and roles of values (axiology) in research (Creswell, 2007). These different ways of looking at the world of research have considerable influence on the researchers' choice of methodology. It is, therefore, reasonable to first discuss the different philosophical assumptions within the field of research, before moving into the choice of methodology.

3.2.1. Evolving paradigms in research: Different philosophical assumptions within the field of research

Every researcher brings their own beliefs, values, and assumptions to the research. These personal beliefs, values, and assumptions are referred to as paradigms, worldviews, or set of beliefs; with paradigm being the most popular (Creswell, 2007; Guba & Lincoln, 1994). Nevertheless, there is considerable confusion surrounding the term paradigm, since scholars use it differently. For instance, Crotty (1998) discussed paradigms under epistemology and theoretical perspectives. However, Denzin and Lincoln (2003) referred to paradigm as "researcher's epistemological, ontological, and methodological premises" (p. 33). Further, Denzin and Lincoln (2011) used the words paradigms, perspectives, or interpretive framework interchangeably. In simple terms, the paradigm can be described as a researcher's stance regarding the nature of the reality and conduct of the research. Different paradigms have been developed in the history of research. Most commonly used paradigms include, but are not limited to, positivism, post-positivism, constructivism, and critical theory (Creswell, 2007; Denzin & Lincoln, 2011; Tashakkori & Teddlie, 1998). The researcher must recognise all the philosophical assumptions within different research paradigms.

Positivism is the paradigm that dominated the field of inquiry in the early 19th century. Positivists claim realism—there is a single, external, objective reality which is fully apprehensible (ontology). Consistent with this ontological assumption, positivists assume objectivist epistemology—researcher and those being researched are independent, and value-free axiology—values of the researcher has no role in inquiry (Guba & Lincoln, 1994). As an implication of all these assumptions in the conduct of the research, positivist researchers use experimental/manipulative

methodology, since they advocate that reality can be captured objectively (Neuman, 2014). In the middle of the 19th century, positivist research came under fire, mainly for ignoring the role of an observer in research (Tashakkori & Teddlie, 1998); and post-positivism emerged in response to the growing disapproval around the assumption of positivism.

The paradigm of post-positivism advanced the assumptions of positivism. The ontological assumption of post-positivism is critical realism—there is an objective reality but it cannot be captured perfectly, as stated by positivism, due to "imperfections in our sensory and intellectual capacities" (Clark, 1993, p. 213). Similarly, post-positivists claim a modified objectivist epistemology—total objectivity is impossible (Clark, 1993). Likewise, post-positivists assume value-laden axiology—values of the researcher has an influence in inquiry (Lincoln & Guba, 1985). It is important to note that proponents of post-positivism express the researcher's influence in a study as undesired but inevitable (Miller, 2005). What this implies for the conduct of the research is that the researcher should work to identify and reduce their bias. Post-positivists use modified experimental/manipulative or can include qualitative methodologies (Guba & Lincoln, 1994). Post-positivist research gained extensive acceptance in the scientific community. However, there were researchers whose philosophical assumptions were fundamentally different to that of positivist and post-positivist paradigms; thus, leading to the development of constructivism.

The assumptions of constructivism are opposite to that of positivism. In contrast to the realism, as claimed by positivists, constructivists maintain relativism. According to Guba and Lincoln (1994), relativism holds that:

> Realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures), and dependent for their form and content on the individual person or groups holding the constructions. (p. 111)

Relativism ontology, suggests that realities are multiple rather than single; constructed rather than discovered; and subjective rather than objective. Also,

relativism accepts the notion that reality is socially-based or social, as mentioned in the above quote. Constructivists, therefore, identify with the notion of social reality. Social reality is "largely what people perceive it to be; it exists as people experience it and assign meaning to it" (Neuman, 2014, p. 104). For constructivists, social reality is fluid since the perception of, or meaning assigned to, a specific object/thing/experience (construction) continuously changes as people interact with others (Neuman, 2014). The researcher working within the paradigm of constructivism must represent "complexities of [participants'] views rather than narrow the meanings into a few categories or ideas" (Creswell, 2007, p. 20). Proponents of constructivism acknowledge the specific socio-cultural context within which the participants live, since it can influence the meaning-making process (Crotty, 1998). Similarly, the epistemology underlying constructivism is subjectivism—researcher and those being researched are inseparable, and axiology is value-bound (Denzin & Lincoln, 2003). Instead of trying to reduce the influence (as argued by post-positivists), constructivists accept that their background or experiences shape how they interpret the meanings the participants have about a phenomenon. Constructivists believe that researchers and those being researched co-create understanding. As an implication of these epistemological assumptions in the conduct of the research, constructivist researchers position themselves within the research by making their personal background and experiences explicit (Creswell, 2007). Accordingly, the methodology used by constructivists is mainly qualitative.

More recently, other paradigms, such as critical theory and its variants, have been developed. Critical theory shares some attributes of constructivism. However, the inquiry aim is mainly transformation, restitution, and emancipation (Guba & Lincoln, 1994), which is outside the scope of the present study; and, therefore, not mentioned in detail. Of all these paradigms, positivism is the foundation exclusive to quantitative methodology. However, the qualitative methodology can be carried out in the spirit of post-positivism, constructivism, and critical paradigms (Ponterotto, 2005; Yilmaz, 2013). The above discussion suggests that different paradigms represent different lenses through which researchers look at the world and which, eventually, shapes the choice of methodology.

3.2.2. Choice of methodology

As a starting point in any study, researchers identify: what do we intend to find about a particular phenomenon? Then, the researcher needs to recognise: what kind of data (quantitative, qualitative, or both) is needed to answer the research question? Quantitative methodology is appropriate when the research question is best answered by numerical data or statistical analysis (Guba & Lincoln, 1994; Hammarberg et al., 2016). Similarly, a quantitative methodology is suitable when the purpose is to explain relationships between the variables of a phenomenon, generalise or predict a phenomenon (Yilmaz, 2013). Alternatively, qualitative methodology is appropriate when the focus is on the qualities, processes, and meanings that cannot be measured quantitatively (Denzin & Lincoln, 2003). In such cases, qualitative data are required to interpret the phenomenon from participants' perspective, as well as within participants' context (Creswell, 2007). Likewise, mixed-methodology is appropriate when the intention is to complement, develop, expand, or triangulate data obtained from a quantitative or qualitative mode of inquiry (Tariq & Woodman, 2013). Each type of research has its strengths and limitations. The point is not about choosing one type over the other; rather, selecting the type which best serves the aim of the research.

In the present study, qualitative methodology aligned best with the nature of the phenomenon of interest and research question. Previous chapters have established that spirituality is a subjective, multidimensional, dynamic phenomenon; and can have multiple meanings or interpretations within and between individuals in a different context. Bearing in mind this complex nature of spirituality, employing a quantitative methodology, based on the predetermined responses from the western evidence, was not congruent for the present study. Accordingly, the research question "how do older adults maintain spirituality in RCFs in Nepal?" required me to explore this complex phenomenon from the perspectives of those who were experiencing it in the socio-culturally and linguistically diverse context of Nepal. I chose a qualitative methodology since it enables the researchers to obtain insight into the complexities of the phenomenon of interest, as perceived by the participants, in a particular context, and over time (Creswell, 2007; Ponterotto, 2005). Furthermore, the aim of the research required me to generate a theory in an area where little

evidence is available; rather than testing existing theories, as in the case of quantitative methodology. As a result, using a positivist paradigm would not do justice to the aim of the present study. In this way, at a most fundamental level, qualitative methodology became the overarching framework of the current study. The next step was choosing from a diverse range of approaches within a broad qualitative methodology.

Qualitative methodology is inclusive of various approaches/designs/types, the most popular being narrative, phenomenology, GT, ethnography, and case-study (Creswell, 2007; Denzin & Lincoln, 1998). Choosing an appropriate approach rests upon the aim of the research. The narrative approach would be preferred when the emphasis of the research is to explore the life stories of individuals; however, if the researcher is aiming to understand the essence of a lived phenomenon, a phenomenological approach would be the best fit (Creswell, 2007). A researcher would choose GT when the focus is on understanding the process underlying a phenomenon, and ultimately develop a theory that is grounded in the data (Mills & Birks, 2014). Likewise, ethnography would be preferred if the research aim is to describe and interpret the shared patterns of culture within a group of individuals. Ethnography aims for thick descriptions of the cultural meanings of the phenomenon to be studied (Merriam & Tisdell, 2016). Lastly, the case-study approach is selected when the purpose of the research is to explore an issue or problem in a bounded system/s over time, within specific contexts, using a case/s as a particular example (Creswell, 2007; Harrison et al., 2017). Here, a case may involve one individual, group, incident, event, or programme. Case-study design aims for in-depth case-description, which is based on the extensive sources of data collection (Creswell, 2007). Of all these approaches, GT suited the aim of my research.

The aim of the present study was to provide a theoretical explanation of how older adults maintain spirituality in RCFs in Nepal. Here, "how" was concerned with the process that is involved in maintaining spirituality. Allowing for the unique socio-cultural context of Nepalese older adults, I wanted to use a qualitative approach that recognises the evolving complexities of the participants' strategies that are involved in the process of maintaining spirituality. GT was the ideal choice for the study since the main intent of GT is to provide a rich theoretical explanation of the process

underlying a phenomenon of interest (Denzin & Lincoln, 1998). Process, in GT, as stated by Corbin and Strauss (2008), refers to "sequences of action/interactions/emotions changing in response to sets of circumstances, events or situations" (p. 98). In other words, GT investigates what is actually going on in a particular field (Glaser, 1998). Furthermore, GT is used when little is known about the area of study, or there is no theory to explain that phenomenon, as in the case of the present study (Stern, 1980). The literature review chapter and published integrative review clearly show the gap in the current literature regarding spirituality in Nepalese older adults living in RCFs (Gautam et al., 2019). Moreover, GT provides the opportunity to explicate "a phenomenon from the perspectives and in the context of those who experience it" (Birks & Mills, 2011, p. 16). In this way, after reading the seminal work of Glaser and Strauss (1967), Corbin and Strauss (2008), Charmaz (2006), and with supervisors' support, I was convinced that GT was the ideal methodology for the present study. The section below will explain the details of GT, the chosen methodology.

3.3. Origin of GT: Situating GT in an Historical Context

Qualitative research has been positioned within five moments in the history of research. According to Denzin and Lincoln (1994), these five moments are the traditional period (1900s-1950s), modernist phase (1950s-1970s), blurred genres (1970s-1986s), crisis of representation (1986s-1990s), and post-modern period (1990s-present). GT was developed by two sociologists Barney Glaser and Anselm Strauss, in 1967, within the modernist phase. Glaser and Strauss published the first-ever GT study in the book named *Awareness of Dying* (Glaser & Strauss, 1965). In this book, Glaser and Strauss (1965) explained in detail their research on dying patients in San Francisco hospitals, and the theory of awareness contexts. Two years later, they published *The discovery of grounded theory*; providing the details of the methodological premises of how a theory can be developed from data (Glaser & Strauss, 1967). Glaser and Strauss (1967) titled this novel methodology as GT, and explained how "the discovery of theory from data–systematically obtained and analysed in social research–can be furthered" (p. 1). The development of GT, as stated by Glaser and Strauss (1967), was in response to the need to fill a prominent gap between theory and research that was, evident in an era where the emphasis of

social research was mainly on testing existing theories (Charmaz, 2008). Glaser and Strauss, therefore, advocated that the foundation of theory development should rest on the data obtained from empirical research. However, in the 1960s, qualitative research was criticised for being unsystematic, or restricted to description. Glaser and Strauss challenged those criticisms by developing a new way of doing qualitative research. From his quantitative training at Columbia University, Glaser brought into GT a systematic way of analysing qualitative data (Kenny & Fourie, 2014). Similarly, from his training in SI informed by pragmatist philosophy (details will be discussed later), Strauss made "the study of process, action, and meaning" explicit in GT (Charmaz, 2003, p. 253). Exclusive to GT were multiple new ideas, such as concurrent data collection and analysis, theoretical sampling, theoretical sensitivity, coding, constant comparison, theoretical saturation, and memo writing (to be discussed later) (Glaser & Strauss, 1967). Glaser and Strauss provided a detailed explanation of how qualitative research can generate a theory, with the aim of explaining why and how of a phenomenon. In this way, GT became a significant innovation in the modernist phase of qualitative research.

3.4. Evolution of GT and Major Debates

Since its inception, GT has evolved, and continues to do so. Following, their co-authored seminal text, *The discovery of grounded theory*, Glaser and Strauss began publishing separately (Corbin & Strauss, 2008, 2015; Glaser, 1978, 1998, 2002a, 2002b; Glaser & Holton, 2004; Strauss, 1987; Strauss & Corbin, 1997, 1998). Glaser and Strauss had different views about the ways of working with data, which made it difficult for them to continue to work together. The main reason underpinning their divergent views was their different educational, as well as philosophical, background. Glaser had rigorous quantitative training, whereas Strauss' background was in pragmatism and SI (Corbin & Strauss, 2015). It is also important to note that Strauss passed away in 1996, and it was Juliet Corbin, a nurse, who carried the legacy of Strauss. Since Glaser maintained the original concept of GT as stated in *The discovery of grounded theory*, his approach to GT is termed as classic GT. In contrast, Strauss evolved from his original writing according to contemporary thinking and, therefore, his approach is termed as Straussian/Corbin and Strauss' GT (Annells, 1997; Mills & Birks, 2014). The classic and Corbin and Strauss' GT

approaches differ mainly in relation to the underlying philosophy, role of the literature review, position of the researcher, coding, and research outcome (Cooney, 2010; Mills & Birks, 2014; O'Connor et al., 2018). The next section presents both sides of the major debate in the field between classic and Corbin and Strauss' GT.

3.4.1. Underlying philosophy

The underlying philosophy is the most debated topic between classic and Corbin and Strauss' GT. The divergence between classic and Corbin and Strauss' GT, led to an extensive and ongoing discussion among GT scholars. The major critique of the GT methodology, as a whole, is that the ontology and epistemology underlying the methodology was not mentioned explicitly by Glaser and Strauss in their first text (Mills & Birks, 2014; Urquhart, 2013). Glaser has published much about how a classic GT is to be performed; yet, not about the philosophy that underpins the methodology (Glaser, 1978, 1992, 1998; Glaser & Holton, 2005). Strauss and Corbin (1998) mentioned pragmatism and SI. In 2008, Corbin explained details of pragmatism and SI as the underlying philosophy of the Corbin and Strauss' GT (Corbin & Strauss, 2008). Most of the epistemological debates on GT are, therefore, based on the interpretation of individual researchers. For instance, classic GT has been claimed as lying within positivist (Bryant & Charmaz, 2007; Charmaz, 2000; McCann & Clark, 2003) and post-positivist paradigms (Annells, 1997; O'Connor et al., 2018; Ward et al., 2015). Similarly, Corbin and Strauss' GT has been attested as lying within positivist (McCann & Clark, 2003), post-positivist (Charmaz, 2000; Cooney, 2010), leaning to a constructivist paradigm (Annells, 1997; Charmaz, 2006; McCann & Clark, 2003; Ward et al., 2015). These debates are conflicting and confusing.

In my view, the researcher is part of the research and not an objective bystander. Glaser has consistently maintained that theory will emerge without the researcher's influence, which suggests that there is an objective reality which can be captured if the researcher maintains an objective stance; a perspective very close to the positivist paradigm (Guba & Lincoln, 1994). In earlier writings, Corbin and Strauss (1990) mentioned that coding procedures help to "break through subjectivity and bias" (p. 13); "objectivity is necessary to arrive at an impartial and accurate interpretation of events" (Strauss & Corbin, 1998, p. 42); and attaining "complete objectivity is

impossible" (Strauss & Corbin, 1998, p. 43). The words such as impartial or accurate interpretation resemble the notion of a post-positivist paradigm; that there is an objective reality, even though we cannot capture it fully, and it is impossible to maintain an objective stance. However, in recent writings, it is mentioned that there is no objective reality; instead, multiple realities exist (Corbin & Strauss, 2015). Furthermore, Corbin and Strauss (2015) contended that it is sensitivity that the qualitative researcher aims for rather than objectivity; revealing how Corbin and Strauss' GT has shifted with time.

The divergence and debates in GT are the results of the changing ways of thinking in the scientific community. GT developed in the modernist phase (1950s-1970s) where post-positivist thinking was dominant among qualitative researchers (Birks & Mills, 2011). This explains why earlier grounded theorists were still concerned with the notion of objective reality. Then, during the blurred genres (1970s-1986s) and the crisis of representation (1986s-1990s), the main concern of researchers was how to position self in the research (Annells, 1997; Denzin & Lincoln, 1994). Constructivism became a dominant school of thought during this period (Ralph et al., 2015). Influenced by constructivist thinking, Kathy Charmaz, a former student of Glaser and Strauss, developed a new variant of GT called constructivist GT (Charmaz, 2000; Charmaz, 2003, 2006). Charmaz positioned GT within the relativist ontology—there are multiple realities and subjectivist epistemology—researcher and those being researched co-create knowledge (Charmaz, 2014; Denzin & Lincoln, 2003; Guba & Lincoln, 1994). However, in 2002, Glaser published an article, in response to Charmaz's interpretation of objectivist and constructivist GT, and explained that constructivist is a misleading term and GT is not constructivist (Charmaz, 2000; Glaser, 2002b). Glaser's main argument was that constructivist GT would lead to the descriptive "story talk" rather than explanation. The increased emphasis on adding researcher's interpretation in theory co-construction can outshine the participant's voice, which is unwanted imposition (Glaser, 2002b). However, Corbin and Strauss (2015) showed agreement with Charmaz's constructivist viewpoint. The debates in GT revolve around how to best represent the voice of the research participants, a key idea in the third and fourth phases in qualitative research. In the post-modern period (1990s-present), the crisis of representation and legitimacy

of knowledge continues (Annells, 1997; Guba & Lincoln, 1994). With the changing ways of thinking among researchers, debates in GT continue.

3.4.2. Role of the literature review in GT

The role of the literature review in classic and Corbin and Strauss' GT is another debated topic. Glaser maintains that before a study, literature review around the area of inquiry should be avoided because it can "force" existing ideas or concepts into the theory (Glaser, 1978; Glaser & Strauss, 1967). Accordingly, Glaser (1978) recommended literature review only after the analysis is complete, in order to integrate the (emerged) theory into existing literature or theories. The beginning point of the study, for Glaser, is the broad area of interest rather than research problem since he believed that concerns of the participants will eventually "emerge" from the data (Annells, 1997; Glaser, 1992; Glaser & Holton, 2004). Strauss initially agreed with Glaser about delaying literature review (Glaser & Strauss, 1967); however, his view changed. Strauss and Corbin (1998) argued that delaying literature review is impractical since researchers will have knowledge of the literature around the field of inquiry through their education, and work experience. The existing knowledge cannot be removed from the researcher. Instead, it can be used to enhance theoretical sensitivity, which means the capacity to grasp subtle information or signals in the data (Corbin & Strauss, 2008). Accordingly, they argued the literature review can be conducted at the beginning of the study to help develop the research question; identify what is already known about the area of interest, and what requires more research; develop initial interview questions (which can change as the research progress); and satisfy the requirement of ethics committee (Corbin & Strauss, 2008, 2015). A literature review is also conducted after completing the analysis to discuss the developed theory within the context of existing literature or theories (Corbin & Strauss, 2015). What is common to both classic and Corbin and Strauss' GT is integrating the theory into existing knowledge.

3.4.3. Position of the researcher in GT

The next topic of dispute between classic and Corbin and Strauss' GT is concerned with the position of the researcher in GT. Glaser claimed that theory can be generated from the data, without the influence of the researcher, provided his

recommended analytic process is followed (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967). For Glaser (2002b), "a researcher's personal predilection biases the data" (p. 4). The researcher should, therefore, focus on the pattern in the data; rather than their own interpretation of the data, which is an "unwanted intrusion" (Glaser, 2002b, p. 3). While Glaser disregarded the interpretation of the researcher, Strauss and Corbin acknowledged it. According to Strauss and Corbin (1998), analysis in GT is "the interplay between the researcher and data" (p. 13). The researcher brings to the research the personal assumptions through their personal, educational, and professional background (Strauss & Corbin, 1998). Instead of ignoring these personal assumptions, as put forward by Glaser, Corbin and Strauss recommended that the researcher should be aware, and sensitive to, their assumptions during interview and analysis. Being sensitive means continually questioning the data to determine what the participants are actually trying to say and understanding that any interpretation made about the data is provisional unless reinforced by additional data or confirmed with participants (Corbin & Strauss, 2015). Strategies to enhance theoretical sensitivity would be writing reflexive memos throughout the research process, questioning data, making comparisons, looking for the negative case, or thinking about the different meanings of a word (Corbin & Strauss, 2015). Corbin and Strauss accept that researchers should maintain a certain distance in order to think critically about what is happening in the data (Corbin & Strauss, 2008, 2015). In this way, classic and Corbin and Strauss' GT hold different views about the position of the researcher's voice in GT.

3.4.4. Coding

Classic and Corbin and Strauss' GT also vary in terms of coding. Coding is about identifying concepts, sub-categories, and categories from the data. The concept is the basic unit of analysis. As the concepts start accumulating, they are grouped under more abstract concepts called sub-categories, which are again developed and abstracted into categories (Birks & Mills, 2011; Charmaz, 2014; Glaser, 1998; Strauss & Corbin, 1998). Glaser (1992) suggested two types of coding; namely, substantive coding (open and selective) and theoretical coding. In contrast, Corbin and Strauss (2008) recommended open, axial, and selective coding. Although the terminologies used such as open and selective coding match between classic and

Corbin and Strauss' GT, the underlying meaning varies. In classic GT, open coding is described as breaking down the data initially for the emergence of a core category and related concepts; whereas the aim of selective coding is to theoretically saturate the concepts (Holton, 2010). Theoretical coding involves relating substantive categories to the core category (Glaser & Holton, 2005). In the case of Corbin and Strauss' GT, open coding requires fracturing data to identify concepts, categories, their properties, and dimensions. Properties refer to "characteristics that define and describe concepts," and dimensions denote "variations within properties" (Corbin & Strauss, 2015, p. 220). Axial coding refers to coding taking into account the context, conditions, actions-interactions, and consequences around the categories. Finally, selective coding involves refining and integrating the categories into a theory (Corbin & Strauss, 2008, 2015; Strauss & Corbin, 1998). Glaser (2002a) argued that the set of coding procedures developed by Strauss and Corbin force descriptions rather than abstraction by contextualising it. However, Strauss and Corbin (1998) maintained the coding procedures are not meant to be used as a strict guideline; rather as an analytic tool, which can help researcher think critically about the data. Irrespective of the confusing coding terminologies and meaning proposed by different grounded theorists, Mills and Birks (2014) summarised that the core idea is the level of analysis involved in each phase. Therefore, initial, intermediate, and advanced coding applies to both classic and Corbin and Strauss' GT (Chun Tie et al., 2019).

3.4.5. Research outcome

The research outcome is another contested topic between classic and Corbin and Strauss' GT. The goal of theory "generation" in classic GT and theory "development" in Corbin and Strauss' GT varies (Annells, 1997). Classic GT refers to theory as a "set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area" (Glaser & Holton, 2004, p. 3). This definition places a conceptual hypothesis at the centre of the theory, which is stated to emerge from the data. Glaser upholds that GT is inductive in a sense that concepts are generated from the data (Cooney, 2010). However, classic GT does not consider the researcher's insight into concepts and their relationship during analysis (deduction). The logic in classic GT is that the researcher's preconceived insights, although appealing, are avoided, even if recorded in memos (Glaser, 1992). Glaser

considered researchers' ideas as bias. Strauss and Corbin (1998) argued that there is an interplay of both induction and deduction in GT. Concepts are derived from the raw data (induction); yet, they also represent the interpreted meaning of the data (part of researcher's insight). Instead of suspending insight (as in classic GT), in Corbin and Strauss' GT, the researcher's insight about concepts or relationships between concepts is documented in memos and continuously questioned, compared, and confirmed against the data (Corbin & Strauss, 2008, 2015; Heath & Cowley, 2004). The research outcome in Corbin and Strauss' (2015) GT is "a set of well-developed categories… that are systematically developed in terms of their properties and dimensions and interrelated through statements of relationship to form a theoretical framework that explains something about a phenomenon" (p. 62). It is clear from the above discussion that the research outcome varies between classic and Corbin and Strauss' GT, which is why the ways of arriving at that outcome differ.

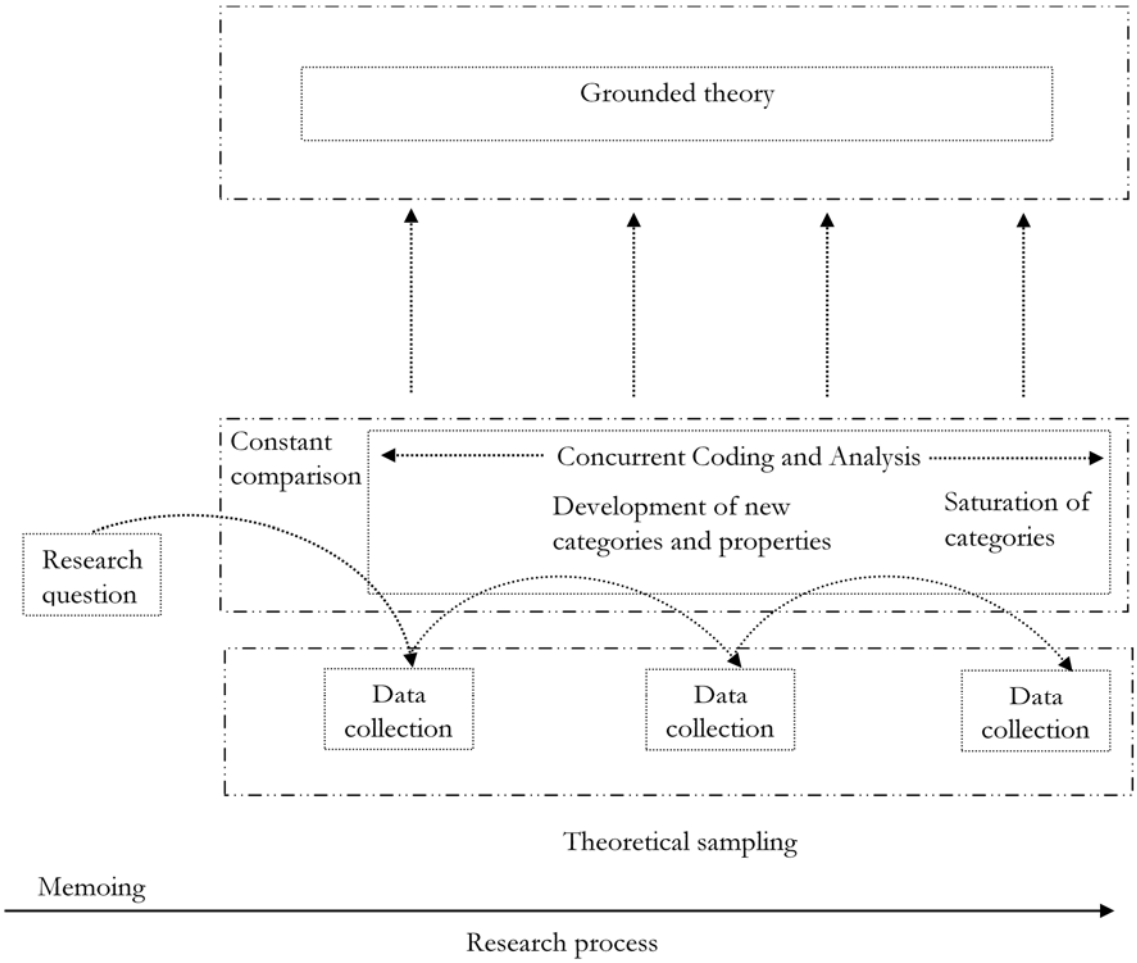
To summarise the major debates in GT, there is no right or wrong way, just a different way of conducting a GT study. Some scholars support classic GT (Evans, 2013; Holton, 2010; O'Connor et al., 2018); some identify with Corbin and Strauss' GT (Annells, 1997; Baldwin et al., 2015; Cooney, 2010; Kim & Hocking, 2018; McCann & Clark, 2003); whereas others follow constructivist GT (Ward et al., 2018). The question, then, is what informs the choice of an appropriate variant for a GT study? The researcher should choose the variant which is congruent with their personal philosophy, research question, aim, and level of expertise (Annells, 1997; Cooney, 2010; Corbin & Strauss, 2015; Mills & Birks, 2014). It is then important to ensure that the chosen methodology permeates the conduct of the whole study. For instance, the timing of the literature review, researcher's positioning in research, and coding procedures employed should be in consensus with the chosen approach.

3.5. Fundamental GT Tenets Shared between Different Variants: Convergence

Different variants of GT recommend different ways of carrying out a study. Nevertheless, the variants share fundamental GT tenets such as theoretical sampling, concurrent data collection and analysis, coding, constant comparative analysis and memo writing (Charmaz, 2000, 2014; Corbin & Strauss, 1990, 2008, 2015; Glaser, 1998; Strauss & Corbin, 1998). Figure 3.1 (p. 69) depicts how these tenets operate in GT.

Figure 3.1

Fundamental GT Tenets (adapted from Wagner, Lukassen, & Mahlendorf, 2010).



A GT study begins with the broad research question to enable the researcher to explore all aspects of the phenomenon. A broad research question requires a certain direction to keep the researcher focused on the aim of the study and fulfil the ethical requirements of conducting research (Birks & Mills, 2011; Smith & Biley, 1997; Stern & Porr, 2011). The initial research questions are not meant to be used as a fixed guideline. As GT is an emergent research design, the questions change and become more focused on developing concepts as the research progress (Corbin & Strauss, 1990). Figure 3.1 illustrates this idea using dashed bent arrows between the research question and data collection.

Multiple sources of data collection can be utilised in GT. Most commonly, grounded theorists collect data through in-depth interviews and observations (Charmaz, 2000; Corbin & Strauss, 2008; Glaser, 1998). Generating data from different sources, such as interviews and observations within interviews, increases the credibility of the findings in GT (Sikolia et al., 2013). One of the unique characteristics of GT is concurrent data collection and analysis, and the data collection is driven by theoretical sampling. The wide gapped dashed line between data collection and analysis shows this process in Figure 3.1. Theoretical sampling starts in the substantive field of interest, with people considered experts, and follows the developing concepts. The researcher selects places, persons, and situations which will facilitate discovering more about the phenomenon under scrutiny (Charmaz, 2014; Corbin & Strauss, 2008; Glaser, 1998). In other words, theoretical sampling is "seeking pertinent data to develop emerging theory" (Charmaz, 2014, p. 193). Indeed, theoretical sampling is vital in GT to increase the credibility of the theory (Breckenridge & Jones, 2009). Data analysis begins immediately after initial interviews.

Data analysis includes the process of coding and constant comparative analysis—methods distinct to GT. Different grounded theorists delineate various ways of coding. Simply put, initial coding involves breaking the data into segments, labelling it, and grouping it into categories. Intermediate coding encompasses exploring the relationships between categories, and advanced coding is about theoretical integration of categories (Mills & Birks, 2014). The constant comparative analysis is another unique feature of GT, where new data are always compared with the developing concepts, sub-categories, categories for similarities and differences (Morse et al., 2009; Urquhart, 2013). Data collection ends when categories are saturated.

The whole process of theory development is continuously guided by memoing. Memoing is the process of documenting ideas about concepts, relationships between the concepts/categories, and analytical decisions made throughout the period of research (Charmaz, 2006; Corbin & Strauss, 2008; Glaser, 1998). Indeed, memoing is very important for developing the researchers' reflective processes, analytic thinking, and methodological decisions which are required when the research design

is emergent—as is the case with GT. The main product of GT is the substantive theory. A substantive theory provides a comprehensive explanation of the process associated with that particular phenomenon situated in a particular context (Creswell, 2007). In this way, all the variants of GT converge on the fundamental GT tenets.

3.6. Choice of GT Variant: Corbin and Strauss' GT

In deciding GT as a methodology, I read generally around the available variants of GT. Then, according to my supervisors' suggestion, I started reading in detail the seminal texts of the classic, Corbin and Strauss', and constructivist GT. The remaining variants did not fit my research aim. Being a novice researcher, with positivist nursing training, it was challenging to grapple with the depth of the philosophical underpinnings of GT. Most of the writing required me to read it multiple times to grasp the actual meaning. However, when I started reading Corbin and Strauss' GT (Corbin & Strauss, 2008, 2015; Strauss & Corbin, 1990, 1998), I could relate to the sociological perspective of SI informed by pragmatist philosophy (Blumer, 1969; Charon, 1995; Corbin & Strauss, 2008; Morgan, 2014). Then, I started reading around pragmatism and SI.

3.6.1. The philosophical underpinning of Corbin and Strauss' GT: Pragmatism and SI

The philosophical underpinning of Corbin and Strauss' GT arises from pragmatism and SI (Chamberlain-Salaun et al., 2013; Corbin & Strauss, 2008, 2015). Pragmatism is a philosophy of knowledge. Charles Peirce was the first to introduce the principle of pragmatism: beliefs are rules of our actions (James, 1907). John Dewey was the leading proponent who advanced the philosophy of pragmatism (Murray, 2014). As the word suggests, actions of the individuals are central in pragmatism, triggered by problems surrounding the individuals, and directed towards solving those problems. For a pragmatist, "knowledge is not about an abstract relationship between the knower and the known; instead, there is an active process of inquiry that creates a continual back-and-forth movement between beliefs and actions" (Morgan, 2014, p. 1049). According to pragmatists, reality is multiple, constantly changing in the dynamic world; and knowledge is produced through continuous action and interaction of self-reflective beings (Corbin & Strauss, 2008;

Murray, 2014; Shalin, 1986). Pragmatism supports that actions are the basis of knowledge.

SI, informed by pragmatist thought, has significantly influenced the underpinnings of Corbin and Strauss' GT. SI is a theory of human behaviour developed by George Herbert Mead (Crotty, 1998). The term SI was coined by Blumer (1969) who further delineated three premises in which SI is based:

> The first premise is that human beings act toward things on the basis of the meanings that the things have for them… The second premise is that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows. The third premise is that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (p. 2)

SI views individuals as active participants in social life, who establish meanings, act according to meanings, interpret others' actions, and modifies one's action and meanings according to that interpretation (Charon, 1995; Holloway & Wheeler, 2010). Meanings are often expressed in symbols such as words, religious objects, and clothing shared by the social group. Additionally, individuals' meanings change as their situation changes. These redefined meanings, in turn, guide new actions (Burns & Grove, 2007). Central to SI are the interactions within or between the individuals in a group. Interactions show what is going on in a particular context. For a symbolic interactionist, the reality is social, constantly changing, and knowledge is produced through interactions within ourselves and others (Charon, 1995; Shalin, 1986). As Corbin and Strauss' GT derived assumptions from both pragmatism and SI, the focus of GT is to understand the process of how people establish meanings, interpret, interact, and take actions while they are solving issues relevant to their context. After reading about pragmatism and SI, I returned to the previous writing of Strauss and Corbin, reread it, discussed with supervisors, and finally could apprehend the philosophical idea and decide that Corbin and Strauss' GT was the best fit for my study.

3.6.2. The relevance of Corbin and Strauss' GT in the current study: Looking through my SI lens

Corbin and Strauss' GT fitted both the aim of my study, which was to provide a theoretical explanation of how older adults maintain spirituality in RCFs, and my personal philosophy. The main focus of Corbin and Strauss' GT, underpinned by pragmatism and SI, is on "meanings given to events and the actions/interactions/emotions expressed in response, along with the context in which those responses and the events occur" (Corbin & Strauss, 2015, p. 25). I assume that maintaining spirituality itself could mean different things to different older adults. Furthermore, in maintaining spirituality, older adults could assign different meaning to events occurring inside RCFs, act/interact/emote differently, within a variety of contexts, which is influenced by their personal history or background (ethnicity, culture, etc.). These multiple assigned meanings represent reality (Corbin & Strauss, 2008). The researcher using Corbin and Strauss' GT is required to be open to multiple complex viewpoints of the participants, which suited the aim of my study. Also, spirituality of older adults has not been examined exclusively in the context of Nepal. Corbin and Strauss (2015) suggest obtaining multiple perspectives on an event adds variation in the analysis. Collecting data from residents, nurses, and caregivers could help to obtain varied meaning of the same concepts and categories. Moreover, it was important to consider cultural meanings and symbols shared by a group of Nepalese residents together with the conditions which could influence their actions and interactions within the RCF. Corbin and Strauss' approach to GT, informed by SI, addresses the importance of assessing these shared meanings and symbols, which could ultimately help to understand the pattern of social behaviour of Nepalese residents within the RCF.

Corbin and Strauss' GT also suited my level of expertise. I valued the coding guidelines provided by Strauss and Corbin. Although, the systematic guidelines prescribed by Strauss and Corbin have been criticised for being too rigid (Charmaz, 2000; Glaser, 1998), these specific guidelines, used analytically, are considered important to maintain rigour in GT and credibility of the research (Birks & Mills, 2011). Furthermore, Strauss and Corbin (1998) have mentioned that the process of GT is not prescriptive. There is room for flexibility according to the situation; hence,

making it suitable for novice researchers learning GT (Annells, 1997; Cooney, 2010; Corbin & Strauss, 1990; Creswell, 2007; Strauss & Corbin, 1998). In this way, with the help of my supervisors, I chose Corbin and Strauss' GT for the study, which was congruent with my research aim, personal philosophy, and level of expertise.

3.7. Positioning Myself within the Research

In the choice of my research question, how do older adults maintain spirituality in RCFs in Nepal, spirituality of older adults living in RCFs is my area of concern. Being a nursing student trained in Nepal, a RN teaching gerontology, and a volunteer working for ageing issues, it was impractical to embark on a GT study detached from my knowledge and experience. I acknowledge that I expected participants to have challenges while maintaining spirituality. However, the main concern was in understanding how participants strategise to move through the challenges and what consequences resulted under different conditions.

Regarding my position within the research, I chose Corbin and Strauss' (2015) suggestion on how to clearly use self-voice to increase sensitivity to data. I positioned myself as a researcher ready to "take the role of the other—walk, so to speak, in that other person's shoes—and try to discern the meaning of words and actions of participants" (Corbin & Strauss, 2015, p. 78). I recognise that taking this position required being explicit from the very beginning of the study about my personal assumptions regarding the study area. My supervisors conducted and recorded a pre-suppositions interview at the beginning of the study, which enabled me to be sensitive to my assumptions. Self-reflections have been made explicit, such as maintaining a reflexive memo throughout the research, writing down whenever research disturbed me, staying close to the excerpts when naming the concepts, sub-categories, categories or core category, discussing concepts with supervisors and colleagues to identify anything that might not be present in the data and potentially imposed, and member-checking with participants whether or not their concerns were covered (Corbin & Strauss, 2008, 2015). I used my self-voice as an insight continuously checked with participants or data.

3.8. Summary

This chapter has delineated the methodological decisions I took in the planning of this study. Different paradigms and their evolution have been presented as a foundation to start the philosophical discussion. Positivism, post-positivism, and constructivism are described in detail. The rationale for choosing qualitative research and GT, instead of other possible methodologies, was presented. I chose a qualitative methodology to explore spirituality, a complex phenomenon. Similarly, GT was chosen for its ability to provide a theoretical explanation of how older adults maintain spirituality in RCFs in Nepal. The GT methodology was been expanded in detail, including its origin, evolution, and key disputes; and the influence of a dominant school of thought on the philosophical debates of GT have been explicated. It is argued that there is no right or wrong variants, just different GT variants. Along with the differences, what unifies different variants of GT, such as theoretical sampling, concurrent data collection and analysis, coding, constant comparative analysis, and memo writing was highlighted with the help of a simple diagram (Figure 3.1). This chapter has also explained the pathway to the choice of Corbin and Strauss' GT. The underlying philosophical assumption of pragmatism and SI was also described. It was argued how Corbin and Strauss' GT is congruent with my research aim, level of expertise, and my philosophical lens of SI. Finally, I have positioned myself within the research by explaining my role in the research and how I managed my voice in the research process. It was claimed that the perspectives of participants will be presented through my SI lens, and self-reflection will be practiced through the entire course of the study. Consistent with these methodological decisions, the following chapter will present the methods used to gather and analyse data.

Chapter Four: Methods

4.1 Introduction

The purpose of this chapter is to describe the methods used to gather and analyse data. This chapter begins by introducing the study setting; following which, I provide a brief overview of the sampling technique used in GT. I then describe the participant recruitment. The next sections deal with data collection techniques and procedures before the details of the data analysis technique and procedure are explained. A working example of analysis from the open coding to selective coding is provided using raw data. The next section will delineate the research ethics considered through the course of the study. The chapter concludes by presenting the steps employed to ensure the trustworthiness of this GT study.

4.2. Study Setting

This study was undertaken in two RCFs situated in Kathmandu, the capital and largest city of Nepal, with approximately 1.5 million people. The two RCFs were chosen after consulting with Ageing Nepal, a not-for-profit NGO working for the rights of older adults in Nepal. This organisation is registered with the Government of Nepal and affiliated to the Social Welfare Council. Ageing Nepal has been involved in several projects focusing on older adults residing in RCFs. The authorities of Ageing Nepal recommended collecting data from both RCF 1 and 2. The context of RCF 1 and 2 is different; hence, including these two settings in a study was important to gain a variety of perspectives about spirituality in RCFs (Sikolia et al., 2013). Details of the two RCFs are presented in chapter five to provide the background for understanding the study findings.

4.3. Sampling Technique

Consistent with GT methodology, theoretical sampling was followed. Theoretical sampling begins with people who are best related to the area of study or considered experts in the field of interest and continues according to the developing concepts. At first, I conducted interviews with two residents who volunteered to participate in the study and met the eligibility criteria. This initial sampling in a GT study has also been termed as purposive or selective sampling (Corbin & Strauss, 2008). After analysing the initial interviews, the selection of additional participants was based on

the developing analytic concepts that guided the ongoing theoretical sampling (Strauss & Corbin, 1998). In theoretical sampling, the researcher selects places, persons, and situations that might help to best answer the question (Corbin & Strauss, 2008). As theoretical sampling progressed, the questions became more theoretically focused on the link between the developing concepts, sub-categories, or categories. A detailed example of theoretical sampling is provided in the data analysis section since it begins after the initial data analysis.

4.4. Recruitment of Participants

Considering the low literacy rate of Nepalese older adults, I conducted a brief information session (in the Nepali language) in the selected RCFs, where all residents, nurses, and caregivers received a verbal explanation about the study. Residents and caregivers willing to participate in the study received a copy of the participants' information sheet and consent form (Appendices B-D) translated into Nepali from English. Those participants who could not read received a verbal explanation of the participants' information sheet and consent form. Similarly, nurses willing to participate received copies (both in English and Nepali language) of the participants' information sheet and consent form. I obtained written consent prior to interviewing participants, and verbal consent before any follow-up interviews. Participants either signed or provided their thumbprint on the consent form.

The residents were eligible to participate in the study if they were aged 60 years and over and had lived in the RCF for at least 6 months. Evidence shows that older adults usually require at least 6 months to come to terms with living in a RCF (Ellis, 2010). Older adults who have recently started living in a RCF would not be able to provide sufficient explanation about the strategies they use to maintain spirituality in a RCF. The study excluded residents living with cognitive impairment or who were having an acute episode of ill health according to the medical record as the methodological approach used and available time were not suitable to elicit their perceptions. Similarly, the RNs and formal caregivers were eligible to participate in the study if they had worked in the RCF for at least 6 months.

It was previously anticipated that up to 30 participants would be sufficient; a requirement in the ethical application and typical for qualitative studies using GT (Creswell, 2007). However, it was clearly mentioned in the ethics application that in

GT the sampling would continue until the concepts and categories are saturated. Hence, the number of participants being recruited was not fixed in advance. In GT, the sample size is not the focus of sampling, since generalisability is not pursued (O'Reilly & Parker, 2012); instead, "it is concepts that are being sampled" (Corbin & Strauss, 2008, p. 139). The depth and integration of the developed concepts and categories determine whether the sample size is enough to answer the research question (Morse, 2000). Once the concepts and categories were saturated the recruitment was ceased. Eventually, the total number of participants recruited was 24 (17 residents, 3 nurses, and 4 caregivers). Tables 4.1 (p. 79) and 4.2 (p. 80) provide details of the recruited participants.

Eleven female and six male residents participated in the study. The age of the residents ranged from 60-103 years. The majority of participants were illiterate and followed the Hindu religion. Eight participants were married, seven had lost their partner, and two were unmarried. Nine residents had children. The duration of stay in the RCF ranged from six months to 21 years. All nurses and caregivers were female, followed the Hindu religion, and ranged in age from 28-52 years. All the nurses were registered; however, the caregivers were not required to have any formal qualifications to work as a caregiver. RNs had education in general nursing but not gerontological nursing in particular. Except for one (Kala), almost all caregivers and nurses received no formal training in caring for older adults in RCFs. The duration of work experience of nurses and caregivers ranged from 7 months to 17 years. All participants spoke Nepali as a first language.

Table 4.1

Residents' Characteristics

S.N.	Name (pseudonym)	Sex	Age (years)	Place of origin (district)	Religion	Education	Past Occupation	Marital status	Children (s-son, d-daughter)	Duration of stay (years)	Previous stay	Self-care efficacy	Interview (mins)
1	Sanu	Female	84	Sindhuli	Hindu	Illiterate	Housewife	Widow	No	20	RCF	Independent	74
2	Maya	Female	70	Okhaldhunga	Hindu	Illiterate	Housewife	Married	No	12	Home	Independent	56
3	Hari	Male	75	Gulmi	Hindu	Illiterate	Labourer	Unmarried	No	5	Home	Partially dependent	96
4	Ram	Male	87	Sankhuwasabha	Hindu	Literate	Farmer	Widower	Yes [2s, 2d]	8	Home	Independent	93
5	Shyam	Male	85	Kavrepalanchok	Hindu	Literate	Security guard	Widower	Yes [3 d]	0.5	RCF	Independent	93
6	Mira	Female	70	Morang	Hindu	Illiterate	Housewife	Married	Yes [1s and 1d]	5	Home	Independent	31
7	Astha	Female	94	Dhading	Hindu	Literate	Housewife	Married	No	3	Home	Partially dependent	33
8	Ganesh	Male	103	Kathmandu	Hindu	Literate	Farmer	Married	Yes [2 s]	5	RCF	Independent	38
9	Lalita	Female	74	Kathmandu	Hindu	Illiterate	Tailor	Married	Yes [2 d]	10	Home	Independent	27
10	Devi	Female	60	Parsa	Hindu	Illiterate	Farming	Widow	No	0.75	Home	Independent	60
11	Tulasi	Female	74	Dolakha	Hindu	Illiterate	Housewife	Married	Yes [2 d]	5	Home	Partially dependent	60
12	Narayan	Male	73	Gulmi	Hindu	Illiterate	Labourer	Married	Yes [1s and 1d]	8	Home	Independent	91
13	Pushpa	Female	83	Bhaktapur	Hindu	Illiterate	Tailor	Widow	Yes [1s]	11	Home	Independent	54
14	Rita	Female	84	Kathmandu	Hindu	Illiterate	Domestic worker	Unmarried	No	21	Homeless	Independent	97
15	Nisha	Female	72	Kavrepalanchok	Hindu	Illiterate	Caterer	Widow	No	0.5	RCF	Independent	89
16	Usha	Female	82	Kathmandu	Hindu	Illiterate	Shopkeeper	Widow	No	6	Home	Independent	41
17	Asok	Male	70	Kavrepalanchok	Hindu	Literate	Mechanics	Married	Yes [2s and 2 d]	5.5	Home	Independent	40

Table 4.2

Nurses' and Caregivers' Characteristics

S.N.	Name (pseudonym)	Age (years)	Religion	Education	Duration of work (years)	Training	Interview (mins)
	Nurses						
1	Hina	40	Hindu	RN	2. 5	No	36
2	Pari	52	Hindu	RN	16	No	34
3	Ganga	28	Hindu	RN	0.5	No	23
	Caregivers						
4	Kala	41	Hindu	Secondary	17	Yes	83
5	Anita	37	Hindu	Higher secondary	9	No	58
6	Merina	35	Hindu	Illiterate	4	No	21
7	Tina	52	Hindu	Illiterate	10	No	20

4.5. Data Collection Techniques

The data collection techniques for the study included face to face in-depth semi-structured interviews in Nepali language and observation during interviews. As explained in chapter three, GT, informed by SI, seeks to understand how people establish meanings, interact, and take actions in particular conditions (Corbin & Strauss, 2008). Interviews facilitated exploration of the "various ways that the respondent attaches meaning to the phenomena under investigation" (Holstein & Gubrium, 1995, p. 77). In-depth semi-structured interviews, consistent with GT, began with open-ended key questions to allow free-flowing discussion related to spirituality, and facilitate comparison between participants (Corbin & Strauss, 2008). For example:

Residents

- Can you please tell me the reason behind your decision to live in the RCF?
- What difference did you find while living in the RCF versus your own home?
- How did you adjust to this environment, and what helped?
- How did you develop new relations or connections?
- Do you wish for any facilities that could make your stay in the RCF more meaningful?

Nurses/caregivers

- What do you think are the most important needs of older adults living in the RCF?
- What kind of challenges do you face while taking care of the residents' needs?
- Are there any changes you would like to see in the delivery of care?

Initial interview questions framed the boundaries of the response but, eventually, the participants accentuated their major concern (Holstein & Gubrium, 1995). Following the participant's lead, subsequent interview questions elicited further information (Burns & Grove, 2007). As the data collection and analysis progressed, the interview questions evolved and focused on developing concepts.

Observation during interviews is a critical component in a GT informed by SI. Observation clarified, expanded the information gained from interviews, and determined the congruence of spoken data (de Guzman et al., 2017; Sedano et al., 2017). Writing field notes during or after the interview helped to record the meanings the particular events or experiences hold for the participants being studied, the actions and interactions occurring in the field, and different conditions influencing the action/interactions (Emerson et al., 1995; Montgomery & Bailey, 2007). Furthermore, the field note provided context to facilitate coding, helped to identify bias, and increased rigour and trustworthiness (Phillippi & Lauderdale, 2018).

4.6. Data Collection Procedure

During the period of data collection, I moved back and forth between two RCFs. Participants determined the date, time of the interview, and location inside the RCF according to their comfort. I spent a few minutes with the participants talking about general things outside of the study purpose to help ease the participants and make them comfortable (Dempsey et al., 2016). I started the interview after confirming with the participants their readiness. The interview commenced with information about the focus of the study. Participants were allowed to ask questions regarding the information sheet or clarify any concerns regarding participation in the research.

Written informed consent for the digital recording, transcription, and taking field notes was obtained from each participant prior to the interview (Appendix D). I asked the participants to choose a pseudo name to use in the reporting of the findings. Most of the participants told me to select the name. Then, the key questions were asked. Whenever the interview crossed one hour, it was only continued after asking if the participant was comfortable with doing so. Interviews were digitally audio-recorded, and field notes were taken during and after interviews. I documented in field notes how participants acted, interacted, and interpreted during interviews the specific facial expressions, gestures, tone of voice, speed, and context of the study.

I transcribed all the interviews conducted in the Nepali language. Transcription is the first step of analysis and errors in the transcription means errors in the translation process (Davidson, 2009). Transcription required listening to the recordings several times and was time consuming. However, it helped me to become familiar with the world of participants, words they used and their perspectives, and eventually to generate ideas regarding different concepts during data analysis (Bailey, 2008). The main professional bilingual translator translated the first three interview transcripts from Nepali to English. Next, another bilingual translator back-translated the English transcripts to Nepali language (Smith et al., 2006), after which I checked the original Nepali transcript and back-translated Nepali transcripts for the retention of the same meaning or conceptual equivalence (Appendix E). In the following section, I will detail the various issues raised and resolved during the translation period of the first three interviews, the documentation of which is essential for the trustworthiness of the research findings (Chen & Boore, 2010; Temple & Young, 2004; van Nes et al., 2010).

One of the issues with the translation process was words or phrases with no English equivalent. For instance, the word *dharma* has no single word translation in English. The word *dharma* can have different meanings when used in varying contexts such as religion, moral behaviour, ethics, code of conduct, duty, or spiritual practices. Similarly, the literal translation of the Nepali phrase *thal thapera khana parya cha* means asking for food in plate. However, residents actually meant I have to live by begging for food. I suggested that the translator use the exact word used in the Nepali transcripts if there was no English equivalent words/phrase, and I verified it later.

Similarly, I advised the translator to indicate in the English transcript, by highlighting or underlying words, if there was any confusion involved in the translation process.

The next issue in the translation process was with the use of expressions. The omission of expressions can impact the interpretation of the data. For instance, there is a difference between "Relations I told you" and "(Laughs)… relations! I told you". Ram was abused by the family back home and had no visits from his son in 6 years; he laughed sarcastically before emphasising the word relations with an explanatory mark. I directed the translator to retain the spaces, expressions, idioms, body language as mentioned in the Nepali transcripts since it adds value to the data. Similarly, another issue in the translation process was the use of pronouns (e.g., he, she, they, there, those, and them), in the same sentence, which sometimes confused the translator. I advised the translator to leave the pronouns as it is. As I conducted the interview, heard the recording several times, and transcribed the interview, I could easily understand to whom the participants were referring. Having the same socio-cultural background helped the translator and me understand the actual meaning and context behind the words used, which was very important to prevent loss of actual meaning during translation (Choi et al., 2012; Xian, 2008). For instance, since the translator was familiar with the socio-cultural setting, the translation of idiom *budo bhayo aja ghar birano* read as "when you become old, even your own home becomes unfamiliar". The literal translation would be "became old and today home is unknown", which is difficult to comprehend.

After resolving the translation issues and verifying the translated transcript, I started coding the interviews. There is debate regarding the timing of translation specifically in qualitative research. Being a novice in GT, English translation of the interview transcripts before analysis helped in identifying and discussing key methodological decisions with supervisors (Chen & Boore, 2010; Santos et al., 2015). Despite being time consuming, Regmi et al. (2010) confirmed that the translation of the whole transcript, rather than categories in the later stages of analysis, is essential to increase rigour and decreases the chance of any gaps in conceptualisation. From the fourth interview onwards, I started sending the Nepali transcripts to the main translator for

English translation, collecting, and verifying the translated transcripts; after which the analysis process commenced.

4.7. Data Analysis Technique

In preparation for the data analysis, I attended an NVivo basic and core skills workshop before field work commenced. Similarly, I attended Professors Jane Mills and Melanie Birks: GT Masterclass in Melbourne, where I had the opportunity to practice coding data using GT methods. Initially, I used NVivo software to organise data, and used a word file for initial coding. As coding progressed, I realised that it was necessary to read the same transcript multiple times, with a different lens each time. For instance, I read the whole of the printed transcript first, and identified concepts. Next, I read the same transcript either focusing on developing concepts, sub-categories, categories, strategies, conditions, consequences, or link between concepts, sub-categories, and categories. Coding on the hard copy using pencil gave me freedom to jot down all my initial thoughts without restriction or concern for organisation. Furthermore, I could easily link a concept, sub-categories or categories to another, and note initial thoughts regarding the relationships between the concepts or sub-categories or categories. This technique suited me the most; hence, I continued this process throughout the data analysis.

4.8. Data Analysis Procedure

Data analysis commenced immediately following the initial interviews. I will present the analysis process starting from a portion of raw data to demonstrate the development of the concepts, categories, properties, dimensions, and link between categories. It will be followed by an explanation of constant comparative analysis, theoretical sampling, and theoretical saturation with the help of memos, field notes, and diagrams. All these elements of data analysis overlap in the theory development process.

4.8.1. Coding and constant comparative analysis

Coding is “delineating concepts to stand for interpreted meaning of data” (Corbin & Strauss, 2015, p. 220). The study followed the process of open, axial, and selective coding as outlined by Corbin and Strauss (2008). Coding is a non-linear process and it involves moving back and forth between open and axial coding during the entire

data analysis process. In open coding, data is broken down analytically to generate concepts, categories, their properties, and dimensions (Corbin & Strauss, 1990). I started with line by line coding to remain close to the data and not to miss any important events, actions, and interactions in the raw data. Later, I moved to coding by sentence or paragraph. However, whenever new concepts or categories developed, I switched back to line by line coding. The following is an example of initial line by line coding related to how residents connect with co-residents (Table 4.3, p. 86). Trace the concept named sharing (in bold) in the open coding as it makes it way to the category.

Table 4.3

Line by Line Coding Related to How Residents Connect with Co-residents

Transcript	Open coding
Ram: That *Ama* [female residents] just sit, have no energy to rise, impaired and helpless. I talk with female residents living upstairs. I go there, sit there for some time, female residents talk, do whatsoever.	Approaching female residents Decreasing physical abilities of co-residents Going upstairs Sitting Talking
Researcher: They talk to you. What else just talking?	
Ram: Yes. Female residents talk. I talk, ask them how they are, how things are, talk about our suffering and happiness. I go sometimes. It is quite odd going there always. Then, I sit here (downstairs), friends are there.	**Sharing general information** **Sharing about suffering and happiness** Episodic visit/not regular Feeling odd going upstairs Sitting downstairs/having friends downstairs
Researcher: So when do you go upstairs?	
Ram: I go upstairs once in the day time. Then, go once [a day], sit for sometimes, observe. Female residents are still not getting up. They are miserable. [I] want to talk to them. [I] want to ask and talk about how they are feeling, how [family] behaved with them, and what suffering brought them here. I want to listen to story, *Bhagwat and Puran* (Hindu scriptures), but there are no female residents upstairs who talk about *Puran, Bhagwat and Gita* (Hindu scriptures), they do not do that. Then, there is one old man out there, don't know what it is. He is a *Pranami* (religious group), this… …*Pranami* person, he meditates, sits, does not go anywhere. That friend (close friend) went out for 1 month, was lonely. A few days back, he came. He is from the same *gotra* (clan), and we talk about every little thing.	Maintaining regular visit upstairs Observing co-residents Decreasing physical abilities of co-residents Empathising Wanting to **share inner feelings** Asking about past, family, suffering Wanting to listen to story Need of **sharing spiritual knowledge** Female co-residents upstairs not discussing spiritual knowledge Co-residents from different religious group Temporary absence of close friend **Sharing every little things** with friends from same religious affiliation

As illustrated in the Table 4.3, line by line coding identified the concept of sharing and its different forms. In a similar way, the line by line coding of other interview transcripts generated several other initial concepts related to how residents connect with co-residents. These initial concepts (i.e., sharing every little things) were

explored in detail in follow-up and subsequent interviews with additional questions, and compared within and between transcripts.

The next step was grouping similar concepts using a conceptual label. Conceptual labelling was the first step in moving line by line codes/concepts from the raw data to the higher level of abstraction (Strauss & Corbin, 1998). As presented in Table 4.4, I noted a number of similar concepts in transcripts which I labelled as sharing. Likewise, being nice and avoiding conflict were other examples of conceptual labelling.

Table 4.4

Conceptual Labelling

Sharing	Being nice	Avoiding conflict
Sharing general information	Speaking politely	Tolerating
Sharing donated food or items	Respecting	Not going against
Sharing objects of spiritual significance	Not saying anything bad	Not complaining
Sharing spiritual knowledge, skills	Being honest	
Sharing inner feelings	Being humble	

Then, as shown in Table 4.5 (p. 88), the concept named ‘sharing’ was grouped along with similar concepts such as being nice, avoiding conflict, and assisting; leading to the category ‘sustaining connections with co-residents’. Sustaining connections with co-residents explained what was going on in the data (Corbin & Strauss, 2008). In other words, residents were using the strategy of being nice, avoiding conflict, assisting, and sharing to sustain their connections with co-residents. Similarly, one property of the category sustaining connections with co-residents was level of interactions, dimensions of which ranged from superficial, intermediate, to deep level. Likewise, another property of the category sustaining connections with co-residents was the intensity of connection between co-residents ranging from weak, moderate, to strong intensity. When concepts, categories, properties, and dimensions are derived from the data, it is termed induction (Strauss & Corbin, 1998). In this way, open coding was conducted. The next level of coding was axial coding. Trace the category sustaining connections with co-residents (in bold) in the axial coding.

Table 4.5

Concepts to Category

Concepts	Category	Properties	Dimensions
Being nice Avoiding conflict Assisting **Sharing**	Sustaining connections with co-residents	Level of interactions Intensity of connection	Superficial, intermediate, deep Weak, moderate, strong

As the category development progressed, axial coding began. Axial coding is also described as coding around a category to identify the conditions, actions-interactions, and consequences specific to that category (Corbin & Strauss, 2015). Axial coding is more intensive as compared to open coding. As demonstrated in Table 4.6, coding around the category 'sustaining connections with co-residents' revealed its own conditions, actions-interactions, and consequences. In other words, the below-mentioned conditions shifted participants' strategies of sustaining connections with co-residents as well as its consequences.

Table 4.6

Example of Axial Coding

Category	Actions/interactions (Strategies)	Conditions	Consequences
Sustaining connections with co-residents	Being nice Avoiding conflict Assisting Sharing	Broken mutual trust, respect, love, or reciprocal assistance Decreasing physical abilities Increasing illness of residents Illness or death of co-residents	Shifting connections

Next, I compared the category sustaining connections with co-residents with similar categories such as preserving connections with nurses/caregivers, and continuing connections with inner-self and higher being/s (Table 4.7, p. 89). These categories were different in that the process, conditions, and consequences underlying each category varied. However, these categories were similar in a way that they were all related to maintaining connections. Therefore, the category sustaining connections

with co-residents later became one of the sub-categories of the main category maintaining connections.

Table 4.7

Grouping of Similar Categories

Sub-categories	Category
Sustaining connections with co-residents Preserving connections with nurses/caregivers Continuing connections with inner-self and higher being/s	Maintaining connections

Coding and constant comparison occurred simultaneously. Corbin and Strauss (2015) defined constant comparison as "the analytical process of comparing different pieces of data against each other for similarities and differences" (p. 85). Within-concept comparison allowed the different aspect of the same concept to be explored (Corbin & Strauss, 2008). Table 4.8 shows an example of a within-concept comparison.

Table 4.8

Comparison between Same Concepts

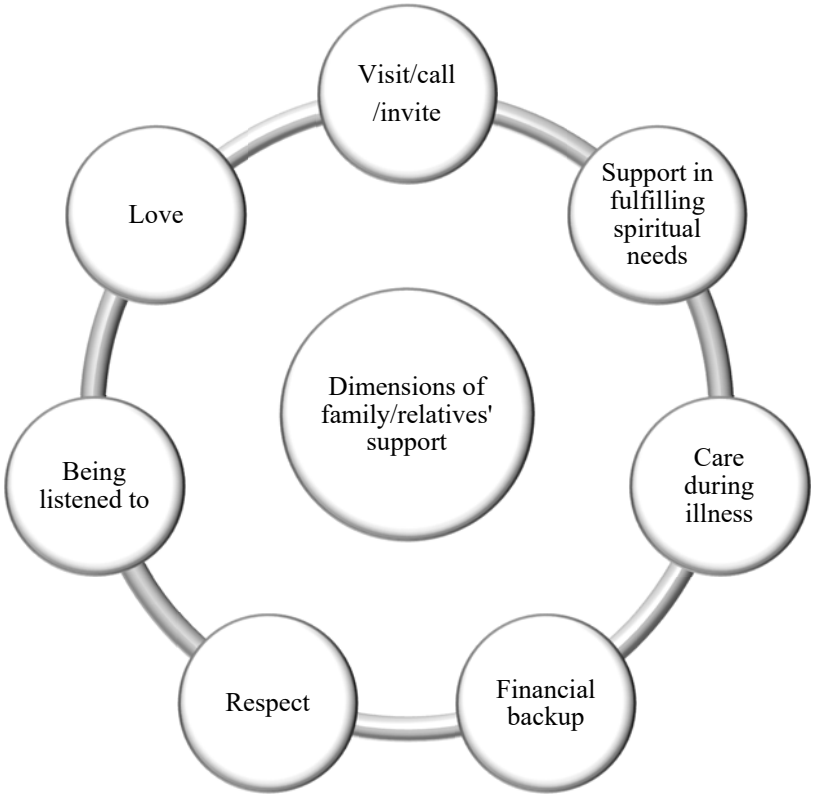
Within-concept comparison			
Comparing with home	Comparing with previous RCF	Comparing with homelessness	Comparing with co-residents

Initially, I had kept all four incidents under the sub-category of evaluating. When compared against the data, it proved otherwise. Residents evaluated the dimensions of residential living by comparing with home, previous RCF, or homelessness, which influenced how they constructed the image of the RCF and identities-as-residents. For instance, some residents described the RCF as "prison" and "not like home"; and self as "entangled," "captured in other's fist," "prisoners," "under someone else's command," and "living idly" because they focused more on the dimensions of residential living such as lack of freedom, decision making power, and income. However, residents compromised with the new identity as a resident by comparing with co-residents having children or property. Thus they were separated into different sub-categories; evaluating and compromising. However, all these incidents of comparing were similar in a sense that they were related to the main category making sense.

Constant comparison is conducted both for classification and to develop the concept at property and dimensional level (Corbin & Strauss, 2008). For instance, similar concepts related to family/relatives' supports were continuously compared between participants, and with all new data at the dimensional level; see Figure 4.1.

Figure 4.1

Dimensions of Family/Relatives' Support



Dimensions added variation to the process. Having one or more dimensions of family/relatives' support, such as visit/call/invite, respect, support in fulfilling spiritual needs, changed the resident's strategies from discontinuing effort to holding on to family/relatives.

In the meantime, the link between the concepts/categories were also analysed and checked with the existing data and further data collection, which is also part of axial coding (Corbin & Strauss, 1990, 2008; Strauss & Corbin, 1998). The hypothesis about the relationships between concepts, sub-categories, or categories derived from the data is making deduction which "must continuously checked out against

incoming data and modified, extended, or deleted as necessary" (Strauss & Corbin, 1998, p. 22). For instance when Shyam told me in the interview that he was not discriminated in the earlier RCF, I asked a series of questions to clarify the concept of discrimination and its link with sadness. At first, he just said discrimination was based on "class" and in the way people caregivers talk, walk, daily things they do, the way they speak. But I explored further by asking following questions.

> Researcher: In this old age home, what makes you happy and what makes you sad?
>
> Shyam: Almost everything makes me happy. But sometimes I feel like leaving when people discriminate.
>
> Researcher: So, is that the only reason? There isn't other discrimination besides behaviour discrimination?
>
> Shyam: In the previous RCF, even though there were fewer numbers of nurses/caregivers, they used to provide better care, whether it be day or night. If someone is sick, someone always used to be with them for care, whether it be another person living in the RCF or the staff member. Nurses/caregivers do not do that here. A few days ago, I had a fever and took rest the whole day and could not go for dinner. However, no one asked or noticed that I had not attended dinner… I told him [manager] about this (referring to discrimination). The manager told that to the people in the kitchen (referring to some caregivers). Then the people (caregivers) here got angry at me. It has happened twice or thrice already.

In this way, every link between concepts or categories was confirmed with further data, or in the subsequent interviews.

4.8.2. Theoretical sampling

Coding and constant comparison generated multiple questions related to the gaps in understanding of the concepts, categories, properties, dimensions of categories, conditions, actions/interactions, consequences, and link between concepts and categories. Questions were sensitising, theoretical, practical, or guiding in nature (Strauss & Corbin, 1998). Asking questions and making comparison is critical in GT

as it gave direction to the theoretical sampling, and sensitised me to the major concepts while undertaking subsequent interviews (Corbin & Strauss, 2008; Strauss & Corbin, 1997). The following is an example of an initial field note with ideas for theoretical sampling underlined.

> Field note (15/3/2018): The first interview was done with the resident who was transferred from a RCF, a widow with no children. Sanu expressed, "This place is everything to me." She has episodic visit from relatives and focused more on maintaining connections with inner-self/higher being/s. She might be used to living in RCF or living in RCF might be her only choice. She stated that she has no one, wealth, or support. The second interviewee moved to RCF from her home. Maya has a history of abuse from husband, but has no children to take care of her. She has no one to visit her. She talked about connecting with higher being/s, caregivers, co-residents, but the physical disability has changed her connections. She said until and unless you have good children living in home is good. What does it mean for residents having children back home or who came from their own choice? They were both female. Women in Nepal are more likely to be devoted towards spirituality. How does a male resident perceive living in RCF? Sanu and Maya are from RCF2 and have been there for more than 10 years. How the process unfolds for the resident who are relatively new? Does the setting of the RCF play a role? How does setting of the RCF influences the perspectives of resident? Both Sanu and Maya described some form of marginalisation while living in RCF. They said we are eating by begging, should be giving in this age but taking donations, rich people don't come to visit us. What does living in RCF mean to other residents? How do they define it? I have to mindful of the words other participants use to describe living in RCF, self, or donations or having/not having visits. I am confused about the marginalisation concept. Are they marginalising themselves or the RCF itself? Is it self-perceived or social instilled? What elements are involved in marginalising? When, under what condition does it occur? What do they do to reduce that feeling? To explore the concept of marginalisation I will ask these questions in follow up and sequential interviews: What comes to your

mind when you hear that someone is living in RCF? How do you feel when someone visits you? Why do you think others do not come to meet you?

This field note illustrates my decision to collect data from male residents, residents from another RCF, having children or family back home. Next is an example of a conceptual memo regarding the major category making sense with more theoretical questions.

Conceptual memo (12/4/2018): Is there a trajectory of making sense?

While making sense participants use range of strategies under isolation, exploration, evaluation, and compromise. There appears to be a trajectory initiating with the isolating phase. How long does each phase take? Is there any range common to all residents? What words do participants use to describe each phase? When and under what condition does the participant move from one phase to another? What are the overall conditions influencing each phase? Who are involved? What is the overall consequence of these phases? How does overall consequence link to the main category of making sense? I need to reanalyse the category of making sense in transcripts with these questions in mind. I have to be mindful of these links in the subsequent interviews. I will add questions such as: Can you share your experience of the first one-two months of arriving here? How long did it take you to adapt? What made it easy for you to adapt here?

The analysis of the subsequent interviews helped to answer the questions raised, added variation to the category of making sense, and revealed different conditions under which it occurred such as facility structure, rules, regulations, as well as attitudes and practices of nurses/caregivers. Furthermore, the link between sub-categories, and how it related to making sense was recognised. Moreover, new concepts like powerlessness, being controlled, discrimination, and sharing were developed.

As regards the concept named sharing, theoretical sampling was then used to explore how and under which conditions different types of sharing occurred between residents. The data analysis of the interviews so far had given hunches about intermediate interactions and moderate intensity of connections. However, I needed

to sample for variations in level of interactions, intensity of connections, focusing on the conditions that lead to variations. I explored the conditions and consequences of none, minimal or regular involvement with co-residents or nurses/caregivers or higher being/s that could provide variation to the category of maintaining connections. It clarified the relationship between different level of interactions and intensity of connection with co-residents, and nurses/caregivers. Furthermore, analysis revealed how strategies in the process of maintaining connections changed conditional on the lack of trust.

Next, I explored the perspectives of nurses and caregivers working in RCF 2. Different organisational conditions shaping the strategies of nurses/caregivers were identified. I then went to RCF 1 to explore variations in strategies of nurses/caregivers conditional on a more intense work environment and its influence on the relationship between residents and nurses/caregivers. I also focused on the variation in the duration of work experience of nurses/caregivers and how it influenced the strategies they used. I wanted to sample the variation in perspective potentially created by the gerontology training, but except one caregiver, no one received any training because it is not mandatory in RCFs in Nepal.

At this stage, the process of refining and integrating categories began, which is also termed as selective coding (Strauss & Corbin, 1998). I integrated all the memos to refine the categories and wrote the conceptual storyline (Birks et al., 2009). The example of refining of the category 'making sense' is mentioned in the methodological memo.

> Methodological memo (12/8/2018): How I refined the category making sense
>
> Making sense is an ongoing process with four phases, namely isolating, exploring, evaluating, and compromising. Understanding how phases progressed was a long and challenging process. It included examining the transcripts for the time markers (first, when, then, after that, slowly, eventually). For instance, I say it was hard. How much can one cry, what can I do? It's the end. Why talk about things that have ended? There is no place to go. When I first came here, I used to think about why I came here? What do I do here? Then it became a habit. [Puspha]. Besides, participants were asked

when, how, with whose help they moved ahead, why they felt a certain way, used a specific word to describe themselves, RCF, or used a particular strategy. Besides, the transcripts of the participants who recently moved to RCF versus who have been there for a long time were compared. The participants who had recently completed six months in the RCF clarified the distinction between phases. I was confused at the beginning looking at the variety of residents' perceptions regarding the residential life. Then, I used brain map to record all the dimensions of residential living reported by the participants (Appendix F).

Perceived image of RCF as a place: A place for those who "are sick," "cannot work," "suffered," "cheated the family," "not successful," or have "no one," "no shelter," and "nothing to eat"; "messy," "dirty," "mental asylum," "prison," "place where you beg for food," "not like home," "shelter," "safe place," "this place has a touch of truth," "this place is good," "bad luck," "like a home."

Perceived image of self as a resident "have no one," "have no home," "have no wealth," "have no support," "thrown," "used to stay in a rich house before," "It is not that I had no property," "stayed in a good house," "a person who never begged for anything," "alone," "eating grains of government," "eating what others offer," "carrying debt," "dead weight," "weak," "prisoners," "entangled," "captured in other's fist," "under someone else's command," "living idly," "live by begging," "lucky."

I then went back to the table of participants, and transcripts, field notes, memos, reading them again, this time only focusing on that category. Through this process, I became clear of the different conditions (why/when), process (how), and consequences (leading to what) of making sense.

Integration was a challenging process. It involved searching for a core category that is sufficiently abstract, unites all the categories, fits within all concepts, is coherent, and provides in-depth explanation (Corbin & Strauss, 2015). I had three main categories—making sense, seeking connection, and maintaining connection—each with their own set of processes, conditions, and consequences. I linked all the major

categories in every way possible along with concepts. *A process of connecting* tied the three main categories altogether and fitted with all the concepts.

4.8.3. Theoretical saturation

Theoretical sampling and analysis continued until the point of saturation, which is "when all major categories are fully developed, show variation, and are integrated" (Corbin & Strauss, 2008, p. 135). Deciding when to stop the data collection was challenging for me. Fusch and Ness (2015) recommended the novice researcher to provide detailed explanation of how data saturation was reached in a study. Similarly, Bowen (2008) and Francis et al. (2010) affirmed this step as assisting the evaluator to determine the trustworthiness of the study findings. Hence, the following section will detail the strategies I used to reach a state where I was convinced that the new data did not add anything substantial to the developed categories and its properties.

As previously mentioned, I moved simultaneously between data collection and analysis, and continued coding, constant comparison, theoretical sampling, documenting ideas, and questions in conceptual, methodological, and reflexive memos (Bowen, 2008; Corbin & Strauss, 2008; Given, 2008; Timonen et al., 2018). Concurrently, I continued making overall diagrams of the developing theory; which developed my abstract thinking, and helped me to identify gaps in conceptual ideas and integrate categories (Corbin & Strauss, 1990; Kennedy-Lewis, 2014). I collected more data or revisited the transcripts to fill those gaps in the conceptual ideas. As the research progressed, the diagram evolved (see Appendix G). I discussed the diagram of the developing theory with some of the participants to member-check whether it covered their major concerns or if they could identify any gap (Bowen, 2008). I incorporated their feedback in the theory. Moreover, being a novice, I continuously pursued advice from my supervisors, colleagues, and methodology consultant to reach a consensus that the point of saturation has been achieved (Aldiabat & Le Navenec, 2018). All the concepts developing from the analysis of the 24th interview fitted within the previously developed categories, and no new concepts significant to the theory developed. Therefore, it was considered that saturation occurred.

4.9. Ethical Considerations

The NHRC and AUTEC approved this study in November 28th, 2017 and December 12th, 2017 respectively (Appendix H). A field supervisor was appointed from Tribhuvan University, the local university of Nepal, to support the field work process. Field work commenced after the administrative approval from the authorities of the selected RCFs. Participant information sheets were provided and written consent was obtained prior to interviews.

Prospective participants were informed that participation in the study was voluntary, and they would be able to withdraw from the project at any time without question. They were assured that non-participation in the study would not affect any services they are being provided in the RCF. No coercive influences or power imbalances were identified as I had no professional connection with both RCFs and had not worked in either of the facilities. I provided participants the opportunity to ask any questions and voice their concerns before they committed to signing the consent form. Their questions and concerns were answered truthfully. Participants decided the date and time of interviews to reduce the power relationship between researcher and participants (Karnieli-Miller et al., 2008). Privacy was established by collecting data from each respondent separately in a quiet place or separate room according to their convenience. Participants were offered the opportunity to ask any questions and voice their concerns during the interview. They were not pressured to complete the whole interview session or forced to answer any questions.

I was continuously observing participants and had planned to postpone the interview should participants show any signs of distress. I was aware that some participants might be dissatisfied with the facility, nurses, and caregivers of the RCF for not meeting their spiritual needs and could express these concerns in some form during the interview. Yet, they might not want the nurses, caregivers, or managers of the RCF to know their concerns. Similarly, nurses and caregivers of the RCF might have concerns about their work. Participants were assured that findings will be reported in a way that participants cannot be individually identified. Furthermore, I did not disclose the personal information shared by participants to anyone. I used the words X, Y in quotes, wherever participants disclosed either the name of the RCF, co-residents, nurses, caregivers, or managers.

Older adults enjoy sharing their life stories about how they dealt with specific situations in life and the lessons they learned. Being listened to is one of the major needs of older adults (Register & Scharer, 2010). However, evidence also suggests that most of the older adults living in RCFs in Nepal are abandoned by their family members. Thus, I was conscious that talking about spirituality could upset them. There was no potential risk identified other than the possibility of emotional distress from recalling unpleasant experiences. This risk was considered less for older adults who had lived in a RCF for more than six months (inclusion criteria) rather than those who had just started living there. Nevertheless, three free confidential counselling sessions from a professional counsellor was available should participants show any sign of distress. Likewise, I was also aware that role ambiguity as a nurse and researcher might occur during the process of data collection, and participants might expect professional help during the period of interviews. Therefore, I clearly stated my role as a researcher and explained that I would not be involved in any professional nursing assessment and interventions. However, in case of any medical concern, I was able to directly inform the nurses/caregivers/managers with the resident's permission. At each instance of entering and leaving the RCF, I informed either the manager, caregiver, or nurse.

Furthermore, the research should always be relevant in the cultural context where it is conducted. I am from the same cultural background and familiar with the Nepalese way of dealing with older people. Participants were treated equally and with full respect regardless of their gender, ethnicity, religion, or culture. Considering the cultural background of the study participants, older adults expect respect from younger adults which was maintained throughout the study. One way of showing respect was saying *Namaste* (Hello) and using culturally appropriate terms, like *buwa* (for older men) and *ama* (for older women), for addressing older adults in Nepal. Another way of showing respect was offering fruit when visiting. As much as possible, I conducted the interview in a regular conversation pattern and shaped the questions according to the participants' way of speaking to make them comfortable. I always ended the interview by thanking participants for the time and information they provided. At the end of the data collection, participants received a gift as an acknowledgement of their participation. On completion of the study, I will provide a summary of the key study outcomes (both verbal and written) to the participants, and

managers of both RCFs. In addition, the plan is to disseminate the study findings through national and international conferences to reach wider audiences.

Maintaining participants' confidentiality is of utmost importance. I transcribed all the interviews and a professional translator signed a confidentiality agreement form (Appendix I) before translating the transcripts. Raw data from the study, including digital recordings, interview transcripts, memos, consent forms, and field notes were kept safely in a locked filing cabinet in a locked office. The electronic material of the study was stored safely on a password-protected laptop and desktop in a locked office. Only I and my supervisors had access to these research materials. The original names of participants were not disclosed to maintain confidentiality while reporting, or presenting the findings of the study. Participants were invited to choose a pseudonym to be used in the write up of any findings. The data generated from the study will be retained for six years in a locked filing cabinet in the primary supervisor's office. All electronic documents will be downloaded onto a memory stick and kept in the same locked filing cabinet. After six years, all hard copies will be shredded via AUT's secure document destruction service, and the memory stick with all electronic documents will be destroyed.

4.10. Steps to Improve Trustworthiness

Rigour in GT research stands for the overall quality of the research outcome. Researchers begin with a specific goal, design a methodology, and employ methods to reach that goal. How well the researcher has achieved the intended goal is evaluated by looking for specific criteria in the final outcome. From the very beginning of the study, the researcher should familiarise themselves with how their work is going to be evaluated in the future. Furthermore, the researcher should clearly demonstrate how they ensured rigour in their study to enhance trustworthiness. Several criteria have been suggested to maintain trustworthiness in GT research; some of which are similar to general evaluation principles in qualitative research such as credibility, transferability, dependability, and confirmability (Creswell, 2007; Lincoln & Guba, 1985). Nevertheless, since the goal of GT, conduct, and research outcome is different among different variants of GT, they each have delineated evaluative criteria for assessing the quality of GT.

Glaser (1998) maintained that the GT study should meet the criteria of fit, work, relevance, and modifiability. Likewise, Charmaz (2006) recommended that GT should meet the criteria of credibility, originality, resonance, and usefulness. In contrast, Corbin and Strauss (2008) suggested 10 criteria that should be met in GT: fit, applicability, concepts, and contextualisation of concepts, logic, depth, variation, creativity, sensitivity, and evidence of memos. Since I chose Corbin and Strauss' variant of GT, I have used these evaluative criteria to add rigour and ensure the trustworthiness of the developed GT.

The first criterion to consider is whether the residents, nurses, and caregivers could relate to the theory. In other words, findings should fit with the experience of the participants. Since GT utilises theoretical sampling, it helped to check the concepts with the participants. In addition, follow-up interviews conducted to develop the concepts aided in continuous verification and allowed prolonged engagement with participants. During data collection, I continuously discussed with participants about developing categories, relationships between those categories, how it linked to the theory, and reviewed analysis based on their feedback. For instance, when I discussed the developing theory with Maya, she explained how it made sense to her. Yet, she pointed out that the phase of isolating in the process of making sense was different for her because of her history of emotional abuse. I refined the sub-category of isolating accordingly. Similarly, Kala, with her 17 years of experience in caregiving, clarified and confirmed the pattern of diverse actions/interactions of the nurses/caregivers. I also checked the final theory with the participants, which is called member checking. The participants told me that the findings resonated with their experiences.

Another criterion to evaluate GT is applicability. Findings should be useful in terms of their potential to change the practice. The gap between spiritual needs perception of the residents, spiritual care provision by nurses/caregivers, and challenges established by residents and confirmed by nurses/caregivers, clearly demonstrates that there are many practice aspects in RCFs that can be changed to restore the spirituality of older adults. It is a crucial aspect to consider when restored spirituality was linked to positive consequences while living in a RCF by all participants. Being an underexplored area in the RCF setting, the findings grounded in the words of the

residents, nurses/caregivers add to the knowledge base of nursing and have scope to change nursing practice in RCFs through policy development.

Further, the concepts developed in the theory should be understood in the professional field, and have density and variation. I discussed my conceptual ideas with colleagues from nursing and non-nursing backgrounds and the GT group of AUT—could relate to most of them. Likewise, my supervisors gave me an opportunity to discuss my findings in front of postgraduate nursing students having experience of working in different RCFs in New Zealand. They recounted their work experience linking it to the concepts of the theory. The researcher should be able to explain the context on which the concepts are based—the next criteria. The socio-cultural background of the participants and the organisational setting was a major context for the study that explained why and how participants perceived, or acted in a certain way. Therefore, findings of this study have been discussed within the socio-cultural context of Nepalese residents.

Similarly, the conceptual ideas of the theory should flow logically and accompanied by descriptive details. In discussion with supervisors, and while sorting out the memos, the missing gaps in the flow were identified and reviewed accordingly. The depth of the analysis was demonstrated by providing rich descriptions along with participants' excerpts. Building variation in the theory is equally important and is facilitated by the negative case analysis. For instance, the case of one resident, Hari, was different compared to other participants. Hari reported losing faith in any form of relationship, either with people or higher being/s after moving to RCF. He was not involved in any form of spiritual programmes. However, other residents kept faith, were involved in different spiritual programmes, and developed different forms of connections in the RCF. This exemplifies the variation in the theory.

Equally, the findings should display creativity and sensitivity. In the beginning of the study, some of the colleagues in Nepal mentioned that the findings will be all about religious connections, and nurses/caregivers would not have much to say. However, the phenomenon of maintaining spirituality was more complex than expected. Exploring how participants strategise to meet their spiritual needs in the face of different challenges was compelling. Finally, the evidence of memos created in

different stages of the study is required and has been made explicit throughout this methodology chapter.

4.11. Summary

This chapter has discussed the methods utilised in the study in order to answer the research question. Two RCFs of Nepal formed the setting for this study. After obtaining ethics approval, a field supervisor was appointed, administrative approvals from two RCFs were taken, and data collection commenced. Participants who were willing to take part in the study received a copy of the translated Nepali version of the participant information sheet and consent form. Those participants who could not read, received a verbal explanation of the same documents. Initial sampling was purposive. Once the concepts started developing, theoretical sampling based on concepts was conducted. In total, 17 residents, 3 nurses, and 4 caregivers were recruited. Interviews and observation during interviews were the major data collection technique for GT using SI as a lens.

This chapter has also provided the details of the data collection procedure in the RCF, transcription, and translation; along with associated issues and how they were resolved. Examples of how open, axial, and selective coding was done, with a set of data, were provided. Finally, the chapter ended by demonstrating my strategies to improve the trustworthiness of the developed GT. According to Corbin and Strauss (2008), the evaluative criteria of GT includes fit, applicability, concepts, and contextualisation of concepts, logic, depth, variation, creativity, sensitivity, and evidence of memos. Since I adopted Corbin and Strauss' variant of GT, I used these evaluative criteria. The next chapter outlines the theory of connecting, developed from the data.

Chapter Five: Setting the Scene

5.1. Introduction

The previous chapter presented the methods used in this GT study. This chapter provides a theoretical explanation of the theory—*A process of connecting*—developed from the data analysis. This chapter begins with a description of the study settings. The background information provided in the introduction chapter covered the overall socio-cultural context of residential living in Nepal. This chapter describes the study settings where the data collection was conducted, along with the general socio-cultural environment of the two specific RCFs; and provides the context for understanding the results of the study. The chapter concludes with a broad overview of the theory of connecting.

5.2. Study Settings

The study was conducted in two RCFs situated in Kathmandu, Nepal. RCF 1 was established in 1920 and had the capacity to house 230 older adults. This facility received a government subsidy. Admission to RCF 1 was free, and the government and donors provided the services. Donors can be anyone from charity, international, private organizations, or local clubs, or individuals who do not belong to any organization. To gain admission, residents needed to provide an application certified by the municipality or the Village Development Committee that the applicant is helpless/dependent, orphan and poor, and over 60 years of age. Two RNs were posted on day and night shift, along with eight formal caregivers who provided direct care to residents. Formal caregivers were those assigned and paid by the RCF to care for older adults; however, they had no professional training. The caregivers were responsible for the cleaning, feeding, shifting, and bathing of residents; as well as preparing food and cleaning the RCF. Nurses and caregivers in public RCFs reported excess workload and limited accessibility for residents. Doctors visited twice a week and were available on call.

Regarding rules and regulations in RCF 1, there was no provision of regular spiritual programmes; only hymn singing, which was conducted by the residents themselves. The caregivers did not join residents in the spiritual programme. One religious place was near to this RCF and all residents who could walk attended the spiritual

programmes occurring there. Those who could not walk did not participate because the buildings were two-storey and not wheelchair friendly. Regarding the family visit, RCF 1 required family members to fill in the detail information at the gate. However, family members did not want to disclose the relationship with the resident because of the deeply rooted social stigma of putting parents in the RCF, resulting in less number of family visits in RCF 1.

RCF 2 was established in 1995 and had capacity for 35 older adults. Older adults paid for the services (one-time payment at admission); however, those who were very poor were provided free services. The admission amount varied among residents. RCF 2 also received a grant from the government. The organisation and donors took care of the remaining facilities. One RN and a formal caregiver was posted during the day; however, nurse was not available in the night. The facility arranged doctors' visits twice a week. Additionally, there were two helpers just for the cleaning, shifting, and feeding of residents; and cleaning the RCF, which reduced the workload of a caregiver/nurse and increased the accessibility for residents. RCF 2 provided regular spiritual programmes such as preaching, prayer, singing hymns, reciting Hindu scriptures, spiritual trips, meditation, and yoga, conducted with the help of a spiritual advisor and caregiver. All residents who could walk attended the spiritual programmes. Those who could not walk did not participate because the building was three-storey and not wheelchair friendly. RCF 2 restricted individual spiritual practice inside the room due to cleanliness issues. However, individual spiritual practice outside the room was allowed.

RCF 2 had a free visiting policy for family/relatives. Likewise, this RCF had different rules regarding end-of-life support as compared to RCF 1. RCF 2 considered the spiritual needs of residents at the end-of-life and after they die. This facility covered all funeral costs, played dedicated hymns, and made special food for others on the 13th mourn day. Staff of RCF 2 mentioned that they fulfil the last wishes of residents; and perform *rudri* (a Vedic chanting) and *aarati* (worshipping) in the place where the resident die. Consequently, the caregiver in RCF 2 was personally involved in the end-of-life care of residents. However, RCF 1 had no such arrangements related to end-of-life support for residents.

In terms of the general socio-cultural environment in the RCFs, most of the residents moved to the RCF from their home. However, four residents were previously living in another RCF before moving to the present RCF. Only one resident was homeless before moving to the present RCF. In the case of residents transferred from the home, most reported a history of physical or verbal abuse from the husband, children, or close relatives. Some residents with a history of abuse made a self-choice to move to the RCF; however, a few of them were forcefully brought to the RCF by their family members. In the case of the residents moving from another RCF, they were forced to move to the present RCF due to the lack of treatment facilities in the previous RCF, migration of relatives, or family members.

In the RCFs, the medium for being in touch with the family/relatives was receiving visits/calls/invites. Except for a few participants, most were getting no or the rare visit/call/invite from their family/relatives. There were two conditions when participants got no visit/call/invite at all: 1) when they had already lost their family or had no close relatives, and 2) when the family/relatives back home were making no attempts to be in touch with the participants. Remaining participants received rare visit/call/invite from their family/relatives, on special occasions. When certain families came to visit older adults, co-residents often abused the member for keeping their parents in such a state. This fear of embarrassment was one of the reasons for fewer family visits. In addition, there were some residents who had come to the RCF against the family's will. Those families did not visit, thinking that residents had damaged their reputation by going to the RCF.

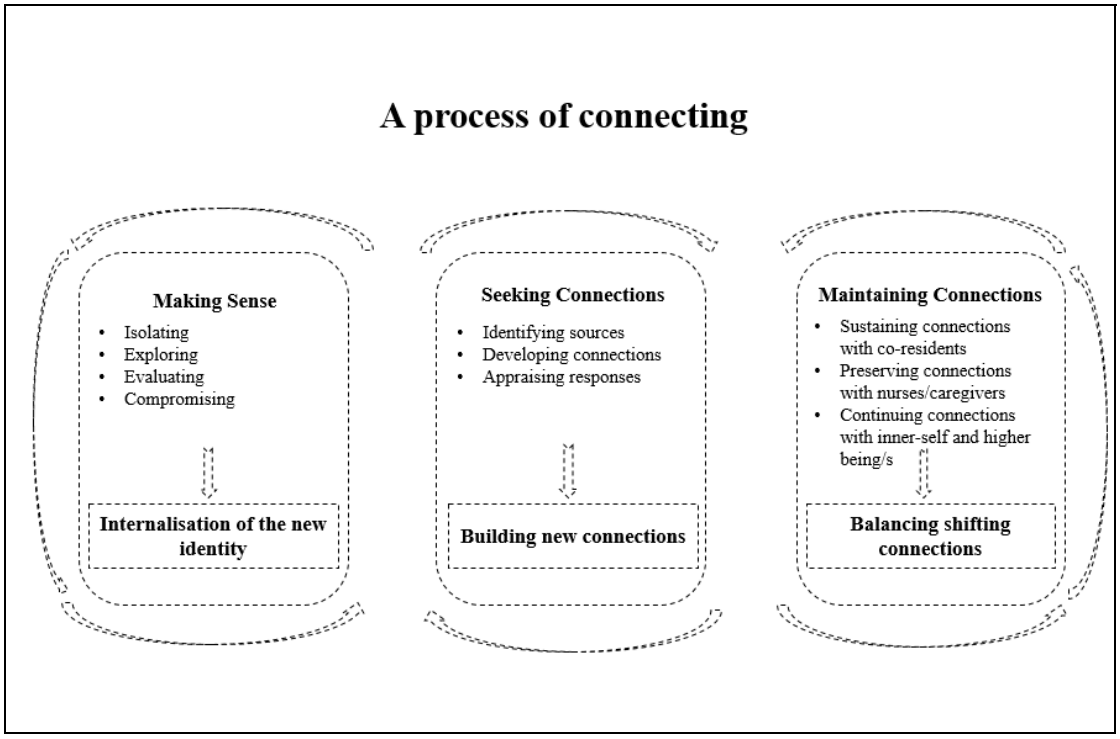
5.3. A Process of Connecting: A Broad Overview

The process of maintaining spirituality in a RCF is complicated, ongoing, and dynamic. Residents described spirituality as the process of connecting with inner-self, higher being/s, co-residents, family/relatives, and nurses/caregivers. The theory—*A process of connecting*—has three main categories or sub-processes: making sense, seeking connections, and maintaining connections. Each of these processes is complicated, dynamic, operated by separate conditions, and has different consequences. *A process of connecting*, begins with making sense and continues with seeking and maintaining connections. A process of connecting is depicted in Figure 5.1. Conditions impacting these sub-processes shift as residents continue living in a

RCF. As a result, residents can move continuously between and within each of these three sub-processes during their residency. The following section will provide the details of the first sub-process, making sense.

Figure 5.1

A Process of Connecting



Making sense refers to the process of how residents make meaning of the new identities-as-residents before they seek and maintain connections in the RCF. Broadly, making sense incorporates the strategies that residents employ after being admitted into the facility and before internalising the new identity. Making sense is a forward-moving process, including the phases of isolating, exploring, evaluating, and compromising. In the isolating phase, residents isolate themselves from people inside the RCF. Similarly, the phases of exploring and evaluating encompass residents exploring and evaluating different dimensions of residential living. In the phase of compromising, residents compromised with their newly formed identity as a resident. Finally, the overall consequence of the process of making sense is the internalisation of the new identity as a resident, which means residents integrating it into their past identity.

Making sense is an iterative phenomenon. The process of making sense is conditional on facility structure, rules, regulations; as well as attitudes and practices

of nurses/caregivers. When any of these conditions change, residents tend to go back to the initial phase of isolation, although for a short time, and eventually through the remaining phases of making sense. Making sense, therefore, is an evolving process. In making sense, most residents move through these four phases, even though the strategies used in each of these four phases and the time required to move from one phase to the other can vary among residents. It is also important to note that residents go through all these phases, irrespective of their previous knowledge regarding residential living, since a new RCF means exposure to a new environment as well as people. When residents internalise their new identity as a person lacking connection, they start seeking connections in the RCF.

Seeking connections refers to the process of how residents pursue different sources of connections before deciding whether or not to maintain those connections in the RCF. Broadly, seeking connections includes the strategies that residents use after internalising the lack of connections in their life as a resident before building new connections in the RCF. Seeking connections is a forward-moving process, involving the strategies of identifying sources, developing connections, and appraising responses. Identifying sources refers to residents searching and choosing sources of connections in the RCF. Similarly, developing connections indicates residents approaching the sources of connections. Appraising responses represents residents evaluating the responses of the sources of connections. In seeking connections, most residents use these three strategies, even though individual's approach within these three strategies can differ. By employing these strategies, residents build new connections while living in a RCF, which is the overall consequence of the process of seeking connections.

The process of seeking connections is conditional on facility arrangement, rules, and regulations; as well as co-resident's language, gender, religious affiliation, and attitudes. Similarly, the attitudes and practices of nurses/caregivers working in the facility influence the process of seeking connection. When any one of these conditions influencing the process of seeking connections are modified, residents tend to go back to identify new sources and then through the successive process. Seeking connections, therefore, is an evolving process. After building connections, residents start maintaining the newly built connections.

Maintaining connections refers to the process of how residents retain their newly built connections with co-residents, nurses/caregivers, inner-self, and higher being/s as they continue living in the RCF. In general, maintaining connections encompasses the strategies that residents initiate after building new connections in the RCF. Maintaining connections is a continuous process of using three strategies concurrently: sustaining connections with co-residents, preserving connections with nurses/caregivers, and continuing connections with inner-self and higher being/s. Sustaining connections with co-residents refers to the process of how residents strengthen or support connections that they built with co-residents, while preserving connections with nurses/caregivers describes how residents protect connections that they built with nurses/caregivers. Continuing connections with inner-self and higher being/s explains how residents keep on connecting with inner-self and higher being/s while living in the RCF. Residents continue to use these three strategies throughout their residency. In maintaining connections, these three strategies were common to most residents despite the variation in approach used by each resident. Finally, the overall consequence of the process of maintaining connections is balancing shifting connections while living in a RCF.

The process of maintaining connections is mainly influenced by conditions such as decreasing physical abilities, increasing illness of residents, illness or death of co-residents, and retirement or resignation of nurses/caregivers. Residents are likely to encounter these conditions as they continue living in RCF. These conditions can alter residents' entire process of maintaining connections. Maintaining connections, therefore, is a dynamic process.

Taken together, the process of connecting is ongoing, involving continual choice of particular strategies—making sense, seeking connections, or maintaining connections— in response to the shifting conditions in the RCF. The dashed bent arrows pointing to the right and left in Figure 5.1 denotes the ongoing nature of the process of connecting. Residents move to making sense whenever the conditions related to the sources of connections change or become unsuitable. For instance, when rules change, the residents return to making sense. Similarly, when close co-residents die, the process of seeking new connections recommence. Therefore, the process of connecting is an evolving process. However, residents find it easier to

recommence at making sense or at seeking new connections once they have more familiarity about how they could begin making new connections.

5.4. Summary

This chapter has detailed the study setting of the two RCFs for understanding the study findings. The capacities, admission process, available service, policies, and socio-cultural environment have been introduced. The chapter also explained the theoretical foundations of the process of connecting. The overview of three main categories of the theory—*A process of connecting*; namely making sense, seeking connections, and maintaining connections—have been provided. Major actions/interactions, conditions, and overall consequences of each process have been outlined. The following chapter will address the first category, making sense.

Chapter Six: Making Sense

6.1. Introduction

The previous chapter provided an overview of the theory—*A process of connecting*. It is established, from the previous chapter, that maintaining spirituality in RCFs, for Nepalese residents, involved *a process of connecting* with inner-self, a higher being/s, co-residents, family/relatives, and nurses and caregivers. In order to maintain spirituality, residents employed a range of strategies inside the RCF, under different conditions, leading to various consequences, which have been ordered under three categories: making sense, seeking, and maintaining connections. This chapter explains in depth the first category—making sense.

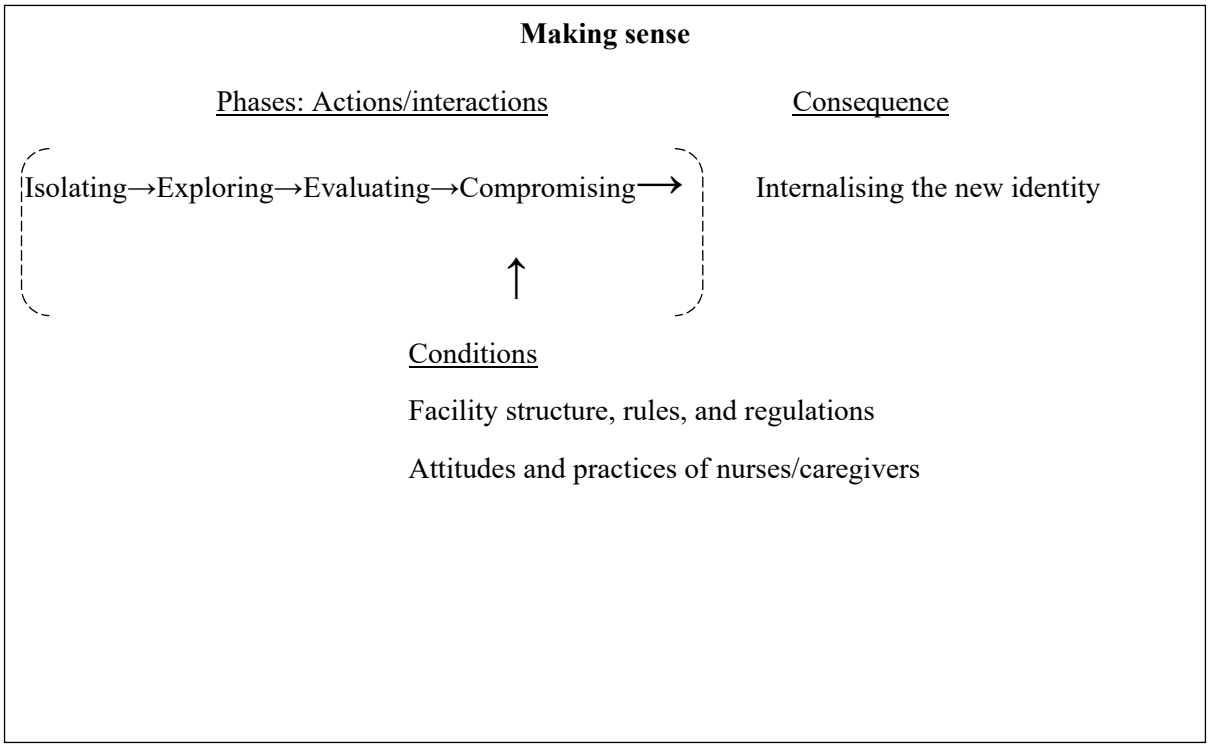
Making sense refers to the process of how residents make meaning of the new identities-as-residents before they seek and maintain connections in a RCF. This chapter begins with an in-depth explanation of the four phases involved in the process of making sense; namely, isolating, exploring, evaluating, and compromising (see Figure 6.1, p. 111). The forward-moving process of making sense is illustrated in Figure 6.1 by right-sided solid arrows moving through each phase. Next, the range of conditions impacting the process of making sense, including facility structure, rules, regulations, as well as attitudes and practices of nurses/caregivers, will be explained (indicated by an upward arrow in Figure 6.1). The chapter concludes with an explanation of the overall consequence of making sense, which is internalising the new identity.

6.2. Phase of Isolating

Isolating was the first phase in the process of making sense. This phase began when residents arrived and started living in the RCF. Isolating-self occurred in different forms; yet, mainly consisted of residents separating themselves physically or emotionally from the people in the RCF by sitting inside a room or in an aloof place or roaming alone in the RCF premises, and avoiding interactions. For most residents, this phase lasted from one to three months.

Figure 6.1

The Process of Making Sense



The reason why residents isolated themselves initially in the RCF varied. The most common reasons for a resident's initial isolation included the feeling of shame, home-sickness, shock, or guilt that developed after being admitted to the RCF. Residents also used the strategy of isolating themselves because they felt physically and emotionally vulnerable in relation to other residents. Isolating was their strategy of avoiding risk to physical or emotional harm and protecting themselves. Similarly, fear of being accused of wrongdoing or possessions being stolen, as well as not knowing how to interact or to be in facility, were other reasons for isolating themselves. One example of a resident's initial isolation comes from Rita. Rita, like most residents, was reluctant to move to a RCF. She wished to survive by working, which was how she previously lived. However, when she could no longer work, she chose to move to a RCF. She isolated herself in the first few months because she developed a sense of shame once she was admitted into the RCF. She recalled:

> [Initially], I used to wear *sari* (traditional dress) and cover my face with it. Then, I used to stay in that corner, where that co-resident is sleeping, and face the other way [towards the wall]. I faced that way so that co-residents would

> not call me… I used to face that way and prepare *batti* (cotton threads used for worshipping) (pause)… All because I was ashamed… even if it was difficult, I would have stayed at my home if I had a family. I had to come here (RCF) because I had nobody. So, I used to feel ashamed. [Rita, R, RCF1]

Rita confined herself to an aloof place inside the RCF because she was embarrassed that she had to come to live at a RCF and had no one to care for her in her old age. She was hesitant to talk to co-residents. She felt that if she initiated any interaction, co-residents would think that she was eventually "going to steal their portion of things and food" (Rita). This view of Rita was shaped by a condition in the RCF where stealing each other's items was common among residents. She was afraid to talk to co-residents due to the possibility of being suspected or accused of stealing. Another example of residents isolating themselves is Usha. Usha also did not want to move to a RCF. She was forced to do so when her husband neglected and abused her verbally and psychologically. She recounted, "we used to fight a lot…my husband did not care for me" (Usha). When Usha was admitted in the RCF, she was still struggling to cope with the neglect and abuse. She isolated herself because she became home-sick once she started living in the RCF:

> In the initial days [in the RCF], (laughs) I used to stay in this window [inside my room]. [I used to] look outside, hoping that my family will come [to visit me]. I did not weave *batti* (cotton threads used for worshipping) – hoping for my family to come. I anticipated that someone [from the family] who loves me would come. [I] strained my eyes looking outside [the window of my room]. However, who would come? None. [Usha, R, RCF2]

As reflected in the excerpt, Usha used to spend most of her time in her room in the RCF, looking outside the window and expecting family members to visit. Or else, she used to roam alone either on the "roof" or the periphery of the RCF, with permission. Like Rita, Usha was afraid to start any interaction with co-residents because she perceived that they might misunderstand her, "How do I speak with co-residents whom I do not know? Some people perceive things badly even if you do not intend to (pause). So, I did not speak [with co-residents]" (Usha). Furthermore, both Rita and Usha did not initiate any interaction with nurses/caregivers and only responded when being asked about something during the time of medication or care. Many residents isolated themselves in similar ways to Rita and Usha, having developed the feeling of shame, fear, or home-sickness after coming to the RCF.

Some residents reported they isolated themselves initially because they were shocked that they were brought to the RCF without their consent. For instance, both Mira and Devi were admitted to the RCF without their approval. Mira recalled, "I used to tell [my family,] I will not go to the RCF, and [I] do not know what it will be like [in the RCF]." Similarly, Devi specified, "[My] relatives told me [about their decision of admitting me into the RCF] the day before I was brought here, while we were having dinner." Both Mira and Devi felt shocked when they were forcefully admitted into the RCF. Mira expressed how "the first two months [in the RCF] felt different"; she continued, "I used to think of home… It was hard. So, I used to… roam [alone] around Pashupati (temple) and remember God." Likewise, Devi described her initial experience in the RCF, "When I first came here [in the RCF], I felt like Oh God! I used to stay in such a [nice] house… [I asked myself], 'What have I done that I had to come to this place (RCF)?' ...It felt like I got a bullet shot in my heart." Due to the feeling of shock, both Mira and Devi used to 'stay alone,' reflecting on their past and trying to figure out what they did wrong that their family or relatives brought them to the RCF. Similar to Rita and Usha, both Mira and Devi used to avoid interaction with co-residents and "keep quiet" upon seeing co-residents nagging, arguing, and physically fighting with each other. As in the case of other residents, Mira and Devi were also reluctant to start any interaction with nurses/caregivers, and only replied to conversation initiated by nurses/caregivers.

A few residents isolated themselves during the first few months in the RCF because of the sense of guilt. Nisha and Pushpa decided to move to the RCF when their family or relatives started abusing them emotionally. "My relatives insulted me, and did not even treat me as a human being" (Nisha); "I have a son, but [my] daughter-in-law took him away [from me]" (Pushpa). However, after coming to the RCF, both experienced a sense of guilt for making that decision. Nisha stated, "I wonder what made me come here [in the RCF to live]? Should I call this [the result of my bad] karma (deeds) or decision?" She mostly isolated herself inside her room and avoided any interaction with co-residents/nurses/caregivers because she felt guilty that by coming to the RCF to live, she had destroyed the name of her family/relatives. She continued, "If someone (referring to other relatives)… finds out that I am living here [in the RCF], then it would not feel good, right?… My brother is famous, including my parents" (Nisha). By isolating-self, she was avoiding "awkward" conversations,

or meetings, where co-residents/nurses/caregivers might ask her about her family background. Pushpa also isolated herself when she developed a sense of guilt after getting admitted to the RCF and avoided any interaction with other people: “When I first came here [in the RCF], I used to think why I came here?” (Pushpa).

The form of isolation varied among residents. For a few residents, the form of isolation was emotional rather than physical. Maya described that the initial days in the RCF were “not difficult” for her because she was “totally frustrated” with her “past life,” where her husband and in-laws treated her “badly.” She expressed that she did not cry even though “there were so many [new] co-residents who used to cry a lot… on the roof [of the RCF]” (Maya). Maya quickly involved herself in activities inside the RCF and started helping the co-residents with disabilities as well as caregivers. However, she clarified, “I did not use to talk much. I used to remain silent, no matter what others said… When you are new [to the RCF], you do not know how others are” (Maya). In contrast to other residents, she did not isolate herself physically; rather, her form of isolation was emotional.

Irrespective of the reasons for isolating-self, and the form of isolation, most residents described the phase of isolation as one of the most “challenging” times in the RCF. During the isolation phase, residents experienced a range of negative emotions such as feeling “sad,” “a bit low,” “lonely,” “bad,” and “depressed.” Common to the experiences of most residents in the isolation phase was the feeling of being physically or emotionally unsafe/vulnerable. Residents employed the strategy of isolating-self in order to ensure their physical and emotional safety when suddenly exposed to the potential risks associated with an unfamiliar environment, as well as people inside the RCF.

Residents used the strategy of isolating-self episodically or regularly. For most residents, isolating-self was episodic, which means they employed this strategy for a specific period, usually at irregular intervals. An example of episodic isolation would be that of Devi. Devi isolated herself in the beginning; however, as time passed, she started interacting with everyone. Nevertheless, when she perceived threatening behaviour from some co-residents, for instance, stealing, she went into episodic isolation:

> Everybody is friendly, but 2-3 co-residents are like this (sign language indicating bad), with whom I do not want to talk. They curse others to die. They steal and keep things. So, I keep my room locked. I neither enter co-residents' room nor talk to them. I stay in that junction [near my room], quietly… It was a little difficult [condition]… co-residents nag, and it irritates me. They fight. They blame each other about stolen things… I do not like that… I have not lost anything yet, so why should I fight? So, I keep quiet. [Devi, R, RCF2]

Devi confined herself near her room in order to ensure the safety of herself and her possessions, and stopped visiting other co-residents' rooms for interaction. She only continued interacting with co-residents when she felt safe. In this way, residents tend to move back to the episodic isolation from selective co-residents when conditions inside the RCF change.

A few residents, however, isolated themselves regularly. For instance, in the beginning, Hari used to isolate himself because he could not walk properly due to the stiffness of the knee joint. Eventually, he became able to walk with the help of a mobility aid. Even then, he chose to regularly isolate himself due to fear of potential harm from co-residents living with cognitive impairment:

> [I sit] either in bed or here (chair)… co-residents throw each other's plates. They fight and wrestle, the ones who are out of their mind… I have made something like a dining table from the [cardboard] boxes, and caregivers bring my food here. I eat here [inside my room]. [I talk] with no one (pause), I do not [talk] (pause). These older women (referring to female co-residents) are more intimidating than older men. They just roam around, find an issue, and start fighting. They will start scolding if they see someone older and weaker (pause) their habit and mind have distorted… I spoke to you today. Otherwise, I do not talk to anyone. [Hari, R, RCF1]

Hari described how he always isolated himself—either inside his room or a chair outside his room. Hari also turned down all invites for any form of interaction with co-residents, nurses/caregivers, or volunteers. Hari confirmed, "That is why the new co-residents do not recognise me." Similarly, despite being physically active, Narayan also decided to isolate himself in his room or in the sitting area outside his room, listening to the radio. He concluded, "[In this RCF,] there are co-residents, whom you cannot even understand… It is better to stay alone than to stay with them" (Narayan). In this way, conditional on individual perspectives, residents decided upon either isolating-self episodically or regularly. It is important to note that residents made this decision only after moving through the entire process of making

sense, seeking, and maintaining connections. After initial isolation, residents gradually proceeded towards the exploring phase.

6.3. Phase of Exploring

Exploring was the second phase in the process of making sense, where residents started exploring the dimensions of residential living. This phase commenced when residents came to terms with the fact that the RCF is the place where they will have to spend the rest of their lives. In the exploration phase, most residents reported making a conscious effort to forget about their past life, which was their primary concern in the isolation phase: “I used to think of home, and then I started to forget [about] it” (Mira); “You have to forget that (past life/family), there is no benefit of recalling that” (Ram); and, “I have to forget that (past life/family)” (Nisha). Eventually, residents started exploring the dimensions of residential living.

The dimensions of residential living that residents explored were safety, care, and health care provision by nurses, doctors, and caregivers. Similarly, residents explored the presence of religious places near the RCF, opportunities for spiritual practices, the involvement of nurses/caregivers in spiritual practices, and the ways of being treated by nurses/caregivers such as equality, respect, clarity, trust, and continuity in care. Other concerns of residents, while exploring the residential living, were opportunities for social interactions with community members and volunteers; opportunities to voice concerns; a chance to work; flexibility in daily routine; source of income or resources (donations); a degree of freedom to talk, eat, and walk. Furthermore, residents also explored the scope of decision making power, privacy, and dignified care during illness and end-of-life in residential living. Concurrently, residents also explored how co-residents talk, behave, or work in the RCF.

To explore the dimensions of residential living, as mentioned above, most residents used the strategy of observing and inquiring. By observing, residents started taking notice of different dimensions of residential living. Similarly, during the phase of exploration, residents initiated interactions with co-residents, nurses/caregivers, or other staff in RCF. The interactions initiated at this point were to inquire about different dimensions of residential living, gather information, and get familiar with

those dimensions. One resident, Shyam, gave an example of how he explored different dimensions of residential living:

> I talked to the security guard [of the RCF]. [Look] he is there doing his duty. Eventually, I asked him and learned about the nature of everyone [inside the RCF] and other things (referring to different dimensions of residential living). Then after, I started looking around, and it happened (referring to familiarity)… Then, [I talked to] the co-resident sitting there, [who] was from my village… I did not know him before but had known his father, brothers, and other families. I knew him only after coming to the RCF. [Shyam, R, RCF2]

Shyam initiated interactions with the security guard of the RCF and a co-resident in order to inquire about different dimensions of residential living. He also started observing the different dimensions of residential living. Another resident, Tulasi, used similar strategies during the phase of exploration, "A co-resident showed me around [the RCF], and after that, I familiarised myself [with different dimensions of residential living]." In the phase of exploration, some residents also initiated interactions with nurses/caregivers; yet, interactions were mainly restricted to acquiring information regarding different dimensions of residential living.

By exploring the dimensions of residential living, residents were gathering information, or getting familiar, and determining what was expected or desired from them as a resident. Ram shared his experience in the phase of exploration:

> After coming to this RCF, it took me almost one-two months to understand how people are (referring to co-residents/nurses/caregivers/managers)… Then, I understood their ways, where they work, and what they talk (pause) It has been six years, but female residents and staff have never said *ta yesto* (anything wrong about me). The biggest thing is your mouth (the way you speak). If you speak properly and say, "*Hajur, baini, chhori* (respected, sister, and daughter)," what will they do? I tell them sister, daughter, granddaughter, go there, and hug them. Then, they say *Ba*! (Father). [Ram, R, RCF2]

Ram perceived that being respectful and referring to co-residents, nurses/caregivers, and other staff as a family was the expected/desired behaviour from a resident; and, as such, decided to act accordingly. What he anticipated to receive from this strategy was a respectful treatment from everyone inside the RCF. In the same way, during the phase of exploration, Shyam felt that residents were desired or expected to be silent and not complain. As a result, he chose to remain silent about his need to be involved in social and spiritual activities inside the RCF. He believed that if he spoke

about his concerns, he might be removed from the RCF, “I had to wait for three years to be admitted into this RCF (pause) I fear it will all destroy [if I start complaining]” (Shyam).

While some of the expected/desired behaviour from residents were made apparent by nurses/caregivers and co-residents during initial interactions, others were hidden. The way co-residents behaved with each other and nurses/caregivers was interpreted by most of the residents as expected/desired behaviour. For instance, many residents interpreted that giving money/items to nurses/caregivers is a desired/expected behaviour from a resident. Also, residents believed that if they do not give money/items to nurses/caregivers, they might not get dignified care during illness and end-of-life. In this way, residents determined what is expected/desired from them, as a resident, by observing and inquiring about it with co-residents, nurses/caregivers, and other staff.

During the entire period of residency, residents returned to the phase of exploration, whenever conditions impacting the dimensions of residential living changed. One example of such conditions is the recruitment of new nurses/caregivers in the RCF. When this condition surfaced, residents yet again observed and inquired about the dimensions such as how new nurses/caregivers are treating residents, do they provide opportunities to voice concerns, or do they involve residents in decision making? Once again, residents determined the expected/desired behaviour as a resident. The next phase after exploration was evaluating.

6.4. Phase of Evaluating

Evaluating was the third phase in the process of making sense, where residents evaluated the dimensions of residential living. This phase was initiated when residents gathered required information about different dimensions of residential living. Residents evaluated the dimensions of residential living by comparing it with their past life. As a result of the evaluation, residents constructed different images of the RCF and identities-as-residents. For instance, Hari used to be an “independent” person before coming to the RCF. He had to come to the RCF when he could not work. After collecting information about different dimensions of the residential living in the exploration phase, he began to evaluate those dimensions by comparing

them with his past life; for instance, how he used to earn his living and having the freedom to do whatever he liked rather than being dependent on the RCF for food and being restricted by the rules as in the case of residential living:

> [At home,] when you are working, you get money, I used to shop all around… I used to bring and eat whatever I like. Here [in the RCF], it (referring to freedom) will never be as it used to be before [at home]… RCF is a place where you beg for food. No good people are living here, only those who have suffered and own nothing… I would rather die than to beg for food; that is what I wished. However, I ended up here… I never thought I would come to the RCF. I thought I would continue working until I die. People can live independently if they work until the age of 80 to 85. [Hari, R, RCF1]

As a consequence of that evaluation, Hari concluded that RCF is a "place where you beg for food." For him, the inability to generate income after being a resident and depending on RCF for food felt like begging. His previous identity as an "independent" person changed after becoming a resident. He began to perceive himself as a person who has "no one," "nothing to eat," "own nothing," "have suffered," and is "unsuccessful." As did Hari, Narayan, also evaluated the dimensions of residential living by comparing it with his past life. After that evaluation, he concluded that RCF is a "prison" (Narayan). For him, prison meant having no opportunities to voice concerns or do things as he wants, no one to speak on his behalf or listen to him, no rights, and no freedom to go outside the RCF. Likewise, his previous identity changed, and he started to perceive himself as a "prisoner." Other residents also constructed different images of the RCF and identities-as-residents in similar ways.

In most cases, constructed images of the RCF and identities-as-residents were negative. Before coming to the RCF, most residents expressed themselves as a person who used to stay in a "rich" or "good" house, or "never begged for anything." After evaluating different dimensions of residential living by comparing with their past life, some residents concluded that RCF is a "messy" or "dirty" place, which is "not like home," but a "mental asylum." Likewise, some residents started to view themselves as a person with "bad luck," who is "sick," "cannot work," and have "no support," "no one," "no shelter," or "no wealth." For some residents, their new identities-as-residents became that of a person, who is "entangled," "captured in other's fist," "under someone else' command," "living idly," or "has to rely on what others give." A few residents also described themselves as a person who is living "by

begging," "eating grains of government," "eating what others offer," and "carrying [other's] debt." Despite marked variation in the constructed images of the RCF and identities-as-residents, most had negative connotations.

Only a few residents constructed positive images of the RCF and identities-as residents. For those residents, RCF meant "shelter," "safe place," like "a home" or a "good" place which has "a touch of truth." These residents described themselves as "lucky" or blessed to be living in the RCF. Ganesh decided to move to the RCF when his sons went abroad, and he had no one at his home to care for him. Like other residents, Ganesh also explored and then evaluated different dimensions of residential living by comparing it with his past life:

> Back home, there was nobody to cook for me… This RCF is good… I can pray to the Lord… Yes, it is [easy] because of *dharma* (spiritual practices)… I have been staying here happily… I stay reading books… Sometimes I go to Pashupati (temple)… I worship… They had a programme few days back where [religious] scripture was recited …I donated… Yes, they do sing hymns… I must have done something good before, which is why I am in good condition today… If these things (spiritual activities) were not here, I would not stay here. This place (RCF) has a touch of truth, which is why I am here… Home is a disease… How do you get a disease? If someone (children) is suffering [because of parents], you will feel bad. [Ganesh, R, RCF1]

Ganesh concluded that RCF is a "good" place with "a touch of truth" since, unlike at home, he was being taken care of and getting opportunities to participate in spiritual practices of his choice. Ganesh described himself as a blessed person who is getting to live in such a "good condition." Likewise, Tulasi, who was physically and verbally abused by her husband, evaluated different dimensions of residential living by comparing it with the past:

> I would die at home; that was the situation. My husband's other wives… bullied me a lot, even came to my daughter's place. Then, the situation got worse. They even brought a knife, but they hit me with the blunt side, so it did not hurt. If I were still there (home), they would have taken my life… I feel safe here – I was scared that somebody would kill me back there. Here, they provide food, give two sets of clothes every year… Some nurses come in the night also. They provide medicine in the morning and evenings… There is shelter (a roof over your head). [Tulasi, R, RCF1]

For Tulasi, RCF meant a "shelter" or "safe" place. She felt that she was fortunate enough to get admission into the RCF. Likewise, Rita compared different dimensions of residential living with homelessness, her previous situation. She also reported

RCF as a “safe place” like “a home and described herself as a “lucky” person who “got a new life” in the RCF (Rita).

A few residents, who used to live in a RCF before coming to the present RCF, evaluated the dimensions of residential living by comparing it with that of the previous RCF, rather than their home, as in Sanu’s example:

> Janakpur’s RCF (previous RCF) was good. We could listen to *bhajans* (songs with religious themes or spiritual ideas) and *pravachan* (recitation of religious scripture or texts). We used to visit different temples or shrines (holy or sacred places dedicated to a specific deity, ancestor, or figure of respect, where they are worshipped)… Food is messy here [in the present RCF]. Everyone touches food in the kitchen. There was only *Brahmin* (caste) who used to cook and serve in Janakpur’s RCF… it is all messy here [in the present RCF]. [Sanu, R, RCF2]

As revealed in her excerpt, Sanu mainly evaluated two dimensions of residential living; namely, opportunities for spiritual practices and the consideration of the spiritual belief system. As a consequence of that evaluation, she concluded that the current RCF is a “messy” place since food preparation was not according to her spiritual belief system, as was the case of the previous RCF. Furthermore, although the current RCF did arrange regular *bhajans* and *pravachans*, like the previous RCF, visits to temples or shrines were rare. Accordingly, Sanu described the previous RCF as a “good” place. Sanu used to consider herself a “pure” person in the previous RCF due to the regular involvement in the spiritual practices and intake of “pure” food. However, in the present RCF, she began to perceive herself as not a “pure” person. This is how residents constructed different images of the RCF and identities-as-residents in the phase of evaluation. After the evaluation phase, residents gradually moved to the phase of compromising.

6.5. Phase of Compromising

Compromising was the fourth phase in the process of making sense, where residents compromised with the identities-as-residents that they constructed in the evaluation phase. This phase started gradually, once residents constructed identities-as-residents. In this phase, residents compromised with the identities-as-residents by comparing themselves with co-residents. Residents found ways to be at peace with their self-constructed identities. For instance, in the compromising phase, Shyam,

like many other residents, began to compromise his identity-as-a-resident developed in the evaluation phase by comparing himself with co-residents:

> When I see co-resident's cases here [in the RCF], I think my case is [much] better (pause)… Now, [look at the case of] this older man (co-resident), his sons have big buildings and a lot more… His daughters also live around… He is living here since nobody cared for him. He is a rich man from Biratnagar (place), only until he could work himself… In my case, I have no home, sons, and daughters-in-law… This [RCF] is private; the condition of government [RCF] is even worse. They do not care if residents are eating, not eating, living, or dead. The government pays for the staff, no matter what. I have seen [it myself]. [Shyam, R, RCF2]

As analysed in the excerpt, for Shyam, the reference group for comparison was those co-residents who had either sons or daughters-in-law, home, and were rich. He perceived that his case was "better" than those co-residents because, unlike him, they ended up living in a RCF even after having sons, daughters-in-law, home, or being rich. Like other residents, Shyam held the view that if older adults are living in the RCF even after having sons, daughters-in-law, home, or being rich, it means that the family has abandoned them. Further, he felt that his case was "better" than those co-residents who are living in the public RCF, where he evidenced the way residents are treated is even "worse" than the private RCF. Similarly, Lalita started to compromise with the identity-as-a-resident that she constructed, by comparing herself with co-residents:

> Some co-residents have two sons… Each [resident] has their own sad story. We have to eat what others give us (referring to donated foods)... I feel a little hurt due to this. You have to accept that after you come here [in the RCF]… Yes, sometimes, I do feel low. Wealthier co-residents than me have accepted food in a way that is provided to them… Why stay in the RCF if you have enough wealth? [Why to stay in the RCF] if you have a son or daughter-in-law and a home? I do not have anything, which is why I came here… I have accepted this place. [Lalita, R, RCF2]

For Lalita, the reference group for comparison was also those co-residents who had a son, daughter-in-law, home, and were rich. Likewise, another resident, Narayan, used similar strategies in the compromising phase, "Mothers of ministers are [living] here [in the RCF]. Mothers of ministers!" In this way, residents compromised with the identities-as-residents by comparing themselves with co-residents.

Compromising with the identities-as-residents was comparatively more challenging for those residents who had a son, daughter-in-law, home, or were from a well-off

family. One example is Ram. In the beginning, Ram could not compromise with the identity-as-a-resident that he constructed during the evaluation phase and decided to return to his home. He recounted, "I went to my home myself, met them (referring to sons and daughters-in-law), and stayed there for three-four days. However, they did not take care of me. If only they had taken care of me, I would have returned [to my home]" (Ram). In this way, when his sons and daughters-in-law did not take care of him, he decided to continue living in the RCF, "Now, I will not go no matter who comes to take me home, even if son, daughter-in-law or daughter" (Ram). Only then, he began to compromise with the identity-as-a-resident, by comparing himself with co-residents. For him, the reference group for comparisons was also those co-residents who had a son, daughter-in-law, home, or were from a well-off family. Comparing himself with co-residents from a similar background made Ram feel that he was not the only one from that background to be living in a RCF. Another resident, Nisha, who belonged to a well-off family and recently completed six months in the RCF, shared a similar experience about how she was compromising with the identity-as-a-resident. She was also comparing herself with co-residents from a similar background, "One co-resident is also from a good family. Others say that she has paid 5,00,000 Nepalese Rupees [to get admitted into the RCF]. She lives in a single room [in the RCF]… Her sons… went abroad, and brought her here" (Nisha). However, she indicated that she is still struggling to compromise with the identity-as-a-resident. She believed that her family might come to take her back home if the condition in the RCF gets worse for her. She continued, "My close people (family/relatives) say, 'Do not talk to co-residents about anything [related to problems], do not show your sorrow… rather tell us. If there is any difficulty, we will think about an alternative.'…That is why I am living [in the RCF] satisfactorily" (Nisha). Therefore, residents' background played a significant role in determining how residents compromised with the identities-as-residents.

In the compromising phase, what was common to the experiences of most residents was the feeling of having no option other than compromising with the identifies-as-residents. For instance, Tulasi expressed, "have to accept it (referring to identity-as-a-resident) if you do not have another place [to live]." Similarly, other residents used terms such as "must," "have to," or "should," compromise or accept, while describing how they compromised with identities-as-residents. The use of these

terms indicated that residents were left with no choice but to compromise with identities-as-residents, which, in most cases, were negative.

6.6. Conditions Influencing the Process of Making Sense

The process of making sense was conditional on facility structure, rules, and regulations; as well as attitudes and practices of nurses/caregivers. Facility structure was one of the major conditions that impacted the process of making sense, which included the nearness of the RCF to religious places, facility arrangement, and environmental aesthetics of RCF premises. When the RCF was near to the religious place, it facilitated and supported the regular involvement of residents in spiritual practices and programmes. Under this condition, residents constructed comparatively positive images of the RCF and identities-as-residents; in turn, making the compromising phase easier for them. Likewise, when residents were placed together in the same room or floor with co-residents living with cognitive impairments, or when the environmental aesthetics was not maintained in the RCF, residents constructed comparatively negative images of the RCF and identities-as-residents. As a result, the compromising phase became more difficult for residents. For example, Hari was kept on the same floor with co-residents living with cognitive impairment and cleanliness was not maintained in his floor. Influenced by these conditions, he constructed a negative image of the RCF and identity-as-a-resident. For instance, he concluded that the RCF is a "dirty" place, and is similar to a "mental asylum," as revealed in the following excerpt:

> Once I went to the mental asylum in India, they (mentally impaired people) used to do the same thing. I did not know about this RCF, [I asked,] "Is it a mental asylum?" (Laughs) … Then, I woke up in the morning and asked with a co-resident why the other co-resident was shouting. Then, she told me that they are mentally ill. I asked whether it is a mental asylum or RCF, then she said, "It is a RCF, not a mental asylum."… This place [RCF] is dirty. [Hari, R, RCF1]

Hari also began to perceive himself as an unfortunate and "unsuccessful" person having ended up living in such a place. Consequently, these negative images of the RCF and identity-as-a-resident, that he constructed, made the compromising phase more challenging for him.

Another major condition that influenced the process of making sense was the rules and regulations of the facility. When residents were provided with the opportunity to participate in spiritual programmes, given the freedom for individual spiritual practice, provided privacy, freedom to express concerns, walk, and work, or chance to interact socially, they constructed comparatively positive images of the RCF and identities-as-residents. Consequently, the compromising phase became easier for residents. For instance, Shyam was provided with all those opportunities in the previous RCF where he lived. The rules and regulations of the previous RCF had a positive impact on the image of the RCF and identity-as-a-resident that he constructed. The phase of compromising, therefore, became easier for him in the previous RCF:

> The chairperson [of the previous RCF] still calls me… I had a good relationship with everyone in that village [surrounding the RCF]… Although there were very few staff, I had good relationships with them, just like nails and flesh. I do not have that [relation) with the staff here… You cannot do things as per your wish, nor allowed to (referring to the current RCF)… For example, when I was there [in the previous RCF] (pause) 1-2 years ago, they even kept me as a priest for 2-4 years. They had a temple there. After that, (pause) they said, "Why to keep these older adults idle, let us make them hear something." They collected all the [spiritual] books (pause)… If I start boasting about that here [in the present RCF], they [staff] will not believe me. What to do in such a place? [Shyam, R, RCF2]

When Shyam was devoid of the above-mentioned opportunities in the current RCF, he constructed a negative image of the RCF and identity-as-a-resident. He concluded that the current RCF is not as "good" as the previous RCF and as-a-resident of the current RCF, he felt like an "entangled" person; in turn, making the compromising phase more difficult for him.

The next major condition shaping the process of making sense was the attitudes and practices of nurses/caregivers working in the RCF which accelerated/eased the process of moving from isolation to compromise. In this study, while most of the nurses/caregivers recognised residents' strategy of isolating themselves, only a few nurses/caregivers were conscious of how severe the consequences of the isolation could be. Consequently, only a few nurses/caregivers intervened when they found new residents isolating themselves in the RCF, and helped them move from isolation to the compromising phase. For instance, one nurse, Hina, recounted how a new resident in the RCF died isolating herself, "She (referring to one resident) always

used to think of her home. She used to say, "[Did] my daughter come? [Did] my daughter come?"… She also used to think of her wealth [at home]. Then, she died due to depression, poor her" (Hina). Being conscious of what could go wrong if new residents keep on isolating themselves, Hina prioritised the resident's need for interactions along with other needs when residents were isolating themselves. She shared how she initiates interaction and helps new residents move from the phase of isolating to compromising:

> I tell residents that you should not worry, and this place (RCF) is very good. There are friends here, talk to them, and laugh with them. I tell them not to stay alone, that's it, right? I keep saying that. That will lighten resident's hearts. Sad residents can relate to those who are experiencing the same feeling. That is (laughs) what I think. [Hina, N, RCF2]

Hina encouraged residents to avoid staying alone, focus on the positive dimensions of the residential living, communicate with co-residents, and share inner feelings. Another caregiver, Kala, reported using similar strategies in relation to helping residents move from isolation to the compromise phase.

The attitudes and practices of nurses/caregivers further influenced the images of the RCF and identities-as-residents that residents constructed. When nurses/caregivers prioritised the physical needs of the residents over other needs, and did not allocate time for other needs, residents constructed negative images of the RCF and identities-as-residents. In these conditions, residents indicated life in RCF as meaningless, and described themselves as "sick," "weak," or "dead weight." One example is Nisha. While describing how she used to be treated in the previous RCF, Nisha stated, "I understood that others (nurses and caregivers) saw me like a dead weight. I could not buy medicine for myself, neither cook, wash dishes, or clothes for myself… In the previous RCF, four months felt like four years. They (nurses, caregivers, and co-residents) intimidated me after I got sick." Consequently, the compromising phase became more difficult for Nisha in that condition.

In contrast, when nurses/caregivers valued residents' spiritual belief system; involved them in the decision making process; gave opportunity to voice their concern/needs and to contribute according to their capability; or rewarded for simple contributions they made in RCF; residents perceived residential living as purposeful, and described themselves as active, capable, and worthy individual. For instance,

when nurses/caregivers gave Rita, who used to hide from everyone, the opportunity to voice her concerns/needs, she started to speak in group meetings and later, became a lead speaker. In that condition, she constructed a comparatively positive image of the RCF and identity-as-a-resident; in turn, making the phase of compromising easier for her:

> We used to have a [group] meeting every 15 days… and they (nurses/caregivers) used to make me speak… Then, everybody (co-residents) used to agree with me… By group, I mean the group of older adults gathered in the office for the meeting… Yes, it was good. However, it happens no more… They had a microphone for us to speak. Then the staff would start by asking who wants to share their difficulties here and they used to call me. Others did not use to speak, so I would be the one who spoke mostly… I feel I am lucky. I say I am lucky because before, I did not even know how to speak, right? I used to hide. I used to feel ashamed of showing my face. [Rita, R, RCF1]

When group meetings stopped in the RCF, Rita could no longer use her voice as a leader, and it shifted her previous identity as a valued resident. However, Rita started expressing the concerns of residents with volunteers or nursing students visiting the RCF. Similar to Rita, when Maya was allowed to assist/contribute in nurses/caregivers' work, she also described herself as an active, capable, and worthy resident, "I used to help in doing all sorts of work… I never said no to work… I used to serve food to co-resident's room and help to prepare a meal. I got an award for my work" (Maya). Eventually, that condition eased the compromising phase for Maya. However, when Maya could no longer work, it shifted her previous identity as a valued resident.

6.7. Overall Consequence of the Process of Making Sense: Internalising the New Identity

Residents moved through the four phases of isolating, exploring, evaluating, and compromising in response to the shifting conditions, as mentioned above. The overall consequence of the process of making sense was internalising the new identity. Internalising the new identity refers to residents integrating within self the norms of residents, such as the shared pattern of behaviour (practices), core values, beliefs, or goals, which are held by most co-residents in RCF. In other words, when residents internalised the new identity, they started acting according to the group

norms of the RCF. Some residents were mindful of the process of internalisation; in some cases, it also occurred submissively.

The internalisation of the new identity was a complex process that occurred gradually. In this study, despite marked variations in constructed identities among residents, most of them described themselves as a person who has "no one" or is disconnected from past relationships. However, this identity as a person lacking connections did not occur immediately. The main condition that triggered residents' feeling of having no one or disconnected from past relationships was when visits/calls/invites from family/relatives steadily reduced or stopped after they started living in the RCF. Decreasing visits/calls/invites generated different emotional reactions in residents. The most common emotional reactions reported were the feeling of deception, abandonment, and marginalisation.

Nepalese residents, who held filial values, hoped to remain connected with family/relatives even in the RCF. When most residents did not get regular visits/calls/invites from their family/relatives, they experienced it as deception and abandonment. One resident Mira, who had been living there for five years, recounted how her family tricked her moving into the RCF first, and then deceived and abandoned her:

> Family… that is why I am here. Otherwise, I would not be here, did not even want to come here… I cried on the bus, but they told me not to cry and consoled me, then brought me here. They said, "We will come to see you," and "We are always there for you."… Till now, my daughter has not visited me. My uncle and his son, who brought me here, visit exactly once a year. That is it. They do not call. [Mira, R, RCF1]

Usha also shared her experience of being deceived and abandoned by her daughters after moving to RCF, "She (daughter) comes when I call her, who else would? Nobody comes. My eldest daughter is rich now and has forgotten the hard times. She has forgotten how this mother has raised her." Likewise, Ram expressed how his children have deceived and abandoned him by failing to remember his contributions:

> We raised, educated our children, and arranged their marriage. I had two sons and two daughters… *Chhora chhori le yaad garenan* (My children did not think about me). The biggest thing is, *bal chhaunjel sabai ko afno* (when you are strong, everyone owns you). Children! I told you that it had been six years and children, no one has come… It did not come to my son's and daughter's

> thinking that their father has gone through all these miseries [to raise them]. [Ram, R, RCF2]

For other residents, not getting expected visits/calls/invites meant being marginalised. For instance, When Maya did not get regular visits/calls/invites after coming to RCF, she expressed, "They (family/relatives) could [come] if they wanted. They do not come here …they are big rich people. I go myself." In the same way, Sanu stated that "They are rich. They would not come. They are big." Both Maya and Sanu marginalised themselves as an insignificant group of people for living in a RCF which, according to them, is not the socio-culturally ideal place to live. As a result, they perceived that big, rich people do not visit/call/invite people living in a RCF. Likewise, other residents interpreted lack of visit as being marginalised as a group of older adults, neglected by the family, "thrown" or destitute, irrespective of their background.

The lack of connection was the main concern of Nepalese residents. The perceived lack of connection and the associated feeling of deception, abandonment, and marginalisation triggered residents to take further action or become involved in further interactions in order to fulfil the lack of connection. Consequently, the shared goal among residents became seeking connections of some form or the other. In order to achieve that shared goal, the strategies that most residents employed after this point became shaped by the shared pattern of behaviour (practices), core values, and beliefs of the group of residents living in the RCF (detailed in chapter seven).

6.8. Summary

This chapter has introduced making sense, the first main category of the theory—*A process of connecting*. It is established that making sense is a forward moving process, which includes four phases of isolating, exploring, evaluating, and compromising; and leads to the consequence—internalisation of the new identity. The details of each phase have been explained; as well as how facility structure, rules, regulations, and attitudes and practices of nurses/caregivers influence the process of making sense. The final section addressed how residents internalise their new identity. The following chapter explores the second main category of the theory: seeking connections.

Chapter Seven: Seeking Connections

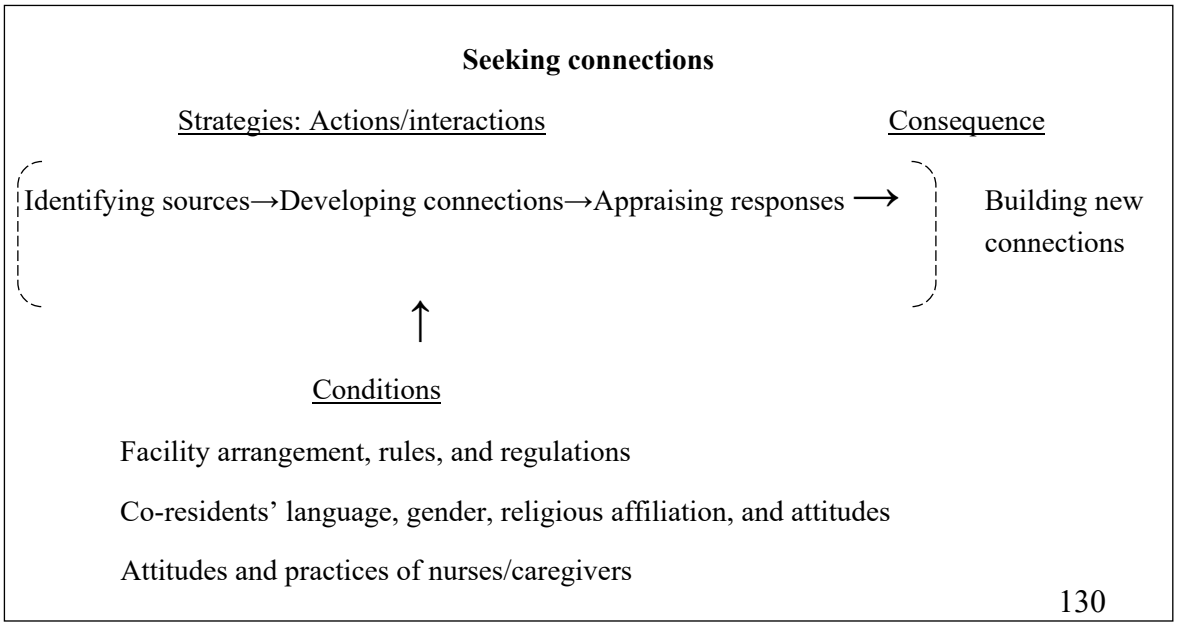
7.1. Introduction

The preceding chapter presented a detailed explanation of making sense, the first main category in the process of connecting. The previous chapter has shown that most residents internalised the lack of connections in their life as a resident. Conditional on the perceived lack of connections, residents then initiated a range of strategies to seek connections in RCFs. This chapter unfolds the second main category—seeking connections.

Seeking connections refers to the process of how residents pursue different sources of connections before deciding whether to maintain those connections in a RCF. This chapter provides an in-depth explanation of the actions/interactions involved in the process of seeking connections; namely: identifying sources, developing connections, and appraising responses (Figure 7.1.). Right-sided solid arrows in Figure 7.1 symbolize the forward-moving process of seeking connections. The range of conditions impacting the process of seeking connections, including facility arrangement, rules, regulations, co-residents' language, gender, religious affiliation, attitudes, and the attitudes and practices of nurses/caregivers, will also be explicated (indicated by an upward arrow in Figure 7.1). Finally, an explanation of the overall consequence of seeking connections—building new connections—is provided.

Figure 7.1

The Process of Seeking Connections



7.2. Identifying Sources

Identifying sources was the first strategy used by residents in the process of seeking connections. Identifying sources mainly consisted of residents searching for, and choosing sources of, connections in RCFs. Identifying sources commenced when residents internalised the lack of connections in their life, as a resident; after which, residents started searching for, and choosing sources of, connection in the RCF. Building on the information gained during the exploration phase, residents identified both internal and external sources of connection in the RCF. Residents identified inner-self and higher being/s as an internal source of connection in the RCF. External sources of connection identified by residents included co-residents, nurses, caregivers, students of different colleges coming for RCF visits, volunteers, donors, other staff (gatekeeper, kitchen staff), and spiritual advisors (*Brahmin, Guru*). Only a few residents recognised family/relatives as their sources of connections while living in the RCF.

Most Nepalese residents identified inner-self and higher being/s as their primary source of connections in the RCF. This choice was shaped by their socio-cultural, religious background, as well as history. According to socio-cultural and religious background, most residents considered connecting with inner-self and higher being/s as the main spiritual task to be fulfilled during old age. Influenced by the history of emotional abuse from family/relatives, most residents initially reported losing faith in relationships, in general. As a result, in the beginning, residents did not consider other people in RCFs as sources of connections.

As time passed, residents started searching for external sources of connections in the RCF. Initially, most residents identified those co-residents as sources of connections who were of the same gender, living near to their room, following the same religious affiliation, and had some form of past connection such as the same town or sharing common-friends. Later, residents started searching for those co-residents who could participate in, facilitate, or respect their spiritual practices. Similarly, most residents initially identified those nurses/caregivers as the sources of connection, who allocated time to communicate with residents. Eventually, residents started searching for those nurses/caregivers who could participate in, facilitate, or respect their spiritual practices. Likewise, some residents started looking for spiritual advisors

who could guide them in spiritual practices. For instance, Sanu identified one caregiver, some co-residents, and a spiritual advisor as sources of connections in the RCF:

> We have *nani* (caregiver). She (caregiver) gives us *arti* (advice, moral lessons, counselling) and preaching (teaching religious messages and beliefs)… I wake up early in the morning [for doing spiritual practices]. They (roommates) scold me for waking up too early. I do not care… I feel extreme happiness, we (other co-residents) all meditate in the morning. We offer *bheti* (cash as an act of religious devotion) to *baba* (religious figure of respect). We have one lady (spiritual advisor) who comes to teach us *murali* (one form of religious teachings). [Sanu, R, RCF2]

When Sanu found that her roommates disrespected her spiritual practices, she started identifying other co-residents involved in spiritual practices like her. Likewise, Sanu started identifying those caregivers and spiritual advisors who participated in, facilitated, and respected residents' spiritual practices. Usha, too, identified those co-residents, caregiver who participated in, facilitated, and respected her spiritual practice as sources of connection:

> My close friend is X (co-resident). Even she (close friend) follows *Om Shanti* (religious group), and we share food if somebody has brought it… Y (caregiver) takes me for a walk around sometimes. She (caregiver) took me to Triveni, Lumbini, and Chandragiri (temples). Then she took me to Salinadi (religious place)… The biggest one we follow is *Shiva* (higher being). *Shiva* is the only one we believe in, not others… After coming here (RCF), I started following *dharma* (spiritual practices). [Usha, R, RCF2]

As with Sanu and Usha, many residents identified sources of connections in the RCF based on the support they received in performing spiritual practices. For residents, having support in conducting spiritual practices meant sharing similar values, beliefs, interest areas, and goals, making the form of interactions meaningful.

A few residents also identified people outside the RCF, such as visitors, students, volunteers, donors, as their source of connections. For instance, Nisha regarded nursing students visiting the RCF as her sources of connection in addition to inner-self and higher being/s. Nisha expressed, "Here (in the RCF), many [nursing] students come to do an internship. They spend a lot of time with me. Everyone calls me mother, mother! One girl took my number, and she called me a few days back." Similarly, Rita and Ram also identified nursing students as their sources of connection in RCF:

> The [nursing] students were here (in the RCF) a few days back. [Nursing] students stay with me for a long time when they come. We also dance and have fun. They make all the older adults dance… Some come here for 15 days, some for 10, 5, 6, and some for 8 days. Moreover, on the last day, they bring Coke, Fanta, biscuits, distribute Frooti (mango drink) and have fun (pause)… Now [I am] wondering when the next [group of nursing students] will come. [Rita, R, RCF1]

> Look, in every 6-8 days, they (nursing students) come… Then, it will be pleasant here [in the RCF]. When you look at these people (nursing students), you feel peace in your heart (laughs)… I told you, nobody talks [other than that]. When they (nursing students) come here, they say grandfather, father, distribute fruits, and then they go there (another end of the RCF)… Even if you are not feeling peaceful, you will find peace when they come here [in the RCF]. [Ram, R, RCF2]

For Nisha, Rita, and Ram, the primary source of connection in RCF, however, was inner-self and higher being/s.

Few residents also identified family/relatives as sources of connections while living in the RCF. In contrast to most of the residents, these residents were getting regular visits/calls/invites from their family/relatives; support in conducting spiritual practice; were being taken care of, listened to, respected, and loved. For instance, Shyam and Tulasi recognised their daughters as sources of connections, even while living in RCFs:

> They (daughters) keep on visiting [me] even though I am living here [in RCF]… My daughters have done so much for me (pause)… keep on calling me… she (one daughter) paid all the cost of my treatment when I was ill… I have seen other's (co-resident's) daughters as well but have not seen doing as much as my daughters (pause)… From their (daughters') help, we called a reputed priest. They (daughters) said you do not have to bear anything, and we will arrange everything… He (priest) conducted the ritual very well… In my *chaurasi* (ceremonial worship done after turning 84 years old), my relatives and brothers came. [I] put on *tika* (the mixture of vermillion powder, yogurt, and rice) and donated a small amount of money. [Shyam, R, RCF2]

> She (daughter) asks me to come (to her house) for 2-4 days, but I do not feel like it… She takes me with her when I am sick. She brings a taxi to take me to the hospital to her home, where a doctor can visit. I have to call her, and she comes (pause). She has given me a phone… My [another] daughter says the same from the village… They love me a lot – which they should. They do love me. [Tulasi, R, RCF1]

Both Shyam and Tulasi anticipated having family support throughout their residency. Nevertheless, they also searched for other sources of connections in RCF, as did

most residents. However, the primary source of connections identified by both Shyam and Tulasi was still inner-self and higher being/s. Despite variation in sources of connections in RCFs, connecting with inner-self and higher/being were fundamental for most residents.

Identifying sources of connection was a continuous process. Over time, conditions surrounding the identified sources of connection changed. For instance, co-residents identified as sources of connections became ill, died; nurses/caregivers resigned; family/relatives stopped visiting/calling/inviting, respecting, or supporting spiritual practices. Under these conditions, residents moved back to identify new sources of connection. Residents continued to identify sources of connections throughout their residency, which is why identifying sources was a continuous and dynamic process. The next strategy used by residents in RCF was developing connections with their identified sources.

7.3. Developing Connections

Developing connections was the second strategy used by residents in the process of seeking connections. After identifying the sources of connections, residents started approaching those sources to develop connections with them. Strategies used by each resident while approaching the sources of connections differed. Nevertheless, what was common to the strategies used by most residents was allocating time for the identified sources of connections and getting involved in regular interactions.

Residents allocated different times of the day for developing connections with identified sources of connections. Most residents allocated morning or night for developing connections with inner-self, higher being/s, or spiritual advisors. Similarly, lunch and after lunchtime was allocated for developing connections with co-residents, visitors, students, volunteers, or donors. Likewise, most residents allocated evening time to develop connections with some nurses/caregivers or other staff considering it as a non-peak hour for them. During the allocated time, residents started getting involved in regular interactions with identified sources of connections. By employing this strategy, residents aimed to develop connections in the RCF.

Residents who identified inner-self, higher being/s, and spiritual advisors as their primary sources of connections, started getting involved in individual, as well as

group, spiritual practices in the RCF. In most cases, spiritual practices included reading or discussing religious scriptures, listening to hymns, chanting hymns, preaching, doing yoga, meditation, praying, worshipping, visiting the temple, making *batti* (cotton threads used for worshipping) and lighting them. Astha, like most of the residents, started participating in a different form of spiritual practices inside the RCF, intending to develop connections with inner-self and higher being/s:

> After I wake up in the morning, I go for prayer and chant hymns in that shed over there [in the RCF]. Yesterday, a group of *Sai Ram* (type of a religious group) came… I go there every day in the mornings. But I cannot go to Pashupati (temple) alone [without friends]… I lighted [cotton threads] 2-4 times [in the temple] after making them. Now I cannot make it because I do not have the strength. I donate items [in the temple], worship… I meditate… Then do exercise [yoga] like this. The [student] nurses teach how to exercise (laughs)… They teach, and I practice it… I am a lonely woman (pause). God is with me… I feel uneasy [when not involved in spiritual practices]. I have regularly participated in prayers. I do what I can, even when I am weak. [Astha, R, RCF1]

Spiritual practices became Astha's "routine" in the RCF. Similarly, Ram started regularly participating in spiritual practices in the RCF, "I go to [listen to the] preaching class. I light up *batti* (cotton threads used for worshipping), and take higher being/s' name. I go to that temple in the morning… I meditate and offer some flowers and rice" (Ram). In general, most residents incorporated spiritual practices in their daily routines in order to develop connections with inner-self and higher being/s.

Some residents, who identified spiritual advisors as sources of connections, started donating items or money in order to develop connections. In return, residents expected guidance from spiritual advisors in performing spiritual practices. For instance, when Tulasi and Rita found that group spiritual practices were occurring without spiritual advisors in the RCF, they searched for spiritual advisors outside the facility and started donating to those spiritual advisors in order to develop connections with them:

> Only if you have wealth, you can do *dharma* (spiritual practices), and otherwise, the *Brahmin* (spiritual advisor) will not come until given money. You have to pay for his recitation [of religious scripture]. If he feels bad [when given nothing or less money], what is the point of doing it? If you give more (items/money), he will leave happy… In *Aausi Purnima* (holy day), the *Brahmin* (spiritual advisor) comes, and [I] put *tika* (the mixture of vermillion

> powder, yogurt, and rice) on him (laughs). I am at least doing that. If he does not come, I feel dissatisfied. When they come, I feel like giving fruits and food. [Tulasi, R, RCF1)

> By other donations, I mean for the priest who used to come here for a long time. I give to the priest 50-100 Nepalese rupees, depending on how much I have in my pouch… The priest asks with hope… I know their behaviour and what they expect. I did *chaurasi* (ceremonial worship done after turning 84 years old) from my own money [with the help of spiritual advisors]. I donated... At that time, I sold my *Tilari, Jhumka, Dhungi* (ornaments), and ring. I contributed 24,000 rupees for the *Puran* (form of spiritual practices). [Rita, R, RCF1]

Similar to Rita and Tulasi, other residents also reported using strategies to develop connections with spiritual advisors when the RCF did not arrange for that. When group spiritual practices occurred in the guidance or presence of spiritual advisors (as arranged in one of the RCFs), it increased residents' opportunities for regular interactions with spiritual advisors; in turn, helping them develop connections with each other. This is how residents strategised to develop connections with inner-self, higher being/s, and spiritual advisors.

Residents who identified co-residents as sources of connections started spending regular time with them to develop connections. In most cases, spending time with co-residents involved sitting together, chatting, asking, and listening to their past stories, discussing religious scriptures, and joining in their spiritual practices such as visiting the temple or worshipping or making *batti* (cotton threads used for worshipping) together. Ram started spending time with those co-residents whom he identified as sources of connections in RCF:

> In the beginning, you will not know people unless you get to know them. If you had come today and walked right away, how would I know you?... I know everything now after talking to you. I got along [with co-residents] like this… I chat, two of them (male co-residents) live there (pointing to the other side of RCF). I do not have friends in my room… He had some books [religious scriptures] to read. [Ram, R, RCF2]

As noted in the excerpt, Ram started chatting and discussing religious scriptures with co-residents to develop connections with them. To develop connections, some residents also started gifting donated material or money to co-residents. For instance, Astha recounted how she developed connections with co-residents, who later became her close friends, by gifting them donated items: "How do I say this? (laughs) [I

shared with co-residents] things that have been donated, and gave gifts, leaf (of religious importance).” In this way, residents worked to develop connections with co-residents.

Residents who identified nurses/caregivers as sources of connections started interacting with them regularly to develop connections. For regular interactions, most residents started waiting for the shift of their choice of nurse/caregivers to express physical needs. Another opportunity for residents to have regular interactions with caregivers was when group spiritual practices in the RCF occurred in the guidance or presence of the caregivers. Under this condition, residents started regularly interacting with the caregivers seeking information on spiritual knowledge or how to conduct spiritual practices. These strategies helped facilitate the development of connections with caregivers. Some residents also started gifting donated material or money to nurses/caregivers identified as sources of connections. For instance, Devi revealed her strategy of developing connections with nurses/caregivers of her choice:

> They (nurses/caregivers) do not say anything, what would they? They come, provide medicine, ask how I am feeling… and [provide] food and go… I talk [with nurses/caregivers]… I do not share my feelings… I only reply to things that the nurses/caregivers ask… Nowadays, I donate in every month (pause)… Whatever I can… My senior citizen allowance does not come now, I get it in Ashad (June-July)… Have to give [money] to the kitchen [staff], other staff (nurses/caregivers), and managers. [They] say, “You just came, do not give money” (laughs)… I say, “Everyone else (all co-residents) gives, so I cannot be the odd one.” [Devi, R, RCF2]

Devi recently completed six months in the RCF. Through the social interactions that she had during that time, she decided to use the strategy of only communicating physical needs with nurses/caregivers. Like many other residents, she perceived that in order to develop connections with nurses/caregivers, residents should be donating something regularly to nurses/caregivers.

Some residents, who identified students, volunteers, donors, other staff as sources of connections, started spending regular time interacting with them. Similarly, the few residents who identified family/relatives as sources of connections also allocated time for them by calling/visiting on important occasions. Nevertheless, those residents were also involved in developing new connections in the RCF. Developing connections was a continuous process. Residents continued working towards

developing connections with identified sources. After putting effort into developing connections with identified sources of connections in RCF, the next strategy used by residents was appraising responses.

7.4. Appraising Responses

Appraising responses was the third strategy used by residents in the process of seeking connections. Appraising responses mainly consisted of residents assessing the response from the external sources of connections against their expectations. Appraising responses began as soon as residents approached external sources of connections in the RCF. Therefore, developing connections and appraising responses occurred concurrently.

After initiating strategies to develop connections with external sources of connections, residents started appraising the response from those sources. The appraisal of the response was mainly based on residents' expectations from a source. For instance, most residents expected that spiritual advisors would guide/assist/facilitate them in performing spiritual practices or participate in/respect their spiritual practices. When the response from the spiritual advisors matched residents' expectations, they decided to continue developing connections with them. In contrast, when a spiritual advisor responded in a different way than expected, residents decided to limit or stop developing connections with that spiritual advisor and started identifying other sources. For example, Tulasi initially identified several spiritual advisors outside the RCF as her sources of connections and worked to develop connections with them. However, after appraising the response from the spiritual advisors, who did not come routinely as expected to help her perform spiritual practices, Tulasi stopped developing connections: "I get angry if they (spiritual advisors) do not come [regularly]." She then started identifying other sources of connections; alongside, continuing to develop connections with those spiritual advisors whose response matched her expectations.

In the case of co-residents, most residents anticipated them to be trustworthy, cooperative, and compassionate. Residents also expected co-residents participate in, facilitate, or respect their spiritual practices. When the response from the co-residents matched residents' expectations, they decided to continue developing those

connections. However, when some co-residents responded differently than anticipated, residents decided to limit or stop developing connections and started identifying other sources. For instance, Narayan had identified co-residents as sources of connections in the RCF and initiated strategies to develop connections with them. Narayan expected co-residents to be cooperative, loving, and easy-going. Narayan also anticipated that co-residents would participate in, facilitate, or respect his spiritual practice. After appraising the response from co-residents based on his expectation, Narayan concluded:

> If the person [co-resident] living beside you in bed talk politely, nicely, aesthetically, lovingly, then you chat with them. You get to know about that person, and that person gets to know you. If they (co-residents) talk boastfully, with attitude, and cynically, you will know nothing [about them], even when they stay beside your bed [in the same room]. [Narayan, R, RCF1]

Narayan also found that most of the co-residents followed different spiritual practices than his own, and did not participate in, facilitate, or respect his spiritual practice, "They (co-residents) do hymn singing in the morning, but it is different… they (co-residents) do not listen to the preaching that I listen to. They do not like it" (Narayan). Thus, Narayan decided to stop developing connections with those co-residents and started identifying other sources of connections.

Another example is Tulasi. Tulasi also anticipated co-residents to be empathetic, loving, and supportive of her spiritual practice. After appraising the response from the co-residents based on her expectations, she stated:

> There is nobody (co-residents) who sympathises with my situation here except higher being/s… Even though there are people (co-residents) who help, my soul has accepted that nobody sympathises with my situation. Others' soul does not love my soul. I understood that... Once God loves you, you do not feel the hurt caused by humans. If you love others (people), you cry with tears… I have two daughters, and that is where my soul will go – where else would it go? …I do not have friends to walk together. Others walk fast, which I cannot. If I had a friend who loved me, we would walk together… [I] have not gone to Pashupati (temple). [Tulasi, R, RCF1]

In this way, when Tulasi's expectation did not match with the response of co-residents, she stopped developing connections with them. Eventually, she started identifying other sources of connections.

As regards the nurses/caregivers, most residents expected them to provide loving, unbiased, dignified, and continuous care. Similarly, most residents anticipated that nurses/caregivers would participate in, facilitate, or respect their spiritual practices while living in the RCF. When nurses/caregivers responded according to their expectations, residents decided to continue developing connections. Alternatively, when the response of some nurses/caregivers did not match residents' anticipated response, they decided to limit developing connections with those nurses/caregivers and started identifying other sources. For instance, Shyam expected nurses/caregivers to provide unbiased, loving, and dignified care. Shyam also anticipated that nurses/caregivers would support him in his spiritual practice. When the response of nurses/caregivers did not match Shyam's expectations, he reported, "You cannot do things as per your wish, nor allowed to." Shyam limited developing connections with those nurses/caregivers and started identifying other sources. On appraisal, the response of one nurse matched Shyam's expectations:

> The nurse is excellent. The nurse is not biased. She goes to everyone, asks them if they need any help, and help accordingly. She does everything. She has quite nicely maintained the timetable of medicine, [she] is lovely… Now, it is worthless to see caste in this era. We do not know her (nurse's) caste. We do not care even if she is a *podini* (lower caste). Not only me, but she has adequately served every one of us. Besides Saturday and other public holidays, she works from 10 in the morning to 5-6 in the evening… See, this sister (nurse) is like God. [Shyam, R, RCF2]

Based on his appraisal, Shyam continued developing connections with that nurse. Rita also anticipated caregivers to be loving, compassionate, and caring; yet, on appraisal, the response of caregivers did not match her expectations:

> What happened now is that nobody (caregivers) is in contact; they all live on that side [of the RCF]. I do not go there. That is why we are not in contact… The caregivers should have asked what they should be doing to serve the older adults better. They are being paid for it. It is not just about washing the vegetables. They are here to care for older adults and should be doing that. They should ask whether we are feeling good, whether we have eaten or not… They (caregivers) can at least ask the older adults about their problems and report that in the office. Yes, I want to see that behaviour in them. That should come in their thoughts. They (caregivers) should learn to love. [Rita, R, RCF1]

In this way, Rita decided to limit developing connections with those caregivers and started identifying other sources.

Appraising response also applied to those residents who identified family/relatives as their sources of connections while living in the RCF. Those residents anticipated that family/relatives would continue visiting/calling/inviting, listening to them, loving, supporting in fulfilling spiritual needs, caring during illness, providing financial backup, and respecting. On appraisal, when the response of family/relatives was as expected, residents continued calling/visiting them on special occasions. However, when the response of family/relatives did not match the intended response, residents decided to limit/stop calling/visiting them. After appraising the response of the family/relatives, Nisha perceived being disrespected by family/relatives and, therefore, decided to stop visiting family/relatives:

> Today is the wedding day of my sister's grandson. She (sister) said she could not come [to pick me up], but she will send someone if I wanted to go. I told her, "I have just arrived and it is hard for me to walk in a crowd, so it will be difficult for me"… She (sister) asked me to come to the party palace (hall) at least. I said, "I do not have clothes that suit the occasion, and the relatives are pretty distinguished, so I will not come"… My relatives at home are angry though. They think I [have] caused them embarrassment. Nobody else has been in this situation (referring to living in RCF). [Nisha, R, RCF2]

Nisha anticipated that family/relatives will embarrass her if she attends the ceremony. As a consequence, despite her ability, Nisha decided not to visit the family/relatives on this special occasion, even after being invited. As in the case of Nisha, when Sanu perceived not being respected by her family/relatives, after appraising their response, she also decided not to visit the family/relatives, "I was invited to one marriage ceremony of my sister's granddaughter. I will not go. Who will take me there [ceremony] in the vehicle, and who will drop me here [in the RCF]? Do I have that respect… Isn't that respect? …They (family/relatives) cannot give that [respect]… I said, "I will not go." In this way, residents decided to continue, limit, or stop developing connections with identified sources. Appraising response was a continuous process. Residents continued to appraise the response of identified sources throughout their residency.

7.5. Conditions Influencing the Process of Seeking Connections

The process of seeking connections was conditional on facility arrangement, rules, regulations, co-resident's language, gender, religious affiliation, attitudes, and the attitudes and practices of nurses/caregivers. These conditions either facilitated or

constrained the process of seeking connections. Major conditions that impacted the process of seeking connection were facility arrangement, rules, and regulations. For instance, when residents having and not having physical, sensory, or mental impairments were kept together in the same room or flat, it constrained the whole process of seeking connections. Due to this condition, even when residents worked to develop connections with co-residents, connection development was constrained by hearing, speech problems, or mental impairments of the fellow residents. Many residents indicated how being surrounded by co-residents who are unable to speak, hear, or understand conversations has impacted the development of connections, as shown in the following excerpts:

> There is one *lato* (co-resident having cognitive impairment), there is another one inside. They (co-residents) don't speak. There are similar *ama haru* (female residents) who do not speak at all… There is another old man who speaks to me but I do not understand his talk… I want to talk but there are no friends to talk… He (one co-resident) comes here sometimes and chat for 1-2 hours, we share our sadness and happiness… Now, the other old men does not talk much. I am alone… Then, those *nani haru* (nursing students) come like this on a brief visit. I talk with them. [Ram, R, RCF2]

> I do not understand what they (co-residents) are saying… When they (co-residents) speak, nothing is understood. [I am] not sure whether their voice has matured or what. Most of them (co-residents) (laughs) are like that. Their speech is not understood. They do not hear, they will hear if you scream. Otherwise, they will not hear when you speak slowly… I have become a lonely person… Actually, I do not have friends. [Hari, R, RCF1]

Like Ram and Hari, other residents also agreed that they had few co-residents to talk to due to the facility arrangement, "What to talk with these *thalase* (bed-ridden co-residents) living downstairs? [I talk] just with these 2-4 people (co-residents)" (Shyam); "There are people (co-residents) here whom you cannot even understand. They do not understand despite explanation… It is better to stay alone than to stay with them" (Narayan); and "In the front and back [of my room], there were deaf (co-residents) only" (Rita).

Instead, when the facility arrangement changed for some residents, it facilitated the process of seeking connections. When Sanu was kept in the same room with a co-resident living with cognitive impairment, and in the same flat with ill co-residents, it constrained her development of connections in the RCF. However, when she was transferred upstairs, it facilitated the development of connections with co-residents:

> First, I used to live downstairs. I had no one to talk. There were friends but in different rooms. I was with *lati* (co-resident having cognitive impairment). She was terrible and used to abuse by hitting me physically. I told the manager that she does that and asked how to live with her? The manager used to tell me, "Face the walls of the room and sleep". I stayed downstairs for 10 months, and then I was transferred upstairs by the manager… After two-four days, they (staff) asked me how I felt living upstairs. I said, "Now I feel like I am living in Kathmandu (city)" (laughs)… I am delighted… We all need someone to talk to. Some of the residents talk with me (laughs). [Sanu, R, RCF2]

Sanu's feeling of loneliness decreased as opportunities to have interactions with co-residents increased when she was transferred upstairs. In that RCF, more able-bodied residents were kept upstairs. As shown in the excerpt, changing the condition (i.e., facility arrangement) altered the entire process of seeking connections.

The next condition that influenced the process of seeking connection was facility rules and regulations. When the RCF organised regular group spiritual programmes in the presence of spiritual advisors and caregivers, it increased residents' opportunities for regular interactions and facilitated the development of connections. Similarly, when the RCF allowed residents the freedom to conduct individual spiritual practices inside their room, it facilitated the process of seeking connections with inner-self and higher being/s. Yet, when the RCF restricted individual spiritual practices inside their room, it constrained residents' process of seeking connections with inner-self and higher being/s. For instance, "They (caregivers) say we are not allowed to hang [religious] photos on the wall. So, they (caregivers) scolded one or two persons (co-residents) for that reason. But I have not put any. I rather go to the temple to pray" (Mira); "That mother (co-resident) rings it (religious bells) and lights up the cotton threads early in the morning when nobody (nurses/caregivers) is there. When nurses/caregivers are here, one (resident) is not allowed to do anything" (Nisha). Rules and regulations regarding spiritual programmes and practices either facilitated/constrained the process of seeking connection.

An additional rule and regulation that impacted the process of seeking connections was the provision of donations for residents. Many residents were not receiving an old-age allowance in the RCF. When RCFs allowed donors to donate money or materials directly to residents, residents had enough resources to share with or give to different sources of connections such as spiritual advisors, co-residents,

nurses/caregivers. This condition eased residents' development of connections with different sources. Nevertheless, when the rules regarding donations changed, and donors were no longer allowed to give money directly to the residents, residents' resources decreased. When resources decreased, residents could not offer money or material back to different sources to develop connections with them. Consequently, this rule constrained the process of seeking connections. Narayan explained how getting donations used to make him happy in the RCF because he had money to provide to nurses/caregivers and co-residents, which helped him develop connections. Nevertheless, when the rule and regulation regarding donation changed, and direct donation stopped, he could no longer offer money or material to those sources:

> They (co-residents) are reluctant to share their names and say, "Why you need our name if you do not give us anything?… Here is the thing about the nurses. If you have money, they will look after you… What is there to be happy about? The donors were donating and distributing here before. …They (donors) could give that (donations), we would be happy. Since we do not get this (donations), we are unhappy… We should get the donations from the hands of the donor. [Narayan, R, RCF1]

For Narayan, having no resources impacted his development of connections with different sources; in turn, making him feel "alone" and unhappy. Tulasi, too, used to collect the donations to give to the spiritual advisor. When donations stopped, she could no longer offer spiritual advisors money or material, which impacted her development of connections with them. Tulasi concluded:

> Now they (management) closed it (donations) since *Bhadra* (August) – but before that, people from outside used to donate food and clothes and it was not difficult here… I feel like doing *dharma* (spiritual practices)… I do not have money here [to conduct spiritual practices]. [Tulasi, R, RCF1]

In this way, rules and regulations regarding donation either facilitated or constrained the process of seeking connections.

The language, gender, religious affiliation, and attitudes of co-residents also influenced the process of seeking connections. Some residents could not understand the language of co-residents. For instance, Nisha expressed how having a roommate who speaks a different language than hers affected seeking connections, "This mother (co-resident) does not understand. She speaks *Newari* language." Similarly,

Hari stated how linguistic variation constrained seeking connections with some co-residents,

> There are people (co-residents) here who do not understand the language [I use]. [I] also do not understand what they are saying. I said to myself that the people from Hilly and areas near the Himalayan region do not understand [my] language. [Hari, R, RCF1]

In terms of gender, most female residents were seeking connections with other female co-residents, which made it challenging for male residents to seek connections, particularly when most residents were female. Male residents often reported feeling "odd" while seeking connections with female co-residents. For instance, Shyam indicated how seeking connections with female co-residents was challenging for him, "It took me no time in case of the people (co-residents) who are like me. It is still hard for me to mix with these cooks (female) and those old women (female residents) there."

Most residents further reported that having similar religious affiliations facilitated the process of seeking connections with co-residents, "I used to listen to hymns a lot before. I have 4-5 female friends. There is also a chubby one upstairs who joins me for hymns" (Pushpa). Likewise, most residents stated that co-residents' attitudes played a major role in seeking connections with them. Most residents indicated that they had difficulty interacting with co-residents whom they perceived were "evil," "mad," "enraged," "unfriendly," "uncooperative," "intimidating," "bossing," "boastful," "sarcastic," "reluctant," and "accusing." When co-residents were unsupportive, it constrained the process of seeking connections. In contrast, when co-residents spoke the same language, were of the same gender, following similar religious affiliation and supportive, it facilitated the process of seeking connections.

Another condition that impacted the process of seeking connection was the attitudes and practices of nurses/caregivers. Some nurses/caregivers prioritised the physical needs of the residents over other holistic needs and under this condition, interactions between residents and nurses/caregivers were minimal and limited to meeting physical needs. This condition constrained the residents' process of seeking connections. On the other hand, when nurses/caregivers considered residents' holistic needs, it facilitated the residents' process of seeking connections. The following

excerpt reveals how the attitudes and practices of different nurses/caregivers affected Sanu's process of seeking connections:

> I feel *ananda* (extreme happiness). I feel empty when *nani* (caregiver) is not around. I miss her. She has helped us to that extent. *Nani* (caregiver) also teaches us (spiritual knowledge). She has excellent behaviour… We talk with *nani* (caregiver). Some residents are friendly, and others are devil. Hence, I keep all my feelings within myself. I do not care what others (co-residents) say. If we need anything, *nani* (caregiver) will know, and she will help… Nurses also visit here. She helps us as much as possible. They (nurses/caregivers) give us medicine as per our needs… They do not do anything else other than that. They give us medicines we want. What else should they do? …I ask for medicines when I need. That is all I do. We have two caregivers. They clean our rooms. They help residents who cannot care for themselves. [Sanu, R, RCF2]

Sanu explained that unlike others, one caregiver prioritised her physical and holistic needs, which facilitated her process of seeking connections. Nurses/caregivers had a role in facilitating the residents' process of seeking connections.

7.6. Overall Consequence of Seeking Connections: Building New Connections

By using a range of strategies in the process of seeking connections, most residents eventually built new connections for themselves in the RCF. The newly built connections, then, were considered as the new family. At this point, the notion of what constitutes a family shifted for most residents. The following expert sums up how the notion of family shifted for Narayan:

> Let there be 1000 crores (approx. 10 billions) of wealth, or 10 brothers or sons or nothing. Even if you have a son and daughter-in-law, if they will not look after the old, they will not be son and daughter in law anymore. If they look after the old, then only they can be called a son or daughter. The person who looks after you when you are not able, they are the real brothers and one's family. I am weak and cannot cook for myself or do anything even though son and daughter-in-law are there. Even if the grandchildren do not look after the old, they are the same. Like the way you came here, and we are chatting now, it is a similar relationship. [Narayan, R, RCF1]

Narayan no longer considered his family as a support system. Instead, Narayan was convinced that when the family does not fulfil their responsibility of looking after the older adult, it cannot be called family. Instead, Narayan considered those people inside the RCF as his family who cared for him when he was not able to do it himself. The meaning of family changed similarly in most cases.

Some residents not only started inferring the newly built connections as their family but also performing rituals with them; otherwise meant to be performed with a family member. After employing different strategies in seeking connections, Ram eventually built new connections with nurses/caregivers in the RCF, and symbolised them as his family. Ram then started performing rituals with those nurses/caregivers, which were meant to be implemented with children, "I have no relationship with my family… I did not do *chaurasi* (ceremonial worship done after turning 84 years old). Who will do?... Then, I just put *tika* (the mixture of vermillion powder, yogurt, and rice) and gave some money to sisters, daughters, granddaughters here [in the RCF]." After building new connections, residents started employing strategies in order to maintain those newly built connections.

7.7. Summary

This chapter has explained the details of seeking connections, the second main category of the theory—*A process of connecting*. It is established that seeking connections is a forward-moving process, including strategies; namely, identifying sources, developing connections, and appraising responses. The details of each of these strategies have been explained; and the explanation of how conditions such as facility arrangement, rules, regulations, co-resident's language, gender, religious affiliation, attitudes, and the attitudes and practices of nurses/caregivers facilitate or constrain the process of seeking connections. The overall consequence of the process of seeking connection (i.e., building new connections) was also discussed. The following chapter will explore the third main category of the theory—maintaining connections.

Chapter Eight: Maintaining Connections

8.1. Introduction

The earlier chapter elucidated seeking connections, the second main category of the theory—*A process of connecting*. Seeking connections presented how residents work to build new connections in RCFs. After building new connections, the next strategy used by residents was maintaining those newly built connections. This chapter elaborates on the third main category, maintaining connections.

Maintaining connections refers to the process of how residents retain their newly built connections with co-residents, nurses/caregivers, inner-self, and higher being/s as they continue living in a RCF. This chapter provides an in-depth explanation of the actions/interactions involved in the process of maintaining connections; namely, sustaining connections with co-residents, preserving connections with nurses/caregivers, and continuing connections with inner-self and higher being/s (see Figure 8.1, p.149). The dashed bent arrows pointing to the right and left in Figure 8.1 denotes the ongoing nature of the process of maintaining connections. The range of conditions impacting the process of maintaining connections, including decreasing physical abilities, increasing illness of residents, illness or death of co-residents, and retirement or resignation of nurses/caregivers, will be explained (indicated by an upward arrow in Figure 8.1). The chapter concludes with an explanation of the overall consequence of maintaining connections, which is balancing shifting connections.

8.2. Sustaining Connections with Co-residents

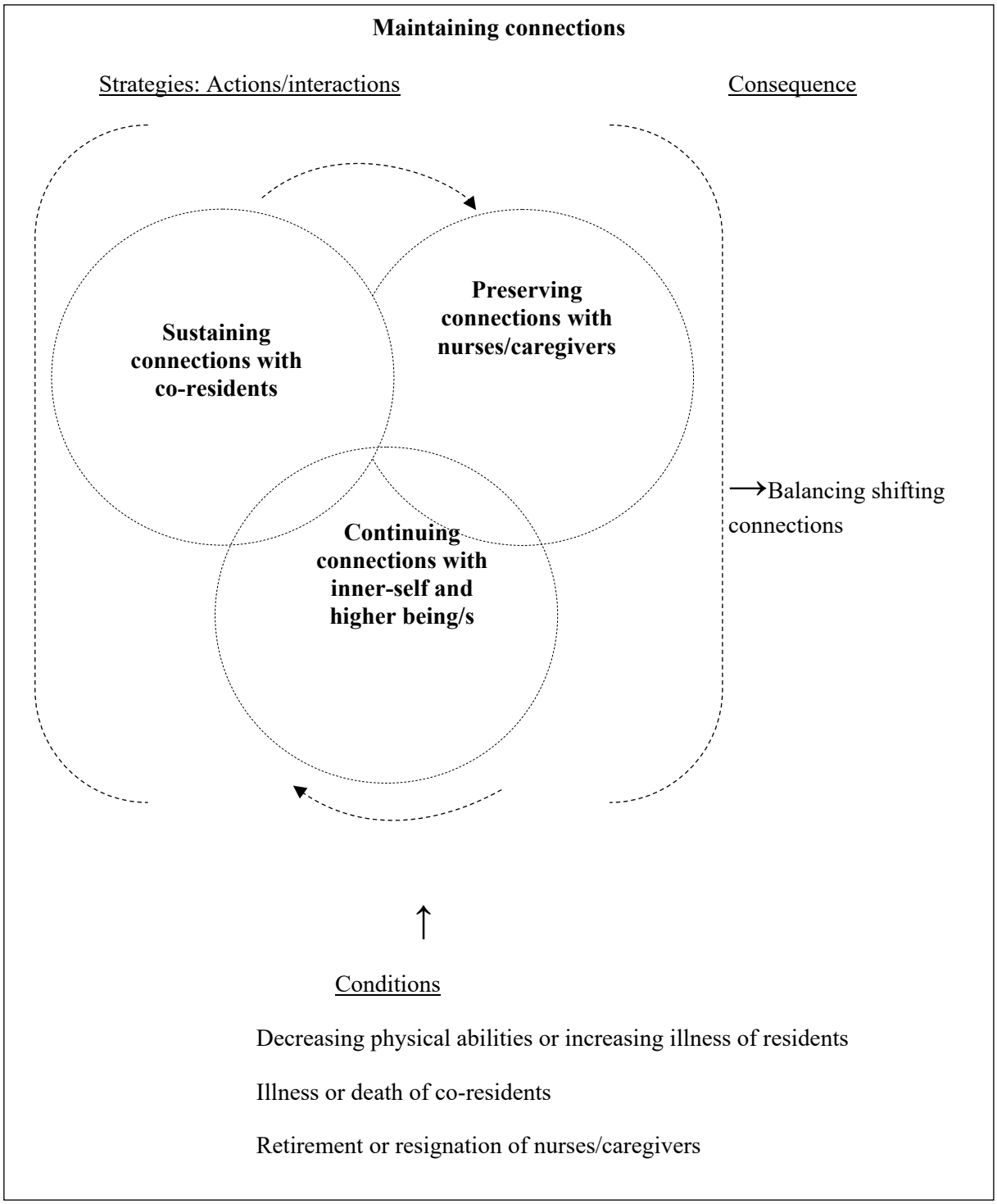
Sustaining connections with co-residents is about how residents strengthened or supported newly built connections with co-residents. To sustain the newly built connections with co-residents, residents initiated and continued a range of strategies such as being nice, avoiding conflict, assisting, and sharing. Most residents used the strategy of being nice. Being nice with co-residents meant speaking politely, respecting them, not saying anything bad, being honest, or being humble. Nisha articulated her strategy of being nice with co-residents:

> [I] do not present myself as a boss. I talk nicely and respect co-residents by referring to them as mothers… There are some [co-residents] who think they

are the boss [of RCF]… This place is called *Ashram* (RCF). There will be different types of people in *Ashram*, right? They will keep saying [bad things]. It's ok. [Nisha, R, RCF2]

Figure 8.1

The Process of Maintaining Connections



Nisha continued, “Wherever I stayed (referring to the previous RCF), nobody (co-residents) said anything bad about me. I do not know what will happen here… let us see what happens.” Nisha decided to follow the same strategy of being nice that she used in the previous RCF, and expected co-residents to respond similarly. Usha, also employed the strategy of being nice, “If you are good, everybody else will be good [to you]. If you are bad, the whole world will be bad, isn’t it? …I do not feel like boasting to co-residents. I do not feel like speaking in a harsh way” (Usha). Both Nisha and Usha put effort into sustaining newly built connections with co-residents.

Another strategy used by most residents to sustain newly built connections with co-residents was avoiding conflict. Conflict mainly occurred when residents used or stole each other’s items, used harsh words during conversations, boasted about property/family/relatives, accused each other of stealing, complained about each other to nurses/caregivers, used more space when in the same room, or constrained each other’s spiritual practices. To avoid conflict and ensure safety, some residents used the strategy of tolerating, not going against, and not complaining about co-residents, even when co-residents interacted negatively. One resident, Maya, gave an example of how she avoided conflict with co-residents:

> I do not fight with co-residents. Few co-residents blame me for the thing that I have not done. I let them blame me… I have not stolen things [from co-residents], so it does not matter even if they blame me for that… [some] co-residents do not help even if they can… There are few co-residents here who verbally abuse others, and I cannot do that… They keep on abusing, and I have to listen to them, which is totally unnecessary… Some of the co-residents are on fire (angry all the time)… When co-residents say bad words, I stay silent sometime and talk again later on. Now, what to do? [Maya, R, RCF2]

As shown in the excerpt, even when Maya encountered negative interactions with co-residents, she tolerated it by staying quiet, not responding, or fighting back. During the time of negative interactions, Maya maintained her safety and, later, re-initiated interactions with the same co-residents. Similarly, another resident, Ganesh, described how he avoids conflict with co-residents, “If you speak [with co-residents] more than you have to, you will suffer, and you might get into a fight.” As in the case of Maya, not responding or fighting back, even when confronted with negative interactions, was Ganesh’s strategy of sustaining newly built connections with co-residents.

Assisting was the next strategy used by some residents in order to sustain new connections with co-residents. Residents assisted co-residents either by putting them back to chair or bed when they fell, aiding them in executing activities of daily living, bringing items or food they want, and caring for them during the time of illness. For instance, Shyam revealed his strategy of assisting co-residents:

> We lift [co-residents]… if we caught them falling… [Look at] that one (co-resident) who is yelling out there, he sometimes falls while walking. Another one living in a different room is my friend… he also cannot (walk). I bring [warm] water to this old-man (co-resident) and to the one you were talking previously. [I help] if co-residents have any difficulties. I do [help] as much as I can… A condition might come when I am not be able to do things (pause). During that time, I might expect someone else's (co-resident's) help. [Shyam, R, RCF2]

The above excerpt also discloses the reason why Shyam used the strategy of assisting. By sustaining new connections with co-residents, what Shyam ultimately anticipated was reciprocal assistance should he need it. Other residents shared similar views regarding sustaining new connections by assisting co-residents, and then expecting reciprocal assistance from them, "Yes, [we] must help co-residents. I got sick recently… And then Z (one co-resident) cared for me, and I recovered" (Usha); "I help my friends (co-residents) as much as possible and expect them to do the same. Maybe when I am in my deathbed, they will help" (Ganesh). While most residents anticipated reciprocal assistance, few residents assisted co-residents altruistically. For example, Maya recounted how she used to assist co-residents selflessly before having knee pain, even when they did not help her back, "I used to help in doing all sorts of work, even when co-residents did not [help me]." Irrespective of the motive behind assisting, residents confirmed that assisting was a vital strategy in sustaining new connections with co-residents.

Residents also discussed sharing as a strategy to sustain newly built connections with co-residents; although the form of sharing that occurred between residents varied according to their level of interaction. The level of interactions that residents sustained with co-residents—superficial, intermediate, or deep—in turn, influenced the intensity of connections between residents. Figure 8.2 (p. 152) depicts the relationship between the level of interactions and intensity of connections between residents.

Figure 8.2

Relationship Between the Level of Interaction and Intensity of Connection Between Residents

Level of interactions	**Intensity of connections**		
	Weak	Moderate	Strong
Superficial	Acquaintance		
Intermediate		Casual friends	
Deep			Meaningful relationships

Residents sustained different levels of interactions with co-residents, which led to different intensities of connections between them. Some residents predominantly sustained a superficial level of interactions with co-residents, which were limited to meeting co-residents spontaneously, exchanging greetings, not sharing anything, or sharing general information such as "how things are going" (Ram). Those residents spontaneously helped co-residents in need but not otherwise; and, as a result, reported having a weak intensity of connections with co-residents. Residents described a weak intensity of connections as having acquaintances, but not close friends to share inner feelings, including happiness or suffering. Hari concluded, "I do not have such close friends, just acquaintances." Hari mainly sustained superficial interactions with co-residents, which is why he ended up having acquaintances.

Most of the residents primarily sustained an intermediate level of interactions with co-residents. Intermediate interactions included meeting co-residents occasionally, exchanging ideas, helping when in need, and sharing spiritual knowledge, skills, donated food or items. Intermediate interactions with co-residents meant sharing everything except inner feelings. Consequently, most residents stated having a moderate intensity of connections with co-residents. For residents, moderate intensity of connections meant having casual friends who are close, but not close enough to share inner feelings. In most cases, residents were reluctant to share inner feelings with co-residents because of the fear of being ridiculed or hurt. Asok shared why he sustained an intermediate level of interactions with co-residents:

> It is not good to share the feeling with co-residents as they are from different places. I talk when children (student nurses) come and ask. I have not shared

> [my inner feelings] with co-residents yet… It is not beneficial talking to co-residents here [in the RCF]. Co-residents mock and underestimate. [Asok, R, RCF1]

Asok did not share his inner feelings with co-residents because of the fear of being humiliated by co-residents because of his past. Sanu also commented, "Why should I share my feelings with co-residents?" Similarly, Tulasi remarked, "Why [should I] talk about things inside my heart? – I can neither rip it off nor show it." As most residents sustained an intermediate level of interactions with co-residents, they reported having casual friends in RCF, who are not close enough (as demonstrated in Figure 8.2).

Only a few residents sustained a deep level of interactions with co-residents. Deep interactions with co-residents comprised sharing everything, including inner feelings, and cultivating mutual trust, respect, value, and love. As a result, those residents described having a strong intensity of connections with co-residents. Residents defined a strong intensity of connections as having meaningful relationships with co-residents, where they could share "every little thing." Shyam concluded, "There are friends, like me, to speak my heart out. You can speak about true feelings or joke with them." In this way, the form of sharing differed between residents according to the level of interactions.

Residents continued using strategies of being nice, avoiding conflict, assisting, or sharing as long as mutual trust, respect, love, or reciprocal assistance were achieved from co-residents. When residents did not attain these responses from co-residents, they shifted the strategies. An example of one condition where mutual trust between residents was broken was when the RCF stopped direct donation and stealing increased inside the facility. In this condition, residents shifted their strategies by fighting back, complaining about the co-resident's behaviour to nurses/caregivers, ceasing connection with specific co-residents, or shifting to the superficial level of interactions. As a consequence, the intensity of connections between those residents reduced.

8.3. Preserving Connections with Nurses/Caregivers

To preserve the newly built connection with nurses/caregivers, residents initiated and continued a range of strategies such as being nice, gifting money/donated material,

and sharing. For most residents, being nice with nurses/caregivers meant talking politely and respecting them. Similarly, some residents reported being nice by not communicating with nurses/caregivers as soon as they entered the RCF, not troubling/disturbing them where possible, and not complaining about their care. Most residents shared a common view that doing the aforementioned activities would make the nurses/caregivers angry. Residents perceived that if nurses/caregivers became angry, they might not receive respectful treatment during a period of illness and end of life. The following excerpt is a clear example of how residents work to preserve newly built connections with nurses/caregivers:

> I tell nurses that, "I am sick, and please bring me medicine"… I do not speak anything bad to nurses/caregivers... When you fall sick, it is all about the way you talk [with nurses/caregivers]. If you ask politely to help you when you are sick, nurses/caregivers will help. If you talk harshly, nurses/caregivers will get angry, and will not look after you. Even nurses/caregivers feel tired and bored. They have to look after everything. When nurses/caregivers come [to RCF]… they need some rest. [Residents] should not immediately demand care [from nurses/caregivers as soon as they arrive]. Nurses/caregivers scold us because we (residents) complain even about the care they are providing us. [Usha, R, RCF2]

Usha, like many other residents, was careful around nurses/caregivers. She was being nice with nurses/caregivers by talking politely, allowing them to rest before conveying any needs, and not complaining about residents' care to managers. Usha decided not to trouble/disturb nurses/caregivers as much as possible, "Till now, nurses/caregivers do not have to look after me. I do it as much as my body allows. One (a resident) should not give trouble to nurses/caregivers. Otherwise, it will lead to problems tomorrow (referring to care during illness and end of life) (Usha). By being nice, Usha anticipated preserving newly built connections with nurses/caregivers and receiving respectful care when ill or approaching the end of life.

Gifting money/donated materials to nurses/caregivers was another strategy used by residents to preserve new connections with them. As stated in chapter seven, some residents also used this strategy of gifting in developing connections with nurses/caregivers. Those residents continued collecting and gifting donated money/material to specific nurses/caregivers on different spiritual occasions to preserve their newly built connections. The main intention of using this strategy was

for getting dignified treatment amidst illness and end of life. Narayan commented, "Here is the thing about the nurses. If you have money, they will look after you." Another resident, Devi, shared her plan to collect money that comes from her old age allowance as well as donations, and give it to one of the caregivers to preserve the newly built connections:

> I have told [to one caregiver], "I will give you money in advance." However, I hope she (caregiver) does not deceive me… I have seen caregivers getting frustrated and angry [on residents]… I have told Y (caregiver) about my concern. I hope caregivers do not do the same to me. Hopefully, I will die nicely (without causing trouble to nurses/caregivers)… Even though I cannot give much, I will give 2000-4000 Nepalese Rupees (approx. 27.10-54.19 NZ$) [to Y] in advance. However, I hope she will take care of me responsibly. [Devi, R, RCF2]

By gifting money, Devi anticipated preserving new connections with a specific caregiver and obtaining dignified care when ill or approaching end of life.

Residents also reported sharing as a strategy to preserve new connections with nurses/caregivers. However, the form of sharing between residents and nurses/caregivers differed according to the level of interactions. The level of interactions between residents and nurses/caregivers—superficial, intermediate, or deep—in turn, influenced the intensity of connections between them. Figure 8.3 depicts the relationship between the level of interaction and the intensity of connections between residents and nurses/caregivers.

Figure 8.3

Relationship Between the Level of Interaction and Intensity of Connections Between Residents and Nurses/Caregivers

Level of interaction	**Intensity of connections**		
	Weak	Moderate	Strong
Superficial	Formal relationship		
Intermediate		Informal relationship	
Deep			Meaningful relationships

Residents were engaged on different levels of interactions with nurses/caregivers, which led to different intensities of connections between them. Some residents were

mainly engaged on a superficial level of interactions with nurses/caregivers. Superficial interactions with nurses/caregivers were limited to exchanging greetings and informing when ill or medicine is needed. Therefore, those residents reported having a weak intensity of connections with nurses/caregivers. For residents, the weak intensity of connections with nurses/caregivers meant having formal relationships. For instance, Asok described how he is only engaged in superficial interactions with nurses/caregivers:

> There is no one (referring to nurses/caregivers) to [take] care [of me, even] if I want. I should take care of myself. Caregivers take care if we [residents] become unable to do so… I do not share [inner feelings] with anyone (nurses/caregivers). Nurses come to serve medicine and go back. What are the benefits of talking to nurses/caregivers? …I have nobody [who is close] here (in the RCF). [Asok, R, RCF1]

Since the level of interactions between Asok and nurses/caregivers was superficial, he indicated his connections with nurses/caregivers as formal, and not "close."

In most cases, residents were primarily engaged in intermediate level of interactions with nurses/caregivers. Intermediate interactions mostly comprised exchanging ideas, helping, joking, and gifting money/donated material on spiritual occasions. Therefore, most residents reported having a moderate intensity of connection with nurses/caregivers. Residents referred to moderate intensity of connections as having an informal relationship that is close but not close enough to share holistic needs. One resident, Rita, gave an example of her intermediate level of interactions with nurses/caregivers:

> When I do not feel well, nurses/caregivers come and say, "What happened to my mother." When I am strong, why do I need it (referring to attention from nurses/caregivers)? As nurses/caregivers walk past, they greet and ask, "how is X (name) mother doing?" [I say], "I am good"… I ask the sisters (nurses) to come to visit me in the room – I tell them, "Madam, why you do not come to visit me?" I have a good sense of humour. I like to talk with a bit of wittiness and humour. Otherwise, what is the fun? That is how I talk to nurses/caregivers, and they like it too (laughs). [Rita, R, RCF1]

However, when it came to sharing holistic needs, Rita commented, "No. I do not want to cause trouble for them [nurses/caregivers]. If I ask, they might do it, but I do not want to cause trouble." As the level of interactions between Rita and nurses/caregivers was intermediate, she specified her connections with

nurse/caregivers as informal but not close enough. Rita concluded, “Only if I had someone… to support me every time [inside RCF]… I am alone… I am [only] close to God.” Another resident, Devi, also engaged in the intermediate level of interactions with nurses/caregivers. Regarding sharing holistic needs, Devi mentioned, “I talk [with nurses/caregivers]… [But] I do not share my [inner] feelings with nurses/caregivers.” As a consequence, Devi also described her connections with nurses/caregivers as informal but not close enough. As in the case of both Rita and Devi, most residents were involved in the intermediate level of interaction with nurses/caregivers, which is why they reported having informal but not close relationships with nurses/caregivers.

Some residents, however, were engaged on a deep level of interactions with the nurses/caregivers. Deep interactions with nurses/caregivers meant sharing holistic needs, symbolising nurses/caregivers as a family, performing spiritual practices together, and gifting. Similarly, deep interactions were described as cultivating mutual respect, value, love, and maintaining continuity in a relationship. For instance, Ram was engaged in deep level of interactions with nurses/caregivers by using the strategies stated earlier. Accordingly, Ram described having a strong intensity of connections with nurses/caregivers. Ram expanded on what it is like having meaningful relationships with nurses/caregivers, “It (RCF) is like a heaven for us… Everyone (Nurses/caregivers) respect me. Now, (pause) everyone refer me as *ba* (father), including these female residents, and children (nurses/caregivers). Nurses/caregivers treat me well.” This is how the form of sharing differed according to the level of interactions.

Residents continued being nice, gifting money/donated material, or sharing until either mutual trust, respect, value, love, or support in fulfilling needs were attained from nurses/caregivers. Further, residents continued preserving new connections when nurses/caregivers supported their spiritual practices. When residents did not receive either of these from nurses/caregivers, they shifted the above-mentioned strategies. An example of a condition where trust was broken between residents and nurses/caregivers is when the RCF stopped direct donation and stealing increased inside the facility. Under this condition, residents perceived either being scammed or robbed by the nurses/caregivers. For instance, Tulasi perceived being robbed when the RCF stopped direct donations, and it was given through the hands of

nurses/caregivers. Like many other residents, Tulasi believed that some nurses/caregivers were taking portions of the donations for themselves. She concluded, “It is not good to take the [donations] that is allocated for the older adults (residents)… the nurses/caregivers already are on a payroll (referring to salary)” (Tulasi). Another resident, Shyam, elaborated, “Lots of rich people (donors) come here [in the RCF]… Donors donate many things upstairs. We see some nurses/caregivers taking all those stuff home.” Likewise, Asok agreed, “Preventing the donation [meant for residents] is a sin.” Accordingly, these three residents shifted their strategies of preserving new connections by either complaining about specific nurses/caregiver’s behaviour to managers or shifting to the superficial level of interactions with them. As a result, the intensity of connections with particular nurses/caregivers decreased for these three residents.

Residents also shifted their strategies of being nice, gifting money/donated material, or sharing when they felt being discriminated, controlled, disrespected, and dominated by some nurses/caregivers during care. Residents also shifted their strategies of preserving connections with nurses/caregivers when they perceived a lack of dignified care during illness, or continuity in care. For instance, Narayan perceived being discriminated by some nurses/caregivers commenting, “Nurses/caregivers differentiate between the lower caste, higher caste, literate, and illiterate [residents].” Similar to Narayan’s feeling of being discriminated due to his caste and educational status, Shyam reported being discriminated by some caregivers due to his “class (economic status).”

> [There is] discrimination based on class… [There is discrimination] in the way caregivers talk… daily things they do, the way they speak, and in everything… In the previous RCF, even though there were fewer numbers of nurses/caregivers, they used to provide better care, whether it be day or night. If someone is sick, someone always used to be with them for care, whether it be another person living in the RCF or the staff member. Nurses/caregivers do not do that here. A few days ago, I had a fever and took rest the whole day and could not go for dinner. However, no one asked or noticed that I had not attended dinner… I told him [manager] about this (referring to discrimination). The manager told that to the people in the kitchen (referring to some caregivers). Then the people (caregivers) here got angry at me. It has happened twice or thrice already. [Shyam, R, RCF2]

When Narayan and Shyam felt being discriminated, they shifted their strategies of preserving new connections by either complaining about specific nurses/caregiver’s

behaviour to managers or shifting to a superficial level of interactions with them. Likewise, another resident, Ram, perceived being controlled by some nurses/caregivers:

> There are three of them (nurses/caregivers) from whom you should take permission… Then, one will say, "*Hait!* (no way), where will you go now? What will happen if you fall?" The other one will say, "Just sit down, and we will give food to eat." The next one will say, "Go! Roam around outside and come back." Then only you roam around (laughs). That is the meaning of preference, fear, and compulsion. [Ram, R, RCF2]

In response to the perceived feeling of being controlled, Ram also shifted his strategies of preserving new connections with particular nurses/caregivers by changing to a superficial level of interactions with them. In this way, the intensity of connections with specific nurses/caregivers decreased for all three residents.

8.4. Continuing Connections with Inner-self and Higher being/s

Continuing connections with inner-self and higher being/s was the next strategy used by residents in the process of maintaining connections. Residents continued connecting with inner-self and higher being/s, by regularly involving themselves in individual as well as group spiritual practices. As stated in chapter seven, residents initiated this strategy in order to develop connections with the inner-self and higher being/s. By continuing involvement in both individual and group spiritual practices, residents perceived a sense of increased physical wellbeing, "hope," "faith," "happiness in the soul," "satisfaction," "relaxation," and "inner peace." Similarly, residents also reported spiritual practices as a means of forgetting painful past experiences and meaningful living. Residents noted that spiritual practices have reduced their loneliness, helped find meaning in suffering, and offered a sense of control.

Residents, however, had to modify their strategies of continuing connections with inner-self and higher being/s, when conditions, including rules regarding individual spiritual practices or group spiritual programmes, changed in the RCF; thereby impacting resident's feelings of being connected with inner-self and higher being/s. For instance, when one RCF discontinued group spiritual programmes, residents' participation in these programmes stopped. Under this condition, residents had to limit themselves to individual spiritual practices. One resident, Ganesh, explained

how the frequency of group spiritual programmes inside the RCF reduced, "When I first came here, they used to have it [group spiritual programmes] in the afternoon too, now they do not do that anymore. RCF also had more funding [for group programmes]…when I was new here [in the RCF]". Ganesh responded by shifting to individual spiritual practices; yet, it decreased his previous feeling of being connected with inner-self and higher being/s.

When the RCF started imposing restrictions on individual spiritual practices, residents had to cease or modify their previous strategies, which also decreased their feeling of being connected with inner-self and higher being/s. For instance, when one RCF changed its rules, spiritual books were removed from residents' rooms and residents were told not to worship inside the room or put pictures of higher being/s on the wall. Ram confirmed, "I had books related to *Tirtha, Bhajans, Geeta, Bhagwat* (spiritual books)… They (caregivers) put in a bag [and took it away]. [I do not know] where have my books gone? What has been done? [I] have not found it yet." Ram had to modify his previous strategies and started meditating or listening to spiritual programmes on radio. Similarly, some residents navigated the imposed restrictions on individual spiritual practices by changing the timing of their spiritual practices to very early in the morning before nurses/caregivers arrived.

In a few cases, residents continued using their previous strategies of connecting with inner-self and higher being/s, even when the RCF did not allow it. Those residents continued separating a small area of their room for worship, and kept pictures of higher being/s, although it became a subject of dispute among co-residents and nurses/caregivers. Although residents continued connecting with inner-self and higher being/s in different ways, imposed restrictions reduced previous feeling of being connected with inner-self and higher being/s. Moreover, when residents' individual spiritual practices were restricted, or there were fewer opportunities for group spiritual programmes, residents reported feeling "empty," "sad," "inadequate," and "hopeless."

Hari and Narayan were exceptional cases. Unlike most residents, Narayan and Hari indicated losing trust in spiritual practices after spending a few years in a RCF. Narayan explained, "I used to go to Pashupati (temple) before. I used to go to Boudha and Swayambhu (temples) also." However, over time, he "lost faith in

spiritual practices" and discontinued it. Hari reported similar feelings, "Before I used to believe more in God than people. Now I have lost faith in God." Narayan and Hari were not involved in any group spiritual programmes or individual spiritual practices.

8.5. Conditions Influencing the Process of Maintaining Connections

The process of maintaining connections was influenced by a range of conditions, including decreasing physical abilities, increasing illness of residents, illness or death of co-residents, and retirement or resignation of nurses/caregivers. When the physical abilities of the residents declined (i.e., residents could not walk or illness occurred), it challenged the execution of all three strategies—sustaining connections with co-residents, preserving connections with nurses/caregivers, and continuing connections with inner-self and higher being/s. For instance, when Pushpa developed urinary incontinence, she could not participate in group spiritual programmes:

> I used to go [to group spiritual programmes inside RCF] before. However, now I have a problem since I fell. I cannot hold on to my urine and stool. Nurses/caregivers told me to stay upstairs, but I stayed here (middle floor) because the toilet is close. I cannot go to listen to hymns anymore. If I go, and I stand up, after a while – it (urine) leaks. I will be embarrassed, so I did not go. Co-residents say, "Why are you wearing thick trousers even when it is so hot?" [Pushpa, R, RCF2]

Pusha added, "There is one [nurse] who visits every day. She only talks about medicine… I could not go [to meet my friends]. Now, I am meeting them less." Urinary incontinence hindered Pushpa's process of maintaining connections with different sources. Accordingly, Pushpa shifted to alternative ways of continuing connections with inner-self and higher being/s, "[Now,] I just remember God from here (bed)." Illness, death of co-residents, as well as retirement and resignation of nurses/caregivers, also impacted the process of maintaining connections. When co-residents perceived as 'close enough/close' were ill or died, the whole process of sustaining connections with co-residents reduced/ceased. In these conditions, residents continued preserving connections with nurses/caregivers and connections with inner/self and higher being/s, but moved back to identifying new co-residents as sources of connections. Likewise, when nurses/caregivers perceived as 'close enough/close' retired or resigned from the job, the entire process of preserving connections with nurses/caregivers ceased. Residents then eventually started

identifying new nurses/caregivers as sources of connections. In the meantime, residents continued sustaining connections with co-residents and connections with inner-self and higher being/s.

8.6. Overall Consequence of Maintaining Connections: Balancing Shifting Connections

In the process of maintaining connections, residents continually used three strategies; namely, sustaining connection with co-residents, preserving connection with nurses/caregivers, and continuing connection with inner-self/higher being/s. The overall consequence of maintaining connections was balancing shifting connections. Residents eventually learned to balance the shifting connections in the RCF. For residents, balancing shifting connections had three different meanings. Firstly, balancing shifting connections in regard to co-residents/nurses/caregivers meant "give and take situation"; that is, giving something and receiving something in return. Secondly, balancing shifting connections denoted altering strategies to balance the changing conditions surrounding different sources. Thirdly, when the feeling of being connected with one particular source decreased, residents balanced it by continuing connections with the other sources. In this way, to balance the shifting connections, residents invested a significant amount of time, energy, and emotion in their relationships inside the RCF.

Despite the effort, residents reported many unfulfilled needs in the RCF. These unfulfilled needs have been termed as spiritual needs. Spiritual needs refer to what residents require in order to maintain their spirituality (i.e., connection with inner-self, higher being/s, family/relatives, co-residents, and nurses/caregivers). Spiritual needs, reported by residents, included regular interactions with family/co-residents/nurses/caregivers; close, respectful, and trusting relationships with family/co-residents/nurses/caregivers; continuity in care, equity, freedom; and regular social interactions. Residents also expressed spiritual needs as the need for dignified care during illness or end of life, regular spiritual programmes, individual spiritual practices, and giving back to others.

8.7. Summary

This chapter has explained the details of maintaining connections, the third main category of the theory—*A process of connecting*. It is has been established that maintaining connections is an ongoing process, including sustaining connections with co-residents, preserving connections with nurses/caregivers, and continuing connections with inner-self and higher being/s. The details of each of these strategies have been explained. How conditions such as decreasing physical abilities, increasing illness of residents, illness or death of co-residents, and retirement or resignation of nurses/caregivers impact the process of maintaining connections has been described. The final section addressed the overall consequence of the process of maintaining connections; that is, balancing shifting connections. The next chapter presents how nurses/caregivers perceived and responded to the spiritual needs of residents.

Chapter Nine: Spiritual Care Provision

9.1. Introduction

The previous three findings chapters—making sense, seeking connections, and maintaining connections—have explained how residents maintain spirituality in a RCF (i.e., connections with inner-self/higher being/s, family/relatives, co-residents, and nurses/caregivers). It is established from chapter eight that although residents used a range of strategies to maintain their spirituality in the RCF, they had many unfulfilled spiritual needs. The current findings chapter corresponds to the specific objective of the study; that is, how nurses/caregivers perceive and respond to residents' spiritual needs. The main purpose of this chapter is to highlight the issue of why only a few nurses/caregivers were involved in providing spiritual care.

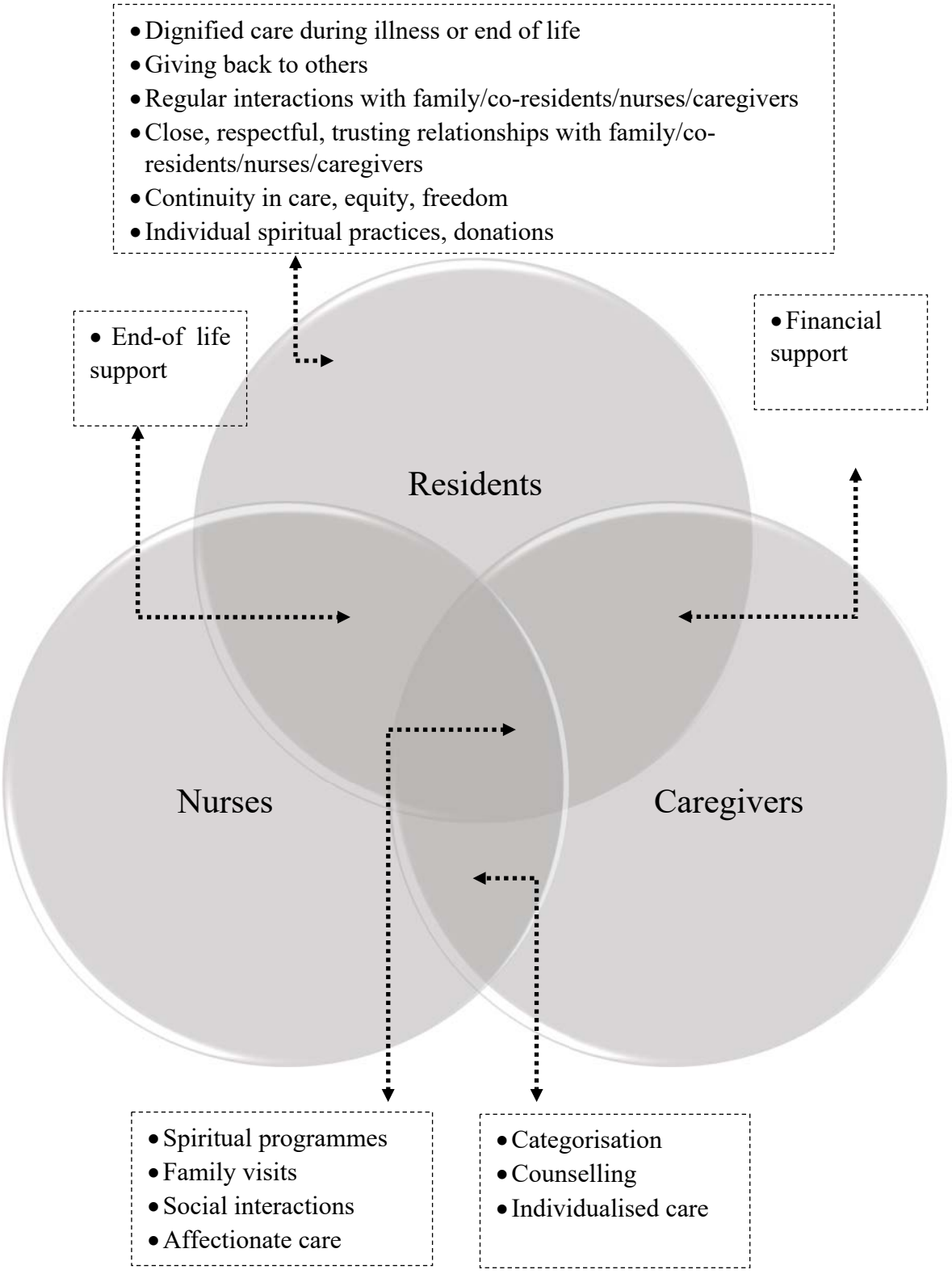
This chapter commences with an in-depth explanation of the actions/interactions involved in the process of spiritual care provision; namely, preparing internally, interacting with residents, integrating care, and involving in spiritual practices of residents. Following, the range of conditions impacting the process of spiritual care provision, including the readiness of nurses/caregivers and managerial support will be explicated. Finally, the consequences of the gap in the spiritual needs of residents and spiritual care provision are explained.

9.2. Process of Spiritual Care Provision

Spiritual care refers to any care undertaken in order to fulfil spiritual needs of residents. It is important to note that nurses/caregivers in this study were aware of most of the spiritual needs of residents, as illustrated in Figure 9.1 (p. 165). Nurses/caregivers did not provide an exact definition of spiritual needs but expressed it using different components. In general, nurses/caregivers shared similar views on the components of the spiritual needs of residents, such as the need for spiritual programmes, social interactions, affectionate care, family visits, counselling, individualised care, and categorisation. However, the need for end-of-life support and financial support was exclusively reported by nurses and caregivers, respectively.

Figure 9.1

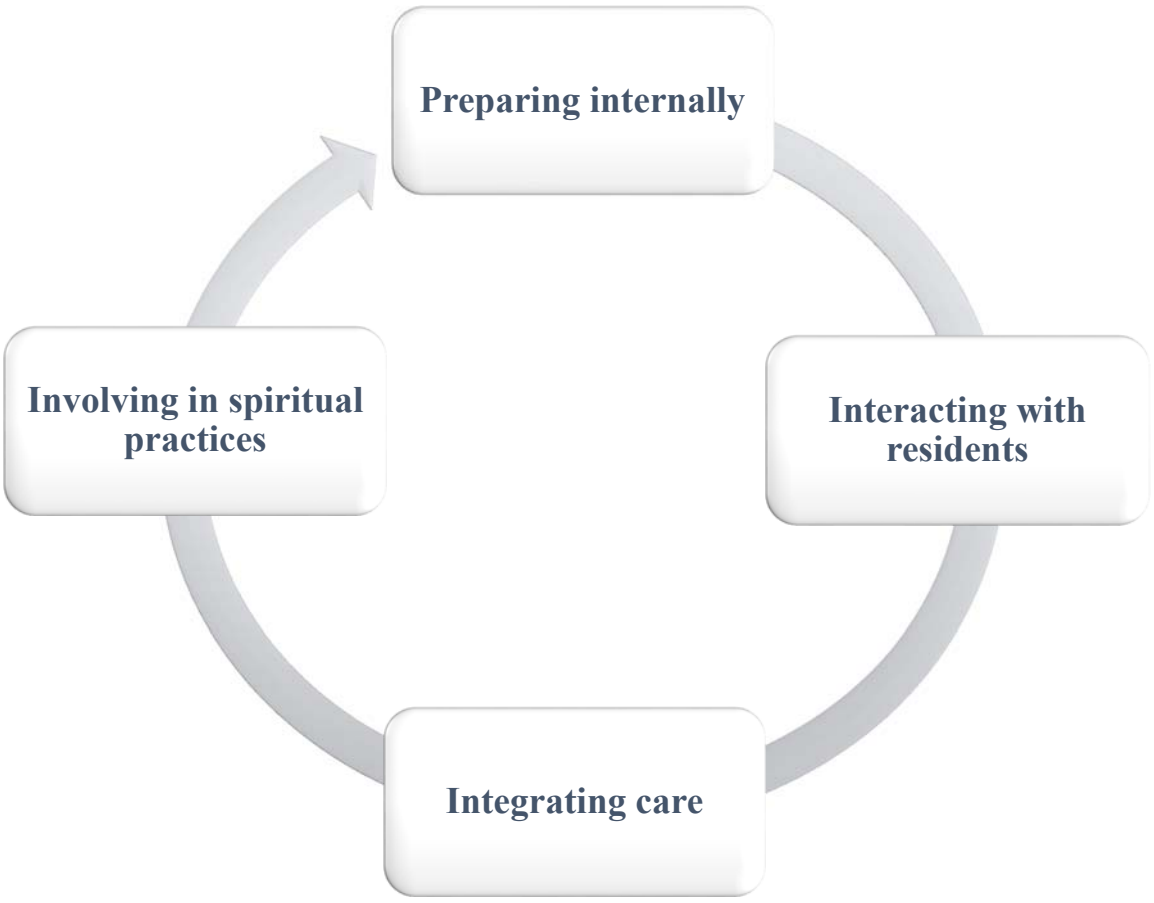
Spiritual Needs: Perspectives of Residents versus Nurses versus Caregivers



Despite being aware of the spiritual needs of residents, only a few nurses/caregivers were involved in providing spiritual care and explained the process of spiritual care provision. Spiritual care provision was described as a continuous process of preparing internally, interacting with residents, integrating care, and involving in spiritual practices of residents. The process of spiritual care provision is depicted in Figure 9.2.

Figure 9.2

The Process of Spiritual Care Provision



Preparing internally was one of the strategies used by nurses/caregivers in the process of spiritual care provision. Nurses/caregivers felt unprepared when they first started working in the RCF and were overwhelmed by the working environment, conditions of residents, and regular complaints. As time passed, nurses/caregivers started preparing internally by placing themselves in the residents' situation,

reflecting on self-experiences, or focusing on the core values of the work. One caregiver, Anita, shared her experience:

> Nurses/caregivers can only work [in RCF] if they believe from the soul that this is my work, I am responsible for it, and realise that we are going to grow old ourselves one day. Otherwise, no one can. It will not work if [staff only] do politics, sits on the chair, and roam around. We have discussed this many times in the office, as well. The manager has discussed it with me several times… This (RCF) is a home, a home outside of individual's first home. If you do well to them, then they will say good things about you… We need to care for them as our own like we do to the older adults at our home. [Anita, C, RCF 1]

Concurring with Anita, one nurse, Ganga, stated, "[Imagine] how difficult it is if we put ourselves in their place, isn't it?" Similarly, another caregiver, Tina, expressed, "Maybe, I will have stay in this place later. I have two daughters. My daughters will have their own homes, who would take care of the parents?" In this way, a few nurses/caregivers prepared themselves internally in order to provide spiritual care.

Interacting with residents was another strategy used by nurses/caregivers to provide spiritual care. Kala explained her initial interaction strategies in the process of spiritual care provision:

> If I go to a new and strange place, how will I feel if nobody will care about me or speaks to me? …I place myself in that situation …when a new older adult come [to the RCF] …carrying sorrow, I mingle with them. I ask them their names, where they are from, and introduce them to others. Whatever their name may be, just give them a name, and they start laughing. They are being called from the same name I have given them. [Kala, C, RCF2]

Kala used strategies such as getting general information about the resident, introducing co-residents, giving a different identity, laying a foundation for future interactions, and guiding residents through the RCF in order to increase residents' familiarity, and help them adjust in the RCF. Kala also stated that providing spiritual care requires taking an individual approach and making interactions as informal as possible. In addition, Kala mentioned that it is essential to continue providing affectionate, respectful care, using a respectful tone, language while interacting; and not scolding, screaming, or reacting while residents are angry. Instead, it is vital to give time for residents to recover from the disturbed mood and reschedule interactions. Similarly, another nurse, Ganga, reported using strategies such as understanding the mental health of residents, encouraging them to share their inner

feelings, developing a close, trusting relationships, and giving them enough time to interact. Ganga continued:

> We can do many things, isn't it? We can make residents participate in different kinds of things, such as spiritual programmes. Similarly, we can arrange social interactions. Communicating with residents about everything, understanding their feelings, isn't it? Creating an environment where residents can share everything that they feel in their hearts. As a result, they will not feel lonely. Isn't it? [We] should do things like that. [Ganga, N, RCF1]

Similar to the interaction strategy of Ganga, Kala elaborated that developing a loving and trusting relationships with residents is vital to make the work of the caregiver easier and concluded that without trusting relationships, residents "will not even allow us to touch them" and will suspect that "we have come to steal their belongings" (Kala). Likewise, few nurses reported encouraging residents to interact with co-residents, preventing them from staying alone, and maintaining positive vibrations in the surrounding. The interactions and strategies used, helped nurses/caregivers to develop trusting relationships with residents.

The next strategy used by nurses/caregivers in the process of spiritual care provision was integrating care by coordinating with co-workers, managers, and negotiating with donors in order to fulfil the spiritual needs of residents. Only a few nurses/caregivers used strategies such as assessing the spiritual needs of residents, informing, seeking help from co-workers, and continually reminding co-workers the core values of the work. Additionally, they were coordinating with managers for initiating and maintaining spiritual programmes, increasing staff to improve quality of care, shifting staff not providing quality care, encouraging vocational work, arranging recreational and spiritual visits, arranging family visits, and fulfilling spiritual needs related to the end-of-life. Kala expressed:

> We have kept regular preaching classes. We have regular spiritual classes. For those who can, we make them attend 1 hour daily; while you came, they were coming down. That happens regularly. Since the time I joined here, the spiritual classes have been going on. It has been about 13-14 years now. It started two years after I came. It wasn't done before. The population of the older adults here was less too. We staff got together and thought of starting it. The 16-17 founders in the operating committee of the board did not see the need for spiritual programmes. What I mean is, this programme (spiritual) was initiated and sustained by the focus of the staff, and they [management] gave us permission [to teach the residents] the kind of things we should do

> after coming to this world. Till now, it has regularly been happening, and free of cost. [Kala, C, RCF 2]

Similar to the integration strategy used by Kala, Ganga reported calling the family, informing them about the resident's condition, making them care for the residents, and encouraging the family to call or visit the residents through coordination with the managers. Likewise, few caregivers and nurses were negotiating with donors to fulfil the spiritual needs of residents by conveying to donors the actual needs as expressed by residents, collecting donations, and organising spiritual trips. The integration strategies used lead to increased balance between the actual needs of residents and care provided in the RCF; and, ultimately, resident-centred care.

Involving in spiritual practices of residents was the other strategy used by nurses/caregivers in providing spiritual care. Only a few nurses/caregivers were actively involved in the spiritual practices of residents. Involving in spiritual practices included listening, accepting, supporting the spiritual belief system of residents, and providing spiritual counselling. Ganga described spiritual counselling:

> As a nurse, we can counsel them, provide them an education… We can show them positive ways. We can develop a beam of hope for them. Anyway… …If we instil inside them the faith that God is there, the trust, although they [residents] already have it inside them. I think if we focus more on that, they will develop… [positive] emotions. [Ganga, N, RCF 2]

Similar to Ganga, other nurses/caregivers described spiritual counselling as constantly reminding residents of the positive aspects of the RCF, making them focus on what they have, and redirecting their attention on spiritual practices inside the RCF. Moreover, Kala was also involved in assessing and fulfilling spiritual needs related to end-of-life:

> We tell them (residents) to do it earlier. We tell them to do it through their own hands, right in front of their eyes. We suggest them not to leave it for later. There was one older adult, she had told us, "After I die, take my body to Triveni, Devghat (place) for the final resting." She had given up all her possessions. She had a family. Therefore, the organisation said that her family would fulfil her last wish. Then one brother (staff) here said, "I should not break a promise, that mother trusted me completely, and told me to do that, I should do it anyhow, should arrange the environment for that." She died in the afternoon, around 2pm, she was taken at night by reserving a vehicle, nobody knew in the office. She was cremated in the night, and her family was also there. She had her grand-daughter, daughters, grandsons, and

> everybody else, but she had said that the funeral was to be done by his [staff] hands. So, he did that [cremation] and came back. [Kala, C, RCF 2]

When nurses/caregivers were involved in the spiritual practices of residents, it developed a sense of kinship between residents, nurses, and caregivers.

9.3. Conditions Influencing Spiritual Care Provision

Spiritual care provision was influenced by two major conditions; namely, readiness of nurses/caregivers and facility support. The readiness of nurses/caregivers to provide spiritual care was determined by their spiritual belief system, training, and experience. The spiritual belief system of nurses/caregivers influenced their perception of spirituality, sensitivity towards the spiritual needs of residents and, in turn, the strategies they use. For instance, caregivers who valued the spiritual belief system in their own lives were more sensitive to the spiritual needs and care of residents as compared to others. Kala, who valued the spiritual belief system in her life, conveyed:

> It is like this – you cannot have any caregiver; the caregiver should be a proper caregiver. What I think is – if you are to recruit employees in the RCF, they should be spiritual. If they are just for the salary, taking [money] and going back, then they will not stay long. [Kala, C, RCF 2]

Similarly, Pari explained:

> Talking about the roles of nurses in this (spiritual care) – Depends how much we have understood, right? You cannot single out nurses. It depends on the spirituality of the nurses, qualifications they have, and how they can utilise it. Someone who has just come after studying nursing course is different. The environment, situations they have come from, how they are raised, how much they have understood the culture is a different part [of the story]… If they are hired from their course, then they will only know inside that course. Education is done. [Only] if they can add and utilise *dikchhya* (moral values). [Pari, N, RCF1]

The training and experience in the care of older adults influenced the level of awareness among nurses/caregivers. Kala was the only one who received training on the care of older adults. She expressed how training changed her perception, “each caregiver must be trained,” and “it will not happen without knowing. It means that the older adults will suffer if others (staff) do not gain that knowledge.” She concluded:

> RCF is not run just by supporting the destitute, giving food to those who do not have or providing medicine and treatment. We need to understand their (residents') feelings. We need to understand their wishes and expectations... The older adults have come here through a long past–through good and bad times… that is why if we go forward taking into account their wishes and expectations, it will be a cherry on top of the cake, and their mental health will also be fresh. [Kala, C, RCF 2]

Other nurses/caregivers reported a lack of confidence regarding spiritual care provision. They were most comfortable in providing physical care and wanted someone else with better knowledge to deal with spiritual needs. One nurse revealed:

> About spiritual [care], we need to teach them what we know… We need to explain to them what they do not understand. That is what I think. Older adults know more than us. We are not engaged in *dharma* (spiritual practices) that much. Only sometimes. We go to the temple every 1 or 2 years. They go there every day. Some of them read *Ramayan* (Hindu scripture). They know everything. Indeed, I ask them what I do not understand, and they tell me. Older adults know a lot. That is because they have been following *dharma* and karma for a long time. [Hina, N, RCF2]

Some nurses/caregivers reported that providing spiritual care is challenging because residents follow different types of spiritual belief system, "Everyone has their own culture, *dharma*, and spiritual belief. Being flexible and working according to the spiritual belief of all of them leads to lots of difficulties while working" (Ganga). Nurses/caregivers highlighted the need for "supportive hands," "educated person," and "trained" co-workers for providing spiritual care. It was clear that nurses/caregivers lacked confidence in providing spiritual care.

Managerial support was another condition that influenced the process of spiritual care provision. Some nurses/caregivers reported a lack of managerial support as a critical challenge in spiritual care provision. Different opinions of managers regarding the needs of residents as compared to nurses and caregivers hindered the coordination required for assessing the spiritual needs of residents and providing spiritual care in the RCF. Kala stated:

> Older adults love spiritual activities. They like to pray, listen to good things. The management only thinks about organisational tasks. In that way, they do not know what the older adults want to do and instruct accordingly. That difference always causes problems. They do the exact opposite of what the older adults want. The older adults understand one thing, and the management does it the other way, then how will that coordinate? The older adults will get angry. Then they involve [in the programmes] forcefully, even when they do not want to. [Kala, C, RCF 2]

Nurses/caregivers expressed that addressing the needs of residents is not just their responsibility; they need support from the managerial level to execute spiritual care based on the assessment. Ganga commented:

> While caring for older adults like this, it is even more difficult. We have to face lots of struggle. Sometimes, things do not turn out the way you thought. We have to decide in any case. However, our decision alone will not work. We have to pursue decisions from people of smaller to a higher level. Not only that, we have to take approval from the government, whether to implement new systems or any changes. [Ganga, N, RCF1]

The basis of evaluation by managers and the recognition of spiritual care also influenced the spiritual care provision. Some nurses/caregivers reported that managers focus on the quantity rather than quality. The subsequent evaluation conducted by the manager affected nurses' and caregivers' job security and promotion at work. Additionally, the spiritual care provided by nurses/caregivers often went unnoticed, reducing the motivation for spiritual care provision:

> Most of the [managers] ask us to show what work we do. They ask us to show… Even when we are doing the work, they (managers) do not get satisfied… However, as managers, [they should understand] the work [we have done] and duties [we have executed]. They should think before they say something like that. [Anita, C, RCF 1]

Lack of time was a significant challenge for providing spiritual care. The excessive workload and lack of staff were influencing the care they were providing. Also, due to the lack of a proper job description, the nurses/caregivers often reported shifting their roles according to the situation, increasing the workload, and limiting their free time in the RCF. Tina expressed, "We have to do everything – we cannot think like 'only this is my job.' We have to do everything we see." Therefore, physical care kept most of the nurses/caregivers occupied in the RCF. Merina added:

> We do not have time even to stand with them for a moment or two–after we come we have to clean up, sweep floors, cut the grass, and then distribute food. Call them for a meal after the bell rings, then cut vegetables or clean up the rooms, bathe them, or wash clothes. We should be doing it (spiritual care). I think that it would be better if we could support them on that (spiritual practices) as well, teach them and make them do it, but where is the time? We are too busy. Indeed, all of them should be involved in hymn singing and worships. [Merina, C, RCF 1]

Almost all nurses/caregivers expressed the need to increase staff in order to reduce the workload and provide spiritual care to residents. Ganga agreed:

> Talking about challenges, according to what I have seen in our [case], we have limited nurses… That is because there is only one nurse in the daytime, I am the only one at night… You tell me! One nurse taking care of 190 older adults is tough; you know it, isn't it? It is out of imagination. It is tough. If an employee can be added, more staff is appointed, then at least quality care will be provided accordingly, isn't it? [Ganga, N, RCF 1]

In this way, the readiness of nurses/caregivers and managerial support impacted the process of spiritual care provision. Influenced by these conditions, most nurses/caregivers were not involved in providing spiritual care, even when they were aware of the spiritual needs of residents. Therefore, in most cases, there was a gap between the spiritual needs of residents and spiritual care provided by nurses/caregivers.

9.4. The Overall Consequence of the Gap between the Spiritual Needs and Spiritual Care Provision

The overall consequence of the gap between spiritual needs and spiritual care provision was spiritual distress among most residents. The properties of spiritual distress, as expressed by residents, were lack of hope, purpose, happiness, acceptance, belongingness, inner peace, and self-integrity while living in the RCF. For instance, Asok stated, "I am not happy. I live here by force, not by my own wish. Living with family members together can be the happiest moment. I am not happy living alone here." Similarly, another resident, Pushpa, concluded:

> What happiness should I talk about? I do not have a home that I was born in, I do not have a home that I made. I do not have anything, no love. I will be happy if God takes me away. [Pushpa, R, RCF 2]

Most of the residents reported not having any hope or purpose in life. Shyam stated, "It is finished, the talk about the future is finished. Now I do not feel like doing anything. Easily… I will not get anything from my choice. It will be good if I can die an easy death." Likewise, Tulasi stated, "I always have a wish, but it is not fulfilled. What can you do if you only have it in the heart?" Lalita agreed, "I do not have hopes like I used to"; and Mira commented, "If I had a choice, I would stay at the home. But now I have to stay here… in RCF." Finally, most of the participating residents suggested not coming to a RCF for as long as possible. Maya concluded, "As long as possible, I feel that no one's children would end up living in RCF. Having your own home, I think it is better to live together no matter what the situation is." In the same way, Rita concluded:

> I want to tell the sisters at home that please do not go around looking for a RCF; stay at your home as much as possible with your sons and daughters, grandchildren and have fun with them. That is my saying. That is because… I am the one who does not have anything, I am the one who has suffered, I have to eat by force, had to live in RCF. I have to wait until my day comes, right? I have to sit wherever they ask me to, on floor or room. We have to be happy wherever the government puts us. That is what I would like to tell others, and it is nothing like your home. [Rita, R, RCF 1]

Alternatively, a few residents felt that spiritual care provision was close to their spiritual needs, which restored their spirituality. The properties of restored spirituality were hope, purpose, faith, happiness, acceptance, satisfaction, belongingness, inner peace, and reduced loneliness. Sanu and Ram were the only participating residents who expressed the properties of restored spirituality in a RCF and used the word "extreme happiness" to describe their residential life. Ram stated, "It is like a heaven for us," and clarified he is not going back even if his children come to take him home. Similarly, Sanu specified, "this place means everything to me." Since the conditions in the RCFs were subject to change, the gap between residents' spiritual needs and care provision also altered over time.

9.5. Summary

This chapter has explained the details of spiritual care provision. This section has shown that spiritual care provision is an ongoing process, including preparing internally, interacting with residents, integrating care, and involving in spiritual practices of residents. How conditions, such as readiness of nurses/caregivers and facility support, impact the process of spiritual care provision has been explored. The final section considered the overall consequence of the gap between the spiritual needs of residents and spiritual care provided by nurses/caregivers. This chapter has also established that differences in the culture of RCFs are barriers to spiritual care. The next chapter will discuss the major findings of the study in the context of existing literature.

Chapter Ten: Discussion

10.1. Introduction

This research aimed to provide a theoretical explanation of how older adults maintain spirituality in RCFs in Nepal. The specific objective of this study was to explore how nurses/caregivers perceive and respond to residents' spiritual needs. Utilising a GT methodology, the theory—*A process of connecting*—was developed from the data, which explains how residents maintain spirituality in RCFs in Nepal. The process of spiritual care provision has also been identified, which corresponds to the specific objective of the study. This chapter discusses the key findings of the study and its significance in the context of the existing knowledge. Since there is no single theory that completely covers the process of meaning-making, connecting, and spiritual care provision, multiple theories have been used to discuss separate components of the current theory.

I begin by discussing meaning-making process in the context of theories of relocation, transition, or adjustment in RCF; personal construct; or social comparison. Next, the continuous and dynamic process of seeking and maintaining connections will be discussed by integrating ideas from Robert and Bower's theory of relationship development in RCF, Erikson's theory of psychosocial development, and Tornstam's theory of gerotranscencdence. Spiritual care provision will then be considered within the limited evidence in this area. The final sections set out the strengths, limitations, recommendations, and conclusions of the study.

10.2. Meaning-making Process

The current study found that meaning-making occurs first in the process of maintaining spirituality. The term spirituality, for residents in this study, meant connections with inner-self, higher being/s, co-residents, family/relatives, and nurses/caregivers. This definition of spirituality corroborates the broad description provided by residents internationally (Baldacchino et al., 2014; Cohen et al., 2008; Eames et al., 2010; Harvey & Cook, 2010; Ihara & Vakalahi, 2011; Krause, 2008; Lee & Sharpe, 2007; Pandya, 2016; Shrestha, 2010). Although in contrast to previous research findings, connections with nature were not mentioned as part of spirituality in the current study. Furthermore, the term meaning-making process in

this study elucidates how residents make meaning of their new identities-as-residents. Most of the grounded theories or models regarding residential living since the 19th century focus particularly on the process of relocation, transition, or adjustment (Brandburg, 2007; Brooke, 1987; Chenitz, 1983; Lee et al., 2002a; McKenzie-Green, 2010; Patterson, 1995; Wilson, 1997). Accordingly, the phases or stages that residents pass through while adjusting to residential living, or the process of continuous adjustment, is well-documented. Although some dimensions of these theories relate to the issue of identity, little is known about how residents make meaning of the new identity-as-residents. The findings of the current study add to the existing body of knowledge by providing detailed information on how residents make meaning of the new identity-as-residents and the conditions influencing their meaning-making. Data from this study indicate that making meaning of the new identity-as-residents is a complex process and includes phases of isolating, exploring, evaluating, and compromising. I argue that it is only after moving through these four phases that residents finally internalise their new identity-as-residents.

The most important finding was that residents isolated themselves physically or emotionally from everyone inside the RCF and did not initiate any interaction in the isolation phase. In most cases, this phase continued for the first one to three months. For residents, this was one of the most difficult phases, where they felt "sad," "low," "lonely," "bad," and "depressed." The adverse symptoms identified in this study are similar to those reported by other residents in prior studies (Brandburg, 2007; Ellis, 2010; McKenna & Staniforth, 2017; Sullivan & Williams, 2016). The theory of adjustment into the RCF, developed by Brooke (1987), claims that emotional distress in the initial few months is a part of the disorganisation phase, where residents experience loss of important relationships, capacity, possessions, activities, or independence. Similarly, Wilson (1997) theorised that the adjustment process in a RCF begins with the overwhelmed phase, characterised by emotional responses such as "being afraid, lonely, sad, and crying" (p. 866). Likewise, Melrose (2013) argued that the adverse emotional reactions that residents develop during the first three months in the RCF are due to the relocation stress syndrome. Relocation stress syndrome refers to "physiologic and/or psychosocial disturbances as a result of transfer from one environment to another" (Manion & Rantz, 1995, p. 108). Indeed, the North American Nursing Diagnosis Association (NANDA) has also

acknowledged relocation stress syndrome as a nursing diagnosis since 1992; and symptoms such as confusion, loneliness, depression, and anxiety as its characteristic features (Melrose, 2013). However, there are studies which suggest that relocation stress syndrome cannot be generalised to all, and it is ideal to explore deeper or hidden meanings in the words of residents in order to better understand their experience of moving into the RCF (Mallick & Whipple, 2000; Walker et al., 2007). Although international evidence explains why residents tend to develop negative emotions in the initial few months in a RCF, the deeper or hidden meanings underlying residents' strategy of isolating themselves and not initiating interactions were not detailed. Understanding the deeper or hidden meanings behind the residents' experience in the isolation phase is vital in order for nurses/caregivers to develop appropriate interventions for new residents.

Residents in this study used the strategy of isolating themselves and not initiating interaction because they developed feelings of shame, fear, home-sickness, shock, and guilt after getting admitted into the RCF. As a consequence, residents expressed sadness, loneliness, and depression in the isolation phase. The feeling of shame that residents developed in the isolation phase may partly be explained by the socio-cultural background of the residents in this study. In Nepalese society, it is regarded ideal for older adults to age in their homes with the support of the younger generation; residential living is only a recent emerging notion. There is a deep-rooted stigma that residential living is only for those older adults who are either destitute or neglected by the family/relatives because the majority of the residents in Nepal come from that background (Dhakal, 2012; National Human Rights Commission-Nepal, 2019; Nepali Times, 2017). Even though there are cases where older adults from a well-off family are paying, or being paid by their children to live in the RCF, they represent a comparatively smaller fraction of the entire picture, and face the same stigma as other residents in the Nepalese society (National Human Rights Commission-Nepal, 2019; Nepali Times, 2017). Accordingly, both the group of residents who paid for admission and those who were admitted without paying developed the feeling of shame after coming to the RCF. Other studies conducted from a similar socio-cultural context, where there is a stigma attached to the residential living, have also reported similar findings concerning the development of

shame in residents (Bashir, 2000; Vahid et al., 2016). In addition, residents felt physically and emotionally vulnerable.

Residents in this study developed a sense of fear after coming into the RCF due to suddenly being exposed to an unfamiliar environment and people, and having to share the same room or flat with co-residents living with cognitive impairment. Likewise, residents were afraid of being accused of wrongdoing or possessions being stolen, and they did not know how to interact or to be in a facility. Isolating-self and not initiating any interaction were strategies used by residents in order to avoid physical or emotional harm and protect themselves. Creating and maintaining an environment where residents feel physically and emotionally safe in a RCF is vital.

Other reasons why residents isolated themselves and did not initiate any interaction in the isolation phase were the feelings of home-sickness, shock, and guilt that developed after coming to the RCF. In Nepal, it is often family/relatives who decide to admit older adults into RCF or force older adults to take this decision; only a few older adults make this choice because of self-will (Asia Pacific Forum of National Human Rights Institutions, 2018; Rai et al., 2018). A recent survey conducted on RCFs throughout Nepal recognised that the main reasons for increasing admission into a RCF are "family dispute and disintegration, loss of the moral education in the society… lack of understanding the responsibility, and generations' long conflict, seeking for… religious place" (National Human Rights Commission-Nepal, 2019, p. 7). Accordingly, residents missed home after coming to the RCF or felt shocked that family/relatives decided that a RCF is a place where they should spend the rest of their life. In a few cases, where residents decided to move to the RCF, such as Nisha and Pushpa, they felt guilty for taking that decision once they got admitted. These findings show that the socio-cultural context of residential living has a vital impact on how residents perceive the experience of moving into the RCF.

Although most nurses/caregivers in this study were aware of the residents' strategy of isolating-self, only a few were conscious of the underlying reasons or its negative consequences. As a result, only a few nurses/caregivers in this study intervened by prioritising residents' need for interactions when they saw residents isolating themselves. Nurses/caregivers working in a RCF need to be well-informed about the meaning underlying residents' experiences in the isolation phase; only then, care will

be meaningful. Although episodic isolation can serve as a protective strategy for residents, regular isolation, the strategy adopted by a few residents, needs to be discouraged by nurses/caregivers.

Another finding of the study was that residents started to explore different dimensions of residential living when they sensed having no other options but to continue living in the RCF. Residents gradually initiated interactions with co-residents, nurses/caregivers, or other staff in RCF in order to inquire about different dimensions of residential living. The exploration phase of this study mirrors the reorganisation phase and orienting stage of adjustment theories in the sense that it is the time when residents started learning about their new life in the RCF (Brooke, 1987; Lee et al., 2002a). However, both these theories did not provide detailed information on the dimensions of residential living that the residents explore. The current study revealed unique information on dimensions of residential living that residents explore in the phase of exploration, as detailed in chapter six.

While exploring the dimensions of residential living, the main concern for residents was determining what is expected/desired from them as a resident. This finding is consistent with the GT *Living life in residential aged care: A process of continuous adjustment* developed by McKenzie-Green (2010) based on Australian RCFs. Similar to the concept of exploring, in the current study, McKenzie-Green identified that residents "build an information framework," regarding different aspects of residential living "deliberately, incidentally, and experientially" (p. 79). Then, based on that information framework, residents decide "how to be" or "how to present an acceptable self" in a RCF (McKenzie-Green, 2010, p. 86). Residents in the current study inquired about expected/desired behaviour with co-residents, nurses/caregivers, or other staff. However, it was mainly the way co-residents behaved with each other and nurses/caregivers that were interpreted as expected/desired behaviour.

Another significant finding of this study is that residents evaluated the dimensions of residential living by comparing it with their past life; and, consequently, different images of the RCF and identities-as-residents were constructed. Images of RCF refer to the mental picture of the place that residents formed after comparing the dimensions of residential living with their past life; for example, RCFs are "prison," "mental asylum," "safe," or "messy". Similarly, identities-as-residents specify the

way residents described themselves once they started living in the RCF, such as a person who has "no one," "impure," is "carrying [other's] debt," living "by begging," or "captured in other's fist." Data revealed that most residents constructed negative images of the RCF and identities-as-residents in the evaluation phase. The details of how residents evaluate the dimensions of residential living or how they construct images of the RCF and identities-as-residents have not been described previously.

There are several possible explanations why residents in the current study constructed negative images of the RCF and identities-as-residents. According to the socio-cultural and religious background of the residents, ageing is considered a spiritual process, and older adults are expected to be involved in various spiritual practices, programmes, giving back to others, or donating to others on days of spiritual importance (Dimock et al., 2019; Gautam et al., 2007; Pandya, 2016; Shrestha & Zarit, 2012). In Nepalese society, it is believed that if older adults are not involved in these activities, they might not gain *moksha*, spiritual peace, and freedom from the endless cycle of rebirth and death (Mishra, 2013). Accordingly, most residents focused on these dimensions of residential living while comparing it with their past. Unlike the past, when most residents could not fulfil these activities regularly in the RCF or they had to accept donations from other people, they formed negative images of the RCF and identities-as-residents. For instance, Maya concluded, "I should be involved in *daan* (donation) and *dharma* (spiritual practices) at this time, but I am eating what is donated."

Similarly, according to socio-culturally defined roles, older male adults are expected to spend old age by continuing to work, earning a living, taking responsibilities of a partner, or managing the future of children. Therefore, most male residents focused on the dimensions of residential living such as freedom, decision-making power, or opportunities to work or voice concerns, while comparing it with their past. Unlike their past, when self-governance was impacted in the RCF, they formed negative images of the RCF and identities-as-residents. For instance, Shyam described himself as a person living "under someone else's command." These findings show that socio-cultural expectations play a significant role in determining the type of images of a RCF and identities-as-residents that residents create.

A theory of personal construct, developed by Kelly (1955), also helps to explain why residents in the current study mainly constructed negative images of the RCF and identities-as-residents. According to Kelly (1955), every individual construes or places unique interpretation upon event or experience. However, individuals from the same culture tend to "construe their experience in the same way" (Kelly, 1955, p. 94). Similarly, an individual's "psychological processes are channelized by the ways in which he anticipates events" (Kelly, 1955, p. 93). Nevertheless, individuals belonging to the same culture anticipate events in a similar way (Kelly, 1955). Consistent with this seminal theory, most residents in the current study had similar socio-cultural expectations regarding how they were going to spend their old age, which was also a major part of their self-identity. However, when those expectations were not met in the RCF, they constructed negative images of the RCF and identities-as-residents.

Similar to the findings of the current study, a recent case study conducted on three RCFs in the UK found that restrictions in RCF put residents' sense of independence and autonomy at risk, which forced them to redefine themselves within institutional limitations (Paddock et al., 2018). Therefore, residents expressed bounded identity in the RCF, which is similar to some of the negative identities reported by residents in the current study (Paddock et al., 2018). It is vital that services provided in a RCF be reflective of residents' socio-cultural expectations in order to promote the construction of positive images of RCFs and identities-as-residents.

One interesting finding is that residents compromised with the new identity-as-residents by comparing themselves with co-residents. The reference group for comparison for most residents were co-residents who had either son, daughter-in-law, home, or were from a well-off family. Most residents perceived that if the co-residents from similar, or comparatively better, backgrounds have reconciled with the new identity-as-residents, then they "must," "have to," or "should," compromise as well. Findings from the current study illustrate the strategy of comparison that corresponds to assumptions of social comparison theory. Social comparison theory claims that individual evaluates self "opinions and abilities" by comparing with others (Festinger, 1954). Previous work in RCFs also supports these findings (Lee et al., 2002b; Paddock et al., 2018). A review study suggested that residents often

compare themselves with co-residents based on health, cognitive, social, financial status, or family visits in order to put things into perspective and cope (Lee et al., 2002b). In a case study, Paddock et al. (2018) found that comparing with co-residents is an adaptive strategy used by residents in order to "forge a positive identity" (p. 655). In that study, residents without dementia compared themselves with co-resident having dementia in order to accentuate their "superior cognitive and physical abilities" (Paddock et al., 2018, p. 655). In social psychology, this strategy of comparing self with less-fortunate people is termed as a downward social comparison (Wills, 1981). It is important to note that residents' socio-cultural context, background, or health status might influence the choice of reference group for comparison. Nevertheless, comparing with co-residents helped residents to compromise with their new identities-as-residents.

Another key finding was that residents gradually internalised their new identities-as-residents after moving through the phases of isolation, exploration, evaluation, and compromise at their pace. There were elements of identities-as-residents that most residents were still struggling to internalise. However, almost all the residents in this study internalised their new identity as a person having "no one." This internalisation occurred gradually but became prominent when visits/calls/invites from family/relatives steadily reduced or stopped as they continued living in the RCF. In this study, most residents reported the feeling of abandonment, deception, and marginalisation only when visits/calls/invites from family/relatives steadily reduced or stopped; rather than immediately on admission. What residents expected was their family/relatives would continue taking care of them even in the RCF. However, when visits/calls/invites from family/relatives steadily reduced or stopped, they felt abandoned, deceived, and marginalised.

Although the feeling of abandonment or being "thrown" by family/relatives is commonly reported by adjustment theories (Brooke, 1987; Chenitz, 1983), the feeling of deception and marginalisation was unique to Nepalese residents. Residents in this study believed that family/relatives tricked them into moving to the RCF when they said they would continue taking care of them even in the RCF but did not do so afterward. Similarly, residents perceived that family/relatives had marginalised them by not visiting/calling/inviting after being admitted into the RCF. In addition to

visits/calls/invites, residents expected that family/relatives would continue loving them, taking their advice, supporting them in fulfilling spiritual needs, caring during illness, providing financial backup, and respecting them even after moving to RCF. Resident's sense of abandonment, deception, and marginalisation needs to be addressed. Data revealed the need for programmes and policies encouraging regular family visits in RCFs, especially on days of spiritual importance to reduce residents' depression, anxiety, loneliness, and increase the feeling of kinship. Similarly, findings of this study support that family/relatives need to be encouraged to remain connected with residents as much as possible, and rules and regulations of RCF must be flexible to allow for regular family visits/calls/invites.

10.2.1 Promoting positive images of RCFs and identities-as-residents

The most striking finding of this study is that residents tend to construct comparatively positive images of RCFs and identities-as-residents under specific conditions. Data show that when there is a religious place inside or near to the RCF, residents are placed according to their cognitive abilities, environmental aesthetics of the RCF premises are maintained, regular spiritual programmes are organised, or individual spiritual practices are allowed, residents construct comparatively positive images of RCFs and identities-as-residents. Similarly, study findings demonstrate that residents construct comparatively positive images of RCFs and identities-as-residents when the privacy of residents is considered; or opportunity is provided for social interactions. These results corroborate some of the findings of a content analysis and case study regarding residents' identity conducted in RCFs in Austria and the UK, respectively (Paddock et al., 2018; Riedl et al., 2013). Similarly, a GT *Finding home* in a RCF in Ireland has also identified that providing privacy and valuing residents as an individual is essential for conserving personal identity (Cooney, 2012).

The current study also found that residents construct comparatively positive images of RCFs and identities-as-residents when nurses/caregivers valued residents' spiritual belief systems, allowed them to contribute according to capacity, rewarded them, included them in decision-making, or gave residents a chance to express needs/concerns. It is clear that in order to promote positive images of RCF and identities-as-residents, managers and nurses/caregivers working in RCFs should

think beyond the physical needs of residents, which is the current scenario in most Nepalese RCFs (National Human Rights Commission-Nepal, 2019). In creating, as well as reforming, rules and regulations, the expectations, needs, capabilities, and spiritual belief system of residents should be considered to promote positive images of RCF and identities-as-residents rather than stereotyping all residents as the same.

10.3. Process of Seeking and Maintaining Connections

In this study, the perceived lack of connection acted as a driving force for residents to seek new and maintain existing connections in the RCF. The concept of connections or relationships between residents or with nurses/caregivers is not new. Previous theories on adjustment or transition in RCFs have incorporated the elements of "relationship-building" or "new social network," "establishing relations" in different stages (Brooke, 1987; Lee et al., 2002a; Wilson, 1997). However, the emphasis of these theories was on understanding new residents' experiences within 10 months (Brooke, 1987), 6 months (Lee et al., 2002a), or 1 month (Wilson, 1997); rather than how they seek and maintain connections in a RCF. The current study showed no evidence to support these theories in a sense that "meaningful" relationship development can occur as early as 1 month or is fixed to occur within 6 or 10 months (Brooke, 1987; Lee et al., 2002a; Wilson, 1997).

Similarly, there are studies that have focused on the relationships between residents or nurses/caregivers (Jones & Moyle, 2016; McGilton & Boscart, 2007; Wilson et al., 2009). However, only one GT has been developed to explain how residents develop relationships in RCFs (Roberts & Bowers, 2015); although it did not address the concept of connecting with inner-self and higher being/s and only included the residents' perspective. The findings of the current study have explained how residents seek, as well as maintain, connections with different sources, such as inner-self, higher being/s, co-residents, and nurses/caregivers.

Data from the current study indicate that seeking connections includes residents identifying sources, developing connections, and appraising responses, which eventually led them to build connections in the RCF. Residents used different strategies to develop connection with different sources depending on the responses that they received. Similarly, the results show that maintaining connections comprise sustaining connections with co-residents, preserving connections with

nurses/caregivers, and continuing connections with inner-self and higher being/s. By maintaining connections with different sources, residents balanced shifting connections in RCF. I argue that the process of seeking and maintaining connections is continuous and dynamic, since conditions surrounding different sources of connections keep changing in a RCF.

10.3.1 Supporting residents' process of connecting with inner-self and higher being/s

A key finding of this study is that residents developed and maintained connections with inner-self and higher being/s by involvement in group spiritual programmes and individual spiritual practices, as allowed. Consistent with this finding, previous studies have demonstrated that connecting with inner-self, higher being/s, or higher power is one of the major spiritual tasks in old age which allows older adults to transcend associated losses (Dalby, 2006; Hedberg et al., 2009; MacKinlay, 2002). Interestingly, the study findings support Erikson's theory, which claims that transcendence is a part of psychological development in old age (Erikson & Erikson, 1997). Erikson's theory has also conceptualised that transcendence is mainly evident in older adults aged 80 and beyond (Erikson & Erikson, 1997). In contrast, the present study found that residents in their 60s and 70s were also involved in connecting with inner-self and higher being/s to transcend reality. A possible explanation for this result might be that transcendence is not just a part of developmental stage but people might develop it early in life as a result of a difficult life situation (Momtaz et al., 2010; Shaw et al., 2016; Sun, 2012; Yoon, 2006). For Nepalese residents, moving to RCF was that difficult life situation. The findings of this study also confirm Tornstam's (2005) theory of gerotranscendence, which claims that as an individual ages, there is a major shift from materialistic to a transcendent view of the world in order to maintain self-integrity. Therefore, seeking and maintaining connections with inner-self and higher being/s, one of the major spiritual tasks for older adults, should be supported in RCFs to maintain residents' self-integrity.

Supporting resident's process of connecting with inner-self and higher being/s is also important because data upholds that it leads to a number of positive outcomes such as increased sense of physical wellbeing, "hope," "faith," "happiness in the soul," "satisfaction," "relaxation," and "inner peace". Similarly, facilitating residents'

process of connecting with inner-self and higher being/s can help residents to forget their difficult past, acquire a sense of the meaningful passage of time, combat loneliness, find meaning in suffering, and a sense of control. These results corroborate the findings of a great deal of previous work regarding the positive impact of spiritual practices in older adults from all cultures (Cowlishaw et al., 2013; Ihara & Vakalahi, 2011; Malone & Dadswell, 2018; Pandya, 2016). Past studies, however, have not addressed how spiritual practices of residents can be supported in a RCF from the perspective of older adults as well as nurses/caregivers.

The current study found that residents' spiritual practices can be supported by organising regular group spiritual programmes in the presence of spiritual advisors or caregivers, and providing freedom for individual spiritual practices, which was missing in one RCF. Residents might prefer different types of spiritual programmes or practices. As a result, regular assessment of what kind of spiritual programmes or activities most residents need or prefer can be helpful. Similarly, findings show that residents' spiritual practices can be supported indirectly by allowing them to be involved in different income generating activities inside the RCF or giving access to old age allowance, which will help them to pay for, or carry out, spiritual practices that they value. However, most Nepalese residents are being deprived of their right to old-age allowance (The Himalayan Times, 2019), which was also evident in the present study.

10.3.2 Facilitating residents' process of connecting with co-residents and nurses/caregivers

A significant finding of this study was that residents developed connections with co-residents, nurses/caregivers by getting involved in regular interactions with them. While interacting, residents appraised the response of co-residents and nurses/caregivers according to their expectations. Residents continued connecting when expectations from co-residents and nurses/caregivers met. Otherwise, residents either limited or stopped interacting with particular co-residents/nurses/caregivers, and started identifying other sources of connections. Consistent with this finding, a GT based on RCFs in the US. has found that "peer and staff responsiveness" is central to the development of relationships in RCF (Roberts & Bowers, 2015, p. 57). Depending on the response of co-residents, nurses/caregivers, residents perceived the

relationship as friendly or unfriendly (Roberts & Bowers, 2015). Moreover, Roberts and Bowers (2015) recommended that the focus of future research should be identifying resident-level and staff-level interventions to teach positive responses that support relationship development. The findings of the current study add to this body of knowledge by identifying the positive responses that residents expect from co-residents and nurses/caregivers. Residents in this study expected co-residents to be trustworthy, cooperative, compassionate, easy-going, respectful, and supportive of their spiritual practices. Similarly, residents expected nurses/caregivers to provide compassionate, unbiased, dignified, continuous care, or be respectful and supportive of their spiritual practices. The findings also demonstrated that when co-residents/nurses/caregivers in this study met expectations of residents, resident's notion of what constitutes a family shifted, and they began to consider those co-residents/nurses/caregivers as their new family. Positive attitudes and practices should be encouraged amongst residents, as well as nurses and caregivers, to facilitate the process of seeking connections in a RCF.

Data from the current study also revealed that the placement or arrangement of residents can constrain their process of seeking connection with co-residents. Therefore, residents' process of seeking connection can be facilitated by arranging them according to their cognitive abilities so that barriers of communication such as hearing, speech problems, or mental impairments can be reduced as much as possible. Also, findings indicate that language, gender, and religious affiliation constrain the process of seeking connection in RCF. This finding highlights the need for considering residents' cognitive abilities, language, gender, and religious affiliations while choosing a shared room in order to create a facilitative environment for interactions. Likewise, the study found that residents' process of seeking connection with nurses/caregivers can be facilitated by allocating time to interact, and prioritise their holistic needs. This finding supports the international guidelines on the care of older adults, specifically the holistic approach recommended by the WHO (2015), Meaningful Ageing Australia (2016), and New Zealand's Healthy Ageing Strategy (Ministry of Health- New Zealand, 2016).

One interesting finding is that residents maintained newly built connections with co-residents by using strategies such as being nice, avoiding conflict, assisting, and

sharing. Similarly, for preserving connection with nurses/caregivers, residents in this study reported being nice, gifting money/donated material, and sharing. These results reflect those of Roberts and Bowers (2015) who theorised that residents work actively in forming a positive atmosphere, so that interaction goals are achieved, or needs are met. However, these strategies do not always ensure the development of a positive relationship since co-residents and nurses/caregivers might not reciprocate positively. As a result, the development of friendly relationships is often challenging for residents (Roberts & Bowers, 2015). Similar to the theory developed by Roberts and Bowers (2015), the present study found that although most residents used positive strategies, they were not able to form meaningful relationships with co-residents and nurses/caregivers. The reason was that most residents lacked trust and maintained an intermediate level of interaction with co-residents, which meant sharing everything except inner feelings. Similarly, in most cases, residents maintained an intermediate level of interaction with nurses/caregivers, which meant sharing only physical needs. The underlying reason was most residents were afraid to share other needs than physical because they felt that they might not get dignified care during illness or end of life if they either troubled/disturbed nurses/caregivers. Likewise, due to the same fear, residents were also reluctant to complain about nurses/caregivers' care in RCFs.

Even though strategies used by residents in the present study were similar to those reported by Roberts and Bowers (2015), gifting money/donated material to maintain connections with co-residents/nurses/caregivers was unique to Nepalese residents. Internationally, RCFs can impose various degrees of restrictions regarding nurses/caregivers accepting cash/gift from residents. For instance, the Code of Conduct for nurses in New Zealand warns that gifting practice could be misinterpreted as nurses taking benefit of the care recipient's vulnerability (Nursing Council of New Zealand, 2012). However, gifting is a common practice among Nepalese residents, and RCFs have no clear policy against it. The current study found that donations do become very important in the almost hidden negotiations for maintaining connections, receiving spiritual care and attention in the cultural milieu of Nepal. Indeed, shifting the donations to management had a profound effect on residents—adding to their shame. Giving donations is deeply entrenched in the Nepalese culture and considered vital for maintaining spirituality. Therefore, donors'

personal choice of giving money/material directly to residents, as well as residents' subjective choice of gifting objects to co-residents/nurses/caregivers can be supported. However, gifting should not be expressed as desired/expected behaviour in order to get dignified care. Getting dignified or respectful care is right of the residents and should not depend on the gifting behaviour. It is the responsibility of nurses/caregivers to create and maintain a trustworthy, as well as a supportive, environment within the RCF, and within professional boundaries. It is prudent for the RCF to have clear policies regarding gifting practices, inform nurses/caregivers about their professional boundaries, and be vigilant in ensuring policies are executed.

10.4 Incorporating the Spiritual Needs of Residents and Providing Spiritual Care

In the literature, spiritual needs and care of cognitively intact older adults living in RCFs is a relatively under-researched area. A recent integrative review shows that there is limited evidence and no agreed definition of spiritual needs or care from the perspective of older adults, nurses, and caregivers in the context of RCFs (Gautam et al., 2019). The concept of spiritual care, in the context of general nursing or palliative care or dementia, has been examined (Gautam et al., 2019). However, there is no theory focusing on the concept of spiritual needs and care of cognitively intact older adults living in RCFs that integrates the perspectives of older adults, nurses, and caregivers. Therefore, the current study addresses this gap in knowledge by presenting the perspective of Nepalese older adults, nurses, and caregivers regarding spiritual needs and spiritual care in RCF.

The present study found that spiritual needs refer to what residents require in order to maintain their spirituality (i.e., connection with inner-self, higher being/s, family/relatives, co-residents, and nurses/caregivers). Spiritual needs identified in this study, from the perspective of residents, as well as nurses/caregivers, were the need for dignified care during illness or end of life, regular spiritual programmes, individual spiritual practices, and giving back to others. Other spiritual needs included regular interactions with family/co-residents/nurses/caregivers, close, respectful, and trusting relationships with family/co-residents/nurses/caregivers, continuity in care, equity, freedom, and regular social interactions. Additionally, the need for financial support, end-of-life support, affectionate care, categorisation,

counselling, and individualised care were also identified as spiritual care. This finding broadly supports previous work in this area which describes spiritual needs as psychological, social, religious, or existential needs (Erichsen & Bussing, 2013; Man-Ging et al., 2015). Unlike the present study, those studies only included the perspective of older adults. Similarly, spiritual care in this study meant any care undertaken in order to fulfil spiritual needs of residents. One of the important findings of this study was that although nurses/caregivers were aware of most of the spiritual needs of residents, only a few were involved in providing spiritual care. As a result, most spiritual needs remained unattended.

The most interesting finding is that spiritual care provision is a continuous process. The study found that in order to provide spiritual care, it is essential that nurses/caregivers internalise their role, establish trusting relationships with residents, provide resident-centred care, and cultivate a sense of kinship. To internalise the role, nurses/caregivers should place themselves in the residents' situation, reflect on self-experiences, and focus on the core values of the work. Similarly, establishing trusting relationships requires nurses/caregivers to take an individual approach to care, make interactions as informal and positive as possible, be polite, provide affectionate and respectful care, use a respectful tone and language, encourage residents to share their inner feelings, and allocate enough time for interactions. Providing resident-centred care meant coordinating with co-workers, managers, and negotiating with donors to fulfil spiritual needs as perceived by residents. Furthermore, cultivating a sense of kinship would require nurses/caregivers to be involved in listening, accepting, supporting the spiritual belief system of residents, and providing spiritual counselling. Similar to the findings of the current study, a few previous studies have demonstrated that spiritual care in RCF means trustworthy, compassionate, respectful, and holistic care (Blank et al., 2018; Rykkje et al., 2013; Wilkes et al., 2011). However, an integrated view of older adults, nurses, and caregivers is missing in those studies. The findings of the current study have also identified detailed strategies that nurses/caregivers should use in order to incorporate spiritual care in RCF rather than only exploring its components.

10.4.1 Facilitating spiritual care provision

The most important finding of this study is that only a few nurses/caregivers were involved in spiritual care provision. Data show that lack of awareness, training, experience, confidence, managerial support, recognition, staff, and time due to excess workload are major challenges in providing spiritual care. I argue that addressing these challenges can facilitate spiritual care provision in a RCF. Findings revealed that nurses/caregivers who valued spiritual belief systems in their life, received caregiving training, or had more experience of working in RCFs were more sensitive towards the spiritual needs of residents and were involved in providing spiritual care. These results are in accord with a descriptive qualitative study conducted in RCFs in New Zealand, which identified the lack of awareness among nurses/caregivers, delicate nature of the topic, and fear of crossing professional boundaries as main barriers of spiritual care provision. Lack of trust between staff and residents, task-oriented model of care, lack of staff, time, and referral mechanisms were also reported as hindering factors to spiritual care (Blank et al., 2018). Therefore, facilitating spiritual care provision would require equipping managers/nurses/caregivers with knowledge on spirituality, what constitutes spiritual needs or spiritual care of residents, and the significance of addressing this issue.

Similarly, nurses/caregivers should be well-trained on spiritual needs assessment, spiritual care provision, as well supervised continually by managers (Blank et al., 2018). Management should address the staff-shortage, recognise and support nurses/caregivers providing spiritual care, arrange for spiritual advisors, and evaluate care based on quality rather than quantity. Further, the current study found that rules and regulations of the RCF directly influenced the extent to which nurses/caregivers could be involved in spiritual care provision or allow individual spiritual practices or arrange family visits or provide end-of-life support. Therefore, rules and regulations in RCF should support residents' spiritual needs. To fulfil spiritual needs of residents and provide spiritual care within a resource-constraint context, nurses and caregivers could start coordinating with co-workers, managers, and negotiating with donors, as did few nurses and caregivers in this study.

Facilitating spiritual care provision is important because, as the current study found, an increased gap between spiritual needs and spiritual care leads to spiritual distress

in residents. In the literature, the term spiritual distress has been used to refer to the unmet spiritual needs of hospitalised older adults (Egan & Brisson, 2006; Monod et al., 2010b; Mundle, 2015). The findings of the current study add to the body of knowledge by elaborating on the concept of spiritual distress in the context of RCF, including the perspective of residents and nurses/caregivers. The symptoms of spiritual distress in the current study included a lack of hope, purpose, happiness, acceptance, belongingness, inner peace, and self-integrity. In contrast, when spiritual care provision was close to the spiritual needs of residents, it helped restore their spirituality. The concept of restored spirituality, as identified in the current study, can be compared to the term spiritual wellbeing or wellness used in the context of hospitalised older adults broadly referring to fulfilled spiritual needs (Monod et al., 2010b). The symptoms of restored spirituality in this study were increased hope, purpose, faith, happiness, acceptance, satisfaction, belongingness, inner peace, and reduced loneliness. Only a few residents in this study expressed these symptoms of restored spirituality. The ultimate goal of spiritual care in RCF should be restoring residents' spirituality.

10.5. Strengths and Limitations

The current study has several strengths. Firstly, this study is the first to investigate spirituality of Nepalese residents from older adults', nurses' and caregivers' perspectives, therefore, it has addressed the significant gap in the literature. Secondly, this study has utilised GT methodology, providing insight into the complex process involved in maintaining spirituality in Nepalese RCFs along with the consequences of different conditions on participants' responses. Another strength of this study is that diverse RCFs and participants were included, as much as possible, in order to cover variation in the theory. Furthermore, this study has highlighted how to integrate spirituality into the care of residents and its benefits, under-researched area in literature. Moreover, when the findings of this study were presented in front of the GT group, colleagues, post graduate students, they could relate to many of the concepts in terms of residential care in Australia and New Zealand. However, it is equally imperative to pinpoint the limitations of the current study.

This study is limited to the group of Nepalese older adults, nurses, and caregivers recruited from the selected RCFs in Nepal. In addition, most participants were Hindu. Future research including a bigger group of participants, more RCFs or covering different religions is needed to add variation and richness to this theory. Another limitation of this study is that participant observation could not be conducted, which could add more richness to the interactions between participants in more private spaces inside the RCFs. However, observation within interviews was conducted, which helped to note behaviours. For instance, even though nurses/caregivers did not address negative ways of interacting with residents (that the residents talked about), observation within interviews clarified it. Also, context is crucial while studying spirituality, and this study is limited to the socio-cultural context of residential living in Nepal. However, the findings, as indicated above, fit with many RCFs; thus, the process may well be transferable to RCFs in other countries. Also, this study did not include residents living with dementia or who were having an acute episode of ill health. The methodological approach and available time were not suitable to elicit the perceptions of those residents.

10.6. Recommendations

Education and practice

- Information on spirituality, spiritual needs, and spiritual care of residents should be included in the nursing curriculum and training manuals (caregiving training).
- Managers, nurses, and caregivers working in RCFs should be educated on how residents make meaning of their new identity-as-residents and do they seek and maintain connections.
- Nurses/caregivers should be trained to prioritise residents' need for interactions, along with other needs, especially when isolation is evident.
- It is vital that nurses/caregivers working in RCFs aid new residents to gain a realistic understanding of every dimension of residential living and what is expected/desired, or not, from them as a resident to prevent misunderstandings.

- Arrange regular positive counselling programmes to remind residents that RCF is one of the government's strategy of protecting older adults, and it is their right to live there not a shame or an equivalence to begging.
- Services provided in RCFs should resonate with residents' socio-cultural expectations and spiritual belief system in order to promote the construction of positive images of RCF and identities-as-residents. Similarly, rules and regulations of RCFs should be flexible enough to allow for residents' capabilities, and promote the construction of positive images of the RCF and identities-as-residents.
- Visits/calls/invites from family/relatives should be promoted in RCF in order to reduce their feelings of abandonment, deception, and marginalisation.
- To promote connections, regular group spiritual programmes in the presence of spiritual advisors or caregivers should be organised, and freedom for individual spiritual practices should be given.
- Residents' right to financial autonomy should be preserved since it significantly impacts their identity-as-residents as well as the process of connecting. The old age allowance needs to be uniformly distributed to all residents. RCF should advocate for providing the old age allowance of those older adults who have no citizenship certificate. Donors can be allowed to donate directly to residents under supervision.
- The model of care being used in most RCFs in Nepal (i.e., the bio-medical model) must be replaced by bio-medical and spiritual care. Nurses/caregivers must be well-informed about the spiritual needs of residents, and well-trained in assessing spiritual needs and providing spiritual care routinely.

Policy

- The Senior Citizen Rules of Nepal need to be revised in order to improve standards for the infrastructure and facilities inside RCFs based on residents' spiritual needs. For instance, physical disability should not be the barrier to spiritual practices, RCF's building should be older adults and wheel-chair friendly.
- The Senior Citizen Rules of Nepal need to form standard caregiving protocols based on the spiritual needs of residents.

- Lack of financial resources in RCFs, trained staff, and quality care in RCFs need to be addressed.

Research

- Design interventional studies using a multidisciplinary approach to conceptualise spiritual care model in RCFs, implement it, and assess its efficacy.
- Future research on how older adults living with dementia maintain their spirituality using the participant-observation method is also recommended.
- Explore the transferability of the theory—a process of connecting—to the hospitalized older adults.

10.7. Conclusion

The aim of the study was to provide a theoretical explanation of how older adults maintain spirituality in RCFs in Nepal. The specific objective was to explore how nurses and caregivers perceive and respond to residents' spiritual needs. A GT methodology was used. A theory—*a process of connecting*—was developed from the data, which explains how residents maintain spirituality in RCFs in Nepal. Moreover, the process of spiritual care provision was identified, which explains how nurses and caregivers perceive and respond to spiritual needs of residents.

A process of connecting offers a fresh, positive, and cost-effective outlook on improving caregiving practices for residents in Nepal. A positive outlook is critical in a scenario where the trend of residential living is increasing, despite associated stigma and problems. Furthermore, this theory supports holistic approach, individualised, or resident-centred care, which is consistent with the current international guidelines regarding the care of older adults such as the WHO, New Zealand's Healthy Ageing Strategy, Joint Commission for Accreditation of Health Organizations, and Meaningful Ageing Australia.

I conclude by thanking all the participants of this study who provided their time and willingness to share every detail of their journey in RCFs. I will always appreciate and value the extensive effort that residents put in, in order to maintain their spirituality in RCFs; a process I would have never known if I had not done this study.

References

Acharya, P. (2008). Senior citizens and the elderly homes: A survey from Kathmandu. *Dhaulagiri Journal of Sociology and Anthropology, 2*, 211-228. https://doi.org/10.3126/dsaj.v2i0.1365

Acharya, S. (2004). *Democracy, gender equality and women's literacy: Experience from Nepal*. Kathmandu, Nepal: UNESCO, Kathmandu Office.

Adhikari, P. (2013). *Determinants of religious activities in the elderly: A case study of age 60 plus Hindus of Kapan VDC, Kathmandu*. http://ageingnepal.org/a-case-study-of-age-60-plus-hindus-of-kapan-vdc-kathmandu/

Aldiabat, K. M., & Le Navenec, C. (2018). Data saturation: The mysterious step in grounded theory method. *The Qualitative Report, 23*(1), 245-226. https://nsuworks.nova.edu/tqr/vol23/iss1/18

Ali, J., Marhemat, F., Sara, J., & Hamid, H. (2015). The relationship between spiritual well-being and quality of life among elderly people. *Holistic Nursing Practice, 29*(3), 128-135. https://doi.org/10.1097/HNP.0000000000000081

Amin, S., Bajracharya, A., Bongaarts, J., Chau, M., & Melnikas, A. J. (2017). *Demographic changes of Nepal: Trends and policy implications*. Government of Nepal. https://www.unicef.org/nepal/media/446/file

Annells, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry, 4*(2), 120-129. https://doi.org/10.1111/j.1440-1800.1997.tb00085.x

Asia Pacific Forum of National Human Rights Institutions. (2018). *New report highlights challenges facing older people*. https://www.asiapacificforum.net/news/new-report-highlights-challenges-facing-older-people/

Asian Development Bank. (1999). *Country briefing paper: Women in Nepal*. https://www.adb.org/sites/default/files/institutional-document/32561/women-nepal.pdf

Bailey, J. (2008). First steps in qualitative data analysis: Transcribing. *Family Practice, 25*(2), 127-131. https://doi.org/10.1093/fampra/cmn003

Baldacchino, D. R., Bonello, L., & Debattista, C. J. (2014). Spiritual coping of older persons in Malta and Australia (part 2). *British Journal of Nursing, 23*(15), 843-846. https://doi.org/10.12968/bjon.2014.23.15.843

Baldwin, A., Birks, M., Mills, J., & Budden, L. (2015). Putting philosophy into PhD. *Working Papers in Health Sciences, 1*(10),1-4.

Bamonti, P., Lombardi, S., Duberstein, P. R., King, D. A., & Van Orden, K. A. (2016). Spirituality attenuates the association between depression symptom severity and meaning in life. *Aging & Mental Health, 20*(5), 494-499. https://doi.org/10.1080/13607863.2015.1021752

Bashir, F. (2000). This solitude is my life… A case study of psychological experiences of residents of an old age home in Lahore. *International Journal of Research in Humanities and Social Studies, 4*(4), 17-21. http://dx.doi.org/10.22259/ijrhss.0404004

Bhandari, M. (2014). *The experience of elderly care home (Bridhashram) life from residents' perspective: A qualitative study at Kathmandu, Nepal.* [Master's thesis, University of Stavanger]. http://hdl.handle.net/11250/277725

Bhattarai, L. P. S. (2014). Neglect and abuse of older people in Nepal: A commentary on a baseline study on reported cases of elder abuse in Nepali press. *Journal of Elder Abuse & Neglect, 26*(3), 333-336. https://doi.org/10.1080/08946566.2013.830040

Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide* (1st ed.). Sage.

Birks, M., Mills, J., Francis, K., & Chapman, Y. (2009). A thousand words paint a picture: The use of storyline in grounded theory research. *Journal of Research in Nursing, 14*(5), 405-417. https://doi.org/10.1177/1744987109104675

Black, H. K. (2012). The influence of African American elders' belief systems on health interactions. *Journal of Religion & Spirituality in Social Work: Social Thought, 31*(3), 226-243. https://doi.org/10.1080/15426432.2012.679839

Blank, M., Wood, S., & Egan, R. (2018). Layers of engagement: Staff perceptions of spiritual care in residential aged care. *Journal of Religion, Spirituality & Aging, 30*(1), 78-98. https://doi.org/10.1080/15528030.2017.1301844

Blumer, H. (1969). *Symbolic interactionism: Perspective and method* (1st ed.). Prentice-Hall.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research, 8*(1), 137-152. https://doi.org/10.1177/1468794107085301

Braam, A. W., Schaap-Jonker, H., Mooi, B., Ritter, D. d., Beekman, A. T. F., & Deeg, D. J. H. (2008). God image and mood in old age: Results from a community-based pilot study in the Netherlands. *Mental Health, Religion & Culture, 11*(2), 221-237. https://doi.org/10.1080/13674670701245274

Brandburg, G. L. (2007). Making the transition to nursing home life: A framework to help older adults adapt to the long-term care environment. *Journal of Gerontological Nursing, 33*(6), 50-56. https://doi.org/10.3928/00989134-20070601-08

Breckenridge, J., & Jones, D. (2009). Demystifying theoretical sampling in grounded theory research. *Grounded Theory Review, 8*, 113-126. https://eresearch.qmu.ac.uk/handle/20.500.12289/883

Brooke, V. (1987). *Adjustment to living in a nursing home: Toward a nursing intervention.* [Doctoral thesis, University of Utah]. https://collections.lib.utah.edu/ark:/87278/s6cv4zck

Bryant, A., & Charmaz, K. (2007). *The SAGE handbook of grounded theory* (1st ed.). Sage.

Buck, H. G. (2006). Spirituality: Concept analysis and model development. *Holistic Nursing Practice, 20*(6), 288-292. https://doi.org/10.1097/00004650-200611000-00006

Burns, N., & Grove, S. K. (2007). *Understanding nursing research: Building an evidnce-based practice* (4th ed.). Saunders.

Callaghan, D. M. (2006). The influence of growth on spiritual self-care agency in an older adult population. *Journal of Gerontological Nursing, 32*(9), 43-51. https://doi.org/10.3928/00989134-20060901-08

Canda, E. R., & Furman, L. D. (1999). *Spiritual diversity in social work practice:The heart of helping* (1st ed.). The Free Press.

Carron, R., & Cumbie, S. A. (2011). Development of a conceptual nursing model for the implementation of spiritual care in adult primary healthcare settings by nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 23*(10), 552-560. https://doi.org/10.1111/j.1745-7599.2011.00633.x

Central Bureau of Statistics. (2012). *National population and housing census 2011, national report*. Government of Nepal.

Central Bureau of Statistics. (2014). *Population monograph of Nepal* (Vol. 1). Government of Nepal.

Chalise, H. N. (2014). Depression among elderly living in Briddashram (old age home). *Advances in Aging Research, 3*(1), 6-11. http://dx.doi.org/10.4236/aar.2014.31002

Chalise, H. N. (2017). Abuse of older adults residing in the community of Nepal. *Journal of Gerontology and Geriatric Research, 6*(2). https://doi.org/10.4172/2167-7182.1000415

Chalise, H. N., & Brightman, J. D. (2006). Aging trends: Population aging in Nepal. *Geriatrics & Gerontology International, 6*(3), 199-204. https://doi.org/10.1111/j.1447-0594.2006.00347.x

Chalise, H. N., Kai, I., & Saito, T. (2010). Social Support and its correlation with loneliness: A cross-cultural study of Nepalese older adults. *The International Journal of Aging and Human Development, 71*(2), 115-138. https://doi.org/10.2190/AG.71.2.b

Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). Linking symbolic interactionism and grounded theory methods in a research design. *SAGE Open, 3*(3). https://doi.org/10.1177/2158244013505757

Charmaz, K. (2000). Grounded theory: Objectivist and contructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-536. Sage.

Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies for qualitative inquiry* (pp. 249-291). Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis* (1st ed.). Sage.

Charmaz, K. (2008). The legacy of Anselm Strauss in constructivist grounded theory. In N. Denzin, J. Salvo, & M. Washington (Eds.), *Studies in symbolic interaction: Vol. 32* (pp. 127-141). https://doi.org/10.1016/S0163-2396(08)32010-9

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage.

Charon, J. M. (1995). *Symbolic interactionism: An introduction, an interpretation, an integration* (5th ed.). Prentice-Hall.

Chaves, L. J., & Gil, C. A. (2015). Older people's concepts of spirituality, related to aging and quality of life. *Ciencia & Saude Coletiva, 20*(12), 3641-3652. https://doi.org/10.1590/1413-812320152012.19062014

Chen, H. Y., & Boore, J. R. P. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing, 19*(1-2), 234-239. https://doi.org/10.1111/j.1365-2702.2009.02896.x

Chen, H., Cheal, K., Herr, E. C. M., Zubritsky, C., & Levkoff, S. E. (2007). Religious participation as a predictor of mental health status and treatment outcomes in older persons. *International Journal of Geriatric Psychiatry, 22*(2), 144-153. https://doi.org/10.1002/gps.1704

Chenitz, W. C. (1983). Entry into a nursing home as status passage: A theory to guide nursing practice. *Geriatric Nursing, 4*(2), 92-97. https://doi.org/10.1016/S0197-4572(83)80057-3

Choi, J., Kushner, K. E., Mill, J., & Lai, D. W. L. (2012). Understanding the language, the culture, and the experience: Translation in cross-cultural research. *International Journal of Qualitative Methods, 11*(5), 652-665. https://doi.org/10.1177/160940691201100508

Chokkanathan, S. (2013). Religiosity and well-being of older adults in Chennai, India. *Aging & Mental Health, 17*(7), 880-887. https://doi.org/10.1080/13607863.2013.790924

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine, 7.* https//doi.org/10.1177/2050312118822927

Clark, G. (1993). Paradigms in science and archaeology. *Journal of Archaeological Research, 1*(3), 203-234. https://doi.org/10.1007/bf01326535

Cohen, A. B., & Hall, D. E. (2009). Existential beliefs, social satisfaction, and well-being among catholic, jewish, and protestant older adults. *International Journal for the Psychology of Religion, 19*(1), 39-54. https://doi.org/10.1080/10508610802471088

Cohen, H. L., Thomas, C. L., & Williamson, C. (2008). Religion and spirituality as defined by older adults. *Journal of Gerontological Social Work, 51*(3/4), 284-299. http://dx.doi.org/10.1080/01634370802039585

Coleman, P. G., Carare, R. O., Petrov, I., Forbes, E., Saigal, A., Spreadbury, J. H., Yap, A., & Kendrick, T. (2011). Spiritual belief, social support, physical functioning and depression among older people in Bulgaria and Romania. *Aging & Mental Health, 15*(3), 327-333. https://doi.org/10.1080/13607863.2010.519320

Cooney, A. (2010). Grounded theory. Choosing between Glaser and Strauss: An example. *Nurse Researcher, 17*(4), 18-28. https://doi.org/10.7748/nr2010.07.17.4.18.c7921

Cooney, A. (2012). 'Finding home': A grounded theory on how older people 'find home' in long-term care settings. *International Journal of Older People Nursing, 7*, 188-199. https://doi.org/10.1111/j.1748-3743.2011.00278.x

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*(1), 3-21. https://doi.org/10.1007/bf00988593

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Sage.

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research* (4th ed.). Sage.

Corsentino, E. A., Collins, N., Sachs-Ericsson, N., & Blazer, D. G. (2009). Religious attendance reduces cognitive decline among older women with high levels of depressive symptoms. *The Journals of Gerontology Series A, 64*(12), 1283-1289. https://doi.org/10.1093/gerona/glp116

Cowlishaw, S., Niele, S., Teshuva, K., Browning, C., & Kendig, H. (2013). Older adults' spirituality and life satisfaction: A longitudinal test of social support and sense of coherence as mediating mechanisms. *Ageing & Society, 33*(7), 1243-1262. https://doi.org/10.1017/S0144686X12000633

Creswell, J. W. (2007). *Qualitative inquiry and reseach design: Choosing among five approaches* (2nd ed.). Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process* (1st ed.). Sage.

Dalby, P. (2006). Is there a process of spiritual change or development associated with ageing? A critical review of research. *Aging & Mental Health, 10*(1), 4-12. https://doi.org/10.1080/13607860500307969

Damianakis, T., & Marziali, E. (2012). Older adults' response to the loss of a spouse: The function of spirituality in understanding the grieving process. *Aging & Mental Health, 16*(1), 57-66. https://doi.org/10.1080/13607863.2011.609531

Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods, 8*(2), 35-52. https://doi.org/10.1177/160940690900800206

de Guzman, A. B., Dalay, N. J. Z., De Guzman, A. J. M., de Jesus, L. L. E., de Mesa, J. B. C., & Flores, J. D. D. (2009). Spirituality in nursing: Filipino elderly's concept of, distance from, and involvement with God. *Educational Gerontology, 35*(10), 929-944. http://dx.doi.org/10.1080/03601270902717962

de Guzman, A. B., Valdez, L. P., Peña, E. G., Quindao, J. D. S., & Quibol, P. J. (2017). The long and winding road: A grounded theory of reminiscence among Filipino residents

in nursing homes. *Educational Gerontology, 43*(6), 277-288. https://doi.org/10.1080/03601277.2017.1279954

de Souza, M. (2016). Contemporary spirituality: An introduction to understandings in research and practice. In M. de Souza, J. Bone, & J. Watson (Eds.), *Spirituality across disciplines: Research and practice:* (pp. 1-7). Springer International Publishing. https://doi.org/10.1007/978-3-319-31380-1_1

Dempsey, L., Dowling, M., Larkin, P., & Murphy, K. (2016). Sensitive interviewing in qualitative research. *Research in Nursing & Health, 39*(6), 480-490. https://doi.org/10.1002/nur.21743

Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Sage.

Denzin, N. K., & Lincoln, Y. S. (1998). *Strategies of qualitative inquiry*. Sage.

Denzin, N. K., & Lincoln, Y. S. (2003). *Strategies of qualitative inquiry* (2nd ed.). Sage.

Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research* (5th ed.). Sage.

Dhakal, M. R. (2012). Ageing and health in Nepal. *Regional Health Forum, 16*(1), 12-16. https://pdfs.semanticscholar.org/d05e/ebccb1cda176c171ca81fc3f8c496da58b23.pdf

Dhital, S., Chalise, H. N., Rupakheti, D. (2015). Migration, ageing and spousal separation: A review of current population trend in Nepal. *Jacobs Journal of Gerontology, 1*(1), 004.

Dhungana, S., Acharya, K. P., & Rai, B. (2004). *Quality of life in elderly people- A comparative study in different elderly homes of Kathmandu*. http://library.nhrc.gov.np:8080/nhrc/handle/123456789/248

Dimock, E. C., Doniger, W., Gold, A. G., Smith, B. K., Basham, A. L., Narayanan, V., & Buitenen, J. A. B. (2019). *Hinduism*. https://www.britannica.com/topic/Hinduism

Dorji, N., Dunne, M. P., Seib, C., & Deb, S. (2017). Quality of life among senior citizens in Bhutan: Associations with adverse experiences, chronic diseases, spirituality, and social connectedness. *Asia Pacific Journal of Public Health, 29*(1), 35-46. https://doi.org/10.1177/1010539516685609

Dunn, K. S. (2008). Development and psychometric testing of a new geriatric spiritual well-being scale. *International Journal of Older People Nursing, 3*(3), 161-169. https://doi.org/10.1111/j.1748-3743.2007.00107.x

Eames, P., Cayley, S. (2010). Spiritual wellbeing for older New Zealanders. *Perspectives in Public Health, 130*(2), 62-63. https://doi.org/10.1177/1757913909360457

Eckersley, R. M. (2007). Culture, spirituality, religion and health: Looking at the big picture. *Medical Journal of Australia, 186*(S10), S54-S56. https://doi.org/10.5694/j.1326-5377.2007.tb01042.x

Egan, M., & Brisson, D. P. (2006). Outreach nurses' perceptions of the spiritual needs of their homebound older clients. *Journal of Religion, Disability and Health, 9*(4), 71-85. https://doi.org/10.1300/J095v09n04_05

Eisenhandler, S. A. (2005). 'Religion is the finding thing': An evolving spirituality in late life. *Journal of Gerontological Social Work, 45*(1/2), 85-103. https://doi.org/10.1300/J083v45n01_06

Ellis, J. M. (2010). Psychological transition into a residential care facility: Older people's experiences. *Journal of Advanced Nursing, 66*(5), 1159-1168. https://doi.org/10.1111/j.1365-2648.2010.05280.x

Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology, 11*. https://doi.org/10.1177/009164718301100406

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing ethnographic fieldnotes* (1st ed.). University of Chicago Press.

Erichsen, N. B., & Bussing, A. (2013). Spiritual needs of elderly living in residential/nursing homes. *Evidence-Based Complementary and Alternative Medicine, 2013*, 1-10. https://doi.org/10.1155/2013/913247

Erikson, E. H., & Erikson, J. M. (1997). *The life cycle completed*. W.W. Norton & Company.

Evans, G. L. (2013). A novice researcher's first walk through the maze of grounded theory: Rationalization for classical grounded theory. *Grounded Theory Review, 12*(1), 37-55. https://www.islandscholar.ca/islandora/object/ir%3A7160/datastream/PDF/view

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*(2), 117-140. https://doi.org/10.1177/001872675400700202

Fetzer Institute/National Institute on Aging Working Group. (1999). *Multidimensional measurement of religiousness, spirituality for use in health research.* Fetzer Institute.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology & Health, 25*(10), 1229-1245. https://doi.org/10.1080/08870440903194015

Francis, L. J., Jewell, A., & Robbins, M. (2010). The relationship between religious orientation, personality, and purpose in life among an older Methodist sample. *Mental Health, Religion & Culture, 13*(7/8), 777-791. https://doi.org/10.1080/13674670802360907

Fry, P. S. (2000). Religious involvement, spirituality and personal meaning for life: existential predictors of psychological wellbeing in community-residing and institutional care elders. *Aging & Mental Health, 4*(4), 375-387. https://doi.org/10.1080/713649965

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416. htps://nsuworks.nova.edu/tqr/vol20/iss9/3

Fung, A. W. T., & Lam, L.C.W. (2013). Spiritual activity is associated with better cognitive function in old age. *East Asian Archives of Psychiatry, 23*(3), 102-107. https://www.easap.asia/index.php/component/k2/item/213-1303-v23n3-p102

Gautam, R., Saito, T., & Kai, I. (2007). Leisure and religious activity participation and mental health: Gender analysis of older adults in Nepal. *BMC Public Health, 7*(1), 299. https://doi.org/10.1186/1471-2458-7-299

Gautam, S., Neville, S., & Montayre, J. (2019). What is known about the spirituality in older adults living in residential care facilities? An integrative review. *International Journal of Older People Nursing, 14*(2), e12228. https://doi.org/10.1111/opn.12228

Geriatric Center Nepal. (2010). *Status report on elderly people (60+) in Nepal on health, nutrition and social status focusing on research needs.* http://www.a-id.org/pdf/health-nutrition-and-social-status-focusing-on-research-needs.pdf

Geriatric Center Nepal, & National Human Rights Commission-Nepal. (2010). *A baseline study on reported cases of elder abuse in Nepali press*. http://ageingnepal.org/wp-content/uploads/2015/05/Elder-abuse-NHRC.pdf

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods*. California. http://methods.sagepub.com/reference/sage-encyc-qualitative-research-methods

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs. forcing*. Sociology Press.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Sociology Press.

Glaser, B. G. (2002a). Conceptualization: On theory and theorizing using grounded theory. *International Journal of Qualitative Methods, 1*(2), 23-38. https://doi.org/10.1177/160940690200100203

Glaser, B. G. (2002b). Constructivist grounded theory? *Forum: Qualitative Social Research*. https://doi.org/10.17169/fqs-3.3.825

Glaser, B. G., & Holton, J. (2004). Remodeling grounded theory. *Forum: Qualitative Social Research, 5*(2). https://doi.org/10.17169/fqs-5.2.607

Glaser, B. G., & Holton, J. (2005). Staying open: The use of theoretical codes in grounded theory. *Grounded Theory Review, 5*(1), 1-20.

Glaser, B. G., & Strauss, A. L. (1965). *Awareness of dying*. AldineTransaction.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Aldine Transaction.

Government of Nepal. (2005). *Disability and Senior Citizen related Act, Law Action.* http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/nepal/nepal_national_action_plan_for_senior_citizens_-_2005.pdf

Government of Nepal. (2016a). *Grant guidelines for institutions working in the field of Ministry of Women, Children and Social Welfare*. https://mowcsc.gov.np/uploads/uploads/EWKbIkad20HFkzla8hgYhrxMMe72FIHQCRzVyhdA.pdf

Government of Nepal. (2016b). *Inclusive cities: Resilient communities: Third United Nations Conference on housing and sustainable urban development (Habitat III).* Ministry of Urban Development. http://habitat3.org/wp-content/uploads/Nepal-HII-National-Report_email.pdf

Government of Nepal. (2016c). *Ninth plan*. https://www.npc.gov.np/images/category/ninth_eng_2.pdf

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Sage.

Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: When to use them and how to judge them. *Human Reproduction, 31*(3), 498-501. https://doi.org/10.1093/humrep/dev334

Han, J., & Richardson, V. E. (2010). The relationship between depression and loneliness among homebound older persons: Does spirituality moderate this relationship? *Journal of Religion and Spirituality in Social Work:Social Thought, 29*(3), 218-236. https://doi.org/10.1080/15426432.2010.495610

Harris, G. M., Allen, R. S., Dunn, L., & Parmelee, P. (2013). "Trouble won't last always": Religious coping and meaning in the stress process. *Qualitative Health Research, 23*(6), 773-781. https://doi.org/10.1177/1049732313482590

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations *Forum: Qualitative Social Research 18*(1). https://doi.org/10.17169/fqs-18.1.2655

Harvey, I. S. (2006). Self-management of a chronic illness: An exploratory study on the role of spirituality among older African American women. *Journal of Women & Aging, 18*(3), 75-88. https://doi.org/10.1300/J074v18n03_06

Harvey, I. S. (2008). Assessing self-management and spirituality practices among older women. *American Journal of Health Behavior, 32*(2), 157-168. https://doi.org/10.5555/ajhb.2008.32.2.157

Harvey, I. S. (2009). Spiritual self-management: A look at older adults with chronic illness. *Journal of Religion, Spirituality and Aging, 21*(3), 200-218. https://doi.org/10.1080/15528030902803871

Harvey, I. S., & Cook, L. (2010). Exploring the role of spirituality in self-management practices among older African-American and non-Hispanic White women with chronic conditions. *Chronic Illness, 6*(2), 111-124. https://doi.org/10.1177/1742395309350228

Harvey, I. S., & Silverman, M. (2007). The role of spirituality in the self-management of chronic illness among older African and Whites. *Journal of Cross-Cultural Gerontology, 22*(2), 205-220. https://doi.org/10.1007/s10823-007-9038-2

Hayward, R. D., & Krause, N. (2014). How religious doubt moderates depression symptoms following older adult bereavement. *Death Studies, 38*(4), 217-223. https://doi.org/10.1080/07481187.2012.742476

Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies, 41*(2), 141-150. https://doi.org/10.1016/S0020-7489(03)00113-5

Hedberg, P., Brulin, C., & Aléx, L. (2009). Experiences of purpose in life when becoming and being a very old woman. *Journal of Women & Aging, 21*(2), 125-137. https://doi.org/10.1080/08952840902837145

Hedberg, P., Gustafson, Y., Brulin, C., & Alex, L. (2013). Purpose in life among very old men. *Advances in Aging Research, 2*(3), 100-105. http://dx.doi.org/10.4236/aar.2013.23014

HelpAge International. (2018). *Demanding an end to elder abuse in Nepal - HelpAge International*. https://helpagecanada.ca/2018/07/demanding-an-end-to-elder-abuse-in-nepal/

Hodge, D. R. (2018). The evolution of spirituality and religion in international social work discourse: Strengths and limitations of the contemporary understanding. *Journal of Religion & Spirituality in Social Work: Social Thought, 37*(1), 3-23. https://doi.org/10.1080/15426432.2017.1350125

Hodge, D. R., Salas-Wright, C. P., & Wolosin, R. J. (2016). Addressing spiritual needs and overall satisfaction with service provision among older hospitalized inpatients. *Journal of Applied Gerontology, 35*(4), 374-400. https://doi.org/10.1177/0733464813515090

Hodge, D. R., Wolosin, R. J., & Bonifas, R. P. (2013). Addressing older Latinos' spiritual needs in hospital settings: Identifying predictors of satisfaction. *Advances in Social Work, 14*(1), 65-81. https://doi.org/10.18060/3743

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). Wiley-Blackwell

Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Sage.

Holton, J. A (2010). The coding process and its challenges. *Grounded Theory Review, 9*, 21-40. https://doi.org/10.4135/9781848607941.n13

Hsu, H. (2014). Effects of religiousness on depressive symptoms among elderly persons in Taiwan. *Clinical Gerontologist, 37*(5), 446-457. https://doi.org/10.1080/07317115.2014.937549

Hughes, D. E., & Peake, T. H. (2002). Investigating the value of spiritual well-being and psychosocial development in mitigating senior adulthood depression. *Activities, Adaptation & Aging, 26*(3), 15-35. https:/doi.org/10.1300/J016v26n03_02

Hupkens, S., Machielse, A., Goumans, M., & Derkx, P. (2016). Meaning in life of older persons: An integrative literature review. *Nursing Ethics, 25*(8), 973-991. https://doi.org/10.1177/0969733016680122

Ihara, E. S., & Vakalahi, H. F. O. (2011). Spirituality: The essence of wellness among Tongan and Samoan elders. *Journal of Religion & Spirituality in Social Work: Social Thought, 30*(4), 405-421. https://doi.org/10.1080/15426432.2011.619916

Ingersoll-dayton, B., Krause, N., & Morgan, D. (2002). Religious trajectories and transistions over the life course. *International Journal of Aging and Human Development, 55*(1), 51-70. https://doi.org/10.2190%2F297Q-MRMV-27TE-VLFK

Iovu, M.-B., Mocean, R., Runcan, R., & Runcan, P. (2015). An exploratory case study of the religiosity, spirituality and death attitudes in two Romanian elderly day centres. *Social Work Review / Revista de Asistenta Sociala, 14*(2), 47-58.

James, W. (1907). *Pragmatism: A new name for some old ways of thinking: Popular lectures in philosophy* (1st ed.). Longmans, Green.

Jang, Y., Borenstein, A. R., Chiriboga, D. A., Phillips, K., & Mortimer, J. A. (2006). Religiosity, adherence to traditional culture, and psychological well-being among African American elders. *Journal of Applied Gerontology, 25*(5), 343-355. https://doi.org/10.1177/0733464806291934

Jasemi, M., Valizadeh, L., Zamanzadeh, V., & Keogh, B. (2017). A concept analysis of holistic care by hybrid model. *Indian Journal of Palliative Care, 23*(1), 71-80. https://doi.org/10.4103/0973-1075.197960

Jones, C., & Moyle, W. (2016). Staff perspectives of relationships in aged care: A qualitative approach. *Australasian Journal on Ageing, 35*(3), 198-203. https://doi.org/10.1111/ajag.12276

Jones, L. G. (1997). A thirst for God or consumer spirituality? Cultivating disciplined practices of being engaged by God. *Modern Theology, 13*(1), 3-28. https://doi.org/10.1111/1468-0025.00029

Jun, J. S., Lee, K. H., & Bolin, B. L. (2015). Stress and spirituality on the depressive symptoms of older adults in assisted living: Gender differences. *Journal of Evidence-Informed Social Work, 12*(6), 588-600. https://doi.org/10.1080/15433714.2014.966229

June, A., Segal, D. L., Coolidge, F. L., & Klebe, K. (2009). Religiousness, social support and reasons for living in African American and European American older adults: An exploratory study. *Aging & Mental Health, 13*(5), 753-760. https://doi.org/10.1080/13607860902918215

Kafle, B., Sharma, V. D., Ojha, S. P., Chapagain, M., Tulachan, P., & Dhungana, S. (2017). Prevalence of depression among elderly living in old age homes of Kathmandu valley and its association with sociodemographic variants. *Health Renaissance, 4*(1), 43-47. https://doi.org/10.3126/jpan.v4i1.16742

Karki, Y. B. (2017). *Population situation analysis of Nepal: With respect to sustainable development.* UNFPA. https://nepal.unfpa.org/sites/default/files/pub-pdf/Nepal%20Population%20Situation%20Analysis.pdf

Karnieli-Miller, O., Strier, R., & Pessach, L. (2008). Power relations in qualitative research. *Qualitative Health Research, 19*(2), 279-289. https://doi.org/10.1177/1049732308329306

Kathmandu Post. (2018). Pashupati home unfit for elderly folks. https://kathmandupost.ekantipur.com/news/2018-10-13/pashupati-home-unfit-for-elderly-folks.html

Kathmandu Post. (2019). *Senior citizens welcome increase in allowance, but say they are not fully happy*. http://kathmandupost.ekantipur.com/news/2019-05-30/senior-citizens-welcome-increase-in-allowance-but-say-they-are-not-fully-happy.html

Kc, S., Upreti, B. R., Paudel, S. B., Acharya, G., Tandukar, A., & Babajanian, B. (2014). *The old age allowance and perception of the State in Rolpa District, Nepal.* https://securelivelihoods.org/publication/the-old-age-allowance-and-perceptions-of-the-state-in-rolpa-district-nepal/

Kelly, G. A. (1955). *A theory of personality: The psychology of personal constructs*. Norton.

Kennedy-Lewis, B. L. (2014). *Using diagrams to make meaning in grounded theory data collection and analysis*: SAGE. https://dx.doi.org/10.4135/978144627305014534926

Kenny, M., & Fourie, R. (2014). Tracing the history of grounded theory methodology: From formation to fragmentation. *The Qualitative Report, 19*(52), 1-9. https://nsuworks.nova.edu/tqr/vol19/iss52/1

Khanal, S., & Gautam, K. M. (2011). *Prevalence and management of geriatric diseases in elderly homes: A case study in Kathmandu*. http://ageingnepal.org/wp-content/uploads/2015/05/OAH-Study-Final.pdf

Kim, H., & Hocking, C. (2018). A grounded theory of Korean immigrants' experiences of re-establishing everyday activities in New Zealand. *Journal of Immigrant & Refugee Studies, 16*(3), 255-274. https://doi.org/10.1080/15562948.2016.1272732

Kim, S. S., Reed, P. G., Hayward, R. D., Kang, Y., & Koenig, H. G. (2011). Spirituality and psychological well-being: Testing a theory of family interdependence among family caregivers and their elders. *Research in Nursing & Health, 34*(2), 103-115. https://doi.org/10.1002/nur.20425

Kim, S. H., Kjervik, D., Belyea, M., & Choi, E. S. (2011). Personal strength and finding meaning in conjugally bereaved older adults: A four-year prospective analysis. *Death Studies, 35*(3), 197-218. https://doi.org/10.1080/07481187.2010.518425

Kirby, S. E., Coleman, P. G., & Daley, D. (2004). Spirituality and well-being in frail and nonfrail older adults. *The Journals of Gerontology: Series B, 59*(3), P123-P129. https://doi.org/10.1093/geronb/59.3.P123

Klemmack, D. L., Roff, L. L., Parker, M. W., Koenig, H. G., Sawyer, P., & Allman, R. M. (2007). A cluster analysis typology of religiousness/spirituality among older adults. *Research on Aging, 29*(2), 163-183. https://doi.org/10.1177/0164027506296757

Knestrick, J., & Lohri-Posey, B. (2005). Spirituality and health: Perceptions of older women in a rural senior high rise. *Journal of Gerontological Nursing, 31*(10), 44-52. https://doi.org/10.3928/0098-9134-20051001-09

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *International Scholarly Research Network Psychiatry, 2012*. https://doi.org/10.5402/2012/278730

Koenig, H. G., & Büssing, A. (2010). The Duke University Religion Index (DUREL): A five-item measure for use in epidemological studies. *Religions, 1*(1), 78-85. https://doi.org/10.3390/rel1010078

Kotrotsiou-Barbouta, E., Sapountzi-Krepia, D., Roupa-Darivaki, Z., Psychogiou, M., Dimitriadou, A., Paralikas, T., Tzounis, T., & Sgantzos, M. (2006). The meaning of spirituality as perceived by hospitalised elderly people in a small city of Greece. *ICUs & Nursing Web Journal* (28), 1-7.

Krause, N. (2008). The social foundation of religious meaning in life. *Research on Aging, 30*(4), 395-427. https://doi.org/10.1177/0164027508316619

Krause, N., & Bastida, E. (2009). Core religious beliefs and providing support to others in late life. *Mental Health, Religion & Culture, 12*(1), 75-96. https://doi.org/10.1080/13674670802249753

Krause, N., & Bastida, E. (2011). Prayer to the saints or the virgin and health among older Mexican Americans. *Hispanic Journal of Behavioral Sciences, 33*(1), 71-87. https://doi.org/10.1177/0739986310393628

Krause, N., & Hayward, R. D. (2014). Church-based social support, functional disability, and change in personal control over time. *Journal of Religion and Health, 53*(1), 267-278. https://doi.org/10.1007/s10943-013-9707-0

Krause, N., & Ellison, C. G. (2003). Forgiveness by God, forgiveness of others, and psychological well-being in late life. *Journal for the Scientific Study of Religion, 42*(1), 77-94. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3046863/

Krause, N., & Hayward, R. D. (2012). Awareness of the historical role of the Church and change in self-esteem among older African Americans. *Applied Psychology: Health and Well-Being, 4*(2), 240-260. https://doi.org/10.1111/j.1758-0854.2012.01072.x

Krause, N., & Hayward, R. D. (2014). Religious involvement and humility. *Journal of Positive Psychology, 9*(3), 254-265. https://doi.org/10.1080/17439760.2014.891153

Krause, N., Liang, J., Bennett, J., Kobayashi, E., Akiyama, H., & Fukaya, T. (2010). A descriptive analysis of religious involvement among older adults In Japan. *Ageing and Society, 30*(4), 671-696. https://doi.org/10.1017/S0144686X09990766

Krok, D. (2016). Sense of coherence mediates the relationship between the religious meaning system and coping styles in Polish older adults. *Aging & Mental Health, 20*(10), 1002-1009. doi:10.1080/13607863.2015.1056772

Kshetri, D. B. B., Smith, C. S., & Khadka, M. (2012). Social care and support for elderly men and women in an urban and a rural area of Nepal. *The Aging Male, 15*(3), 148-152. https://doi.org/10.3109/13685538.2012.666920

Law, R. W., & Sbarra, D. A. (2009). The effects of church attendance and marital status on the longitudinal trajectories of depressed mood among older adults. *Journal of Aging & Health, 21*(6), 803-823. https://doi.org/10.1177/0898264309338300

Lee, D. T. F., Woo, J., & Mackenzie, A. E. (2002a). The cultural context of adjusting to nursing home life: Chinese elders' perspectives. *The Gerontologist, 42*(5), 667-675. https://doi.org/10.1093/geront/42.5.667

Lee, D. T. F., Woo, J., & Mackenzie, A. E. (2002b). A review of older people's experiences with residential care placement. *Journal of Advanced Nursing, 37*(1), 19-27. https://doi.org/10.1046/j.1365-2648.2002.02060.x

Lee, E. K. O., Yoon, H., Lee, J., Yoon, J., & Chang, E. (2012a). Body-mind-spirit practice for healthy aging. *Educational Gerontology, 38*(7), 473-485. https://doi.org/10.1080/03601277.2011.567182

Lee, E. K. O. (2007). Religion and spirituality as predictors of well-being among Chinese American and Korean American older adults. *Journal of Religion, Spirituality and Aging, 19*(3), 77-100. https://doi.org/10.1300/J496v19n03_06

Lee, E. K. O., & Sharpe, T. (2007). Understanding religious/spiritual coping and support resources among African American older adults: A mixed-method approach. *Journal of Religion, Spirituality and Aging, 19*(3), 55-75. https://doi.org/10.1300/J496v19n03_05

Lee, K. H. (2011). The role of spiritual experience, forgiveness, and religious support on the general well-being of older adults. *Journal of Religion, Spirituality and Aging, 23*(3), 206-223. https://doi.org/10.1080/15528030.2011.533398

Lee, K. H., Besthorn, F. H., Bolin, B. L., & Jun, J. S. (2012b). Stress, spiritual, and support coping, and psychological well-being among older adults in assisted living. *Journal of Religion & Spirituality in Social Work, 31*(4), 328-347. https://doi.org/10.1080/15426432.2012.716287

Libois, F., & Somville, V. (2018). Fertility, household size and poverty in Nepal. *World Development, 103*, 311-322. https://doi.org/10.1016/j.worlddev.2017.11.005

Limbu, A. (2012). *Age structure transition and senior citizens in Nepal: The impending challenges* (Policy Discussion Paper – 2/2012). Alliance for Social Dialogue. http://asd.org.np/wp-content/uploads/2015/03/age_structure_transition_and_senior_citizens_in_nepal0.pdf

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lowis, M. J., Edwards, A. C., & Burton, M. (2009). Coping with retirement: Well-being, health, and religion. *Journal of Psychology: Interdisciplinary and Applied, 143*(4), 427-448. https://doi.org/10.3200/JRLP.143.4.427-448

Lowis, M. J., Jewell, A. J., Jackson, M. I., & Merchant, R. (2011). Religious and secular coping methods used by older adults: An empirical investigation. *Journal of Religion, Spirituality and Aging, 23*(4), 279-303. https://doi.org/10.1080/15528030.2011.566543

Lucchetti, G., Lucchetti, A. G., Badan-Neto, A. M., Peres, P. T., Peres, M. F. P., Moreira-Almeida, A., Gomes, C., & Koenig, H. G. (2011). Religiousness affects mental health, pain and quality of life in older people in an outpatient rehabilitation setting. *Journal of Rehabilitation Medicine, 43*(4), 316-322. https://doi.org/10.2340/16501977-0784

Mackenzie, E. R., Rajagopal, D. E., Meibohm, M., & Lavizzo-Mourey, R. (2000). Spiritual support and psychological well-being: Older adults' perceptions of the religion and health connection. *Alternative Therapies in Health & Medicine, 6*(6), 37-45.

MacKinlay, E. (2002). The spiritual dimension of caring: Applying a model for spiritual tasks of ageing. *Journal of Religious Gerontology, 12*(3/4), 151-166. https://doi.org/10.1300/J078v12n03_12

Malakar, I., & Chalise, H. N. (2019). *Perception of elderly towards social security allowance in Nepal*. *South Asian Journal of Social Studies and Economics, 2*(4), 1-9. https://doi.org/10.9734/sajsse/2018/v2i430008

Mallick, M. J., & Whipple, T. W. (2000). Validity of the nursing diagnosis of relocation stress syndrome. *Nursing Research, 49*(2), 97-100. https://doi.org/10.1097/00006199-200003000-00006

Malone, J., & Dadswell, A. (2018). The role of religion, spirituality and/or belief in positive ageing for older adults. *Geriatrics, 3*(2), 28. https://doi.org/10.3390/geriatrics3020028

Man-Ging, C. I., Uslucan, J. O., Fegg, M., Frick, E., & Bussing, A. (2015). Reporting spiritual needs of older adults living in Bavarian residential and nursing homes. *Mental Health, Religion & Culture, 18*(10), 809-821. https://doi.org/10.1080/13674676.2015.1100159

Manion, P. S., & Rantz, M. J. (1995). Relocation stress syndrome: A comprehensive plan for long-term care admissions: The relocation stress syndrome diagnosis helps nurses identify patients at risk. *Geriatric Nursing, 16*(3), 108-112. https://doi.org/10.1016/S0197-4572(05)80039-4

Manning, L. K. (2012). Spirituality as a lived experience: Exploring the essence of spirituality for women in late life. *International Journal of Aging & Human Development, 75*(2), 95-113. https://doi.org/10.2190/AG.75.2.a

Manning, L. K. (2013). Navigating hardships in old age: Exploring the relationship between spirituality and resilience in later life. *Qualitative Health Research, 23*(4), 568-575. https://doi.org/10.1177/1049732312471730

McCarthy, V. L., & Bockweg, A. (2013). The role of transcendence in a holistic view of successful aging: A concept analysis and model of transcendence in maturation and aging. *Journal of Holistic Nursing, 31*(2), 84-92. https://doi.org/10.1177/0898010112463492

McDougle, L., Konrath, S., Walk, M., & Handy, F. (2016). Religious and secular coping strategies and mortality risk among older adults. *Social Indicators Research, 125*(2), 677-694. http://dx.doi.org/10.1007/s11205-014-0852-y

McFadden, S. H. (2009). Universality and particularity: Reflections on glicksman's critique of the study of religion and spirituality among older persons. *Journal of Religion, Spirituality and Aging, 21*(4), 268-274. https://doi.org/10.1080/15528030902821238

McGilton, K. S., & Boscart, V. M. (2007). Close care provider–resident relationships in long-term care environments. *Journal of Clinical Nursing, 16*(11), 2149-2157. https://doi.org/10.1111/j.1365-2702.2006.01636.x

McGowan, J. C., Midlarsky, E., Morin, R. T., & Graber, L. S. (2016). Religiousness and psychological distress in Jewish and Christian older adults. *Clinical Gerontologist, 39*(5), 489-507. https://doi.org/10.1080/07317115.2016.1187696

McKenna, D. M., & Staniforth, B. (2017). Older people moving to residential care in Aotearoa New Zealand: Considerations for social work at practice and policy levels. *Australian and New Zealand Social Work, 29*(1), 28-40. https://doi.org/10.11157/anzswj-vol29iss1id215

McKenzie-Green, B. (2010). *Living life in residential aged care: A process of continuous adjustment*. [Doctoral thesis, Australian Catholic University]. https://doi.org/10.4226/66/5a960d51c684a

Meaningful Ageing Australia. (2016). *National guidelines for spiritual care in aged care*. https://meaningfulageing.org.au/wp-content/uploads/2016/08/National-Guidelines-for-Spiritual-Care-in-Aged-Care-DIGITAL.pdf

Mefford, L., Thomas, S. P., Callen, B., & Groer, M. (2014). Religiousness/spirituality and anger management in community-dwelling older persons. *Issues in Mental Health Nursing, 35*(4), 283-291. https/doi.org/10.3109/01612840.2014.890472

Melrose, S. (2013). Relocation stress: How staff can help. *Canadian Nursing Home, 24*(1), 16-19. http://hdl.handle.net/2149/3330

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research : A guide to design and implementation* (4th ed.). Jossey-Bass.

Miller, K. (2005). *Communication theories: Perspectives, processes, and contexts* (2nd ed.). Peking University Press.

Mills, J., & Birks, M. (2014). *Qualitative methodology: A practical guide*. Sage. https://methods.sagepub.com/book/qualitative-methodology-a-practical-guide

Ministry of Health-Nepal. (2017). *Nepal demographic and health survery 2016*. Ministry of Health. https://www.dhsprogram.com/pubs/pdf/fr336/fr336.pdf

Ministry of Health-New Zealand. (2016). *Healthy Ageing Strategy.* Ministry of Health. https://www.health.govt.nz/our-work/life-stages/health-older-people/healthy-ageing-strategy-update

Ministry of Women Children and Social Welfare-Nepal. (2005). *Disability and senior citizen related act: Law action.* Government of Nepal. http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/nepal/nepal_national_action_plan_for_senior_citizens_-_2005.pdf

Mishra, R. C. (2013). Moksha and the Hindu worldview. *Psychology & Developing Societies, 25*(1), 21-42. https://doi.org/10.1177/0971333613477318

Mishra, S., & Chalise, H. N. (2018). Health status of elderly living in government and private old age home in Nepal. *Asian Journal of Biological Sciences, 11*, 173-178. https://doi.org/10.3923/ajbs.2018.173.178

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Molzahn, A. E. (2007). Spirituality in later life: Effect on quality of life. *Journal of Gerontological Nursing, 33*(1), 32-39. https://doi.org/10.3928/00989134-20070101-07.

Momtaz, Y. A., Ibrahim, R., Hamid, T. A., & Yahaya, N. (2010). Mediating effects of social and personal religiosity on the psychological well being of widowed elderly people. *Omega: Journal of Death & Dying, 61*(2), 145-162. https://doi.org/10.2190/OM.61.2.d

Monod, S. M., Rochat, E., Bula, C., & Spencer, B. (2010a). The spiritual needs model: Spirituality assessment in the geriatric hospital setting. *Journal of Religion, Spirituality and Aging, 22*(4). https://doi.org/10.1080/15528030.2010.509987

Monod, S. M., Rochat, E., Bula, C. J., Jobin, G., Martin, E., & Spencer, B. (2010b). The spiritual distress assessment tool: An instrument to assess spiritual distress in hospitalised elderly persons. *BMC Geriatrics, 10*(1), 88. https://doi.org/10.1186/1471-2318-10-88

Montgomery, P., & Bailey, P. H. (2007). Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research, 29*(1), 65-79. https://doi.org/10.1177/0193945906292557

Moon, Y. S., & Kim, D. H. (2013). Association between religiosity/spirituality and quality of life or depression among living-alone elderly in a South Korean city. *Asia-Pacific Psychiatry, 5*(4), 293-300. https://doi.org/10.1111/appy.12025

Moore, S. L., Metcalf, B., & Schow, E. (2006). The quest for meaning in aging. *Geriatric Nursing, 27*(5), 293-299. https://doi.org/10.1016/j.gerinurse.2006.08.012

Morgan, D. L. (2014). Pragmatism as a paradigm for social research. *Qualitative Inquiry, 20*(8), 1045-1053. https://doi.org/10.1177/1077800413513733

Morse, J. (2000). Determining sample size. *Qualitative Health Research, 10*. https://doi.org/10.1177/104973200129118183

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. E. (2009). *Developing grounded theory: The second generation*. Routledge.

Mundle, R. (2015). A narrative analysis of spiritual distress in geriatric physical rehabilitation. *Journal of Health Psychology, 20*(3), 273-285. doi:10.1177/1359105314566609

Murphy, P. E., Fitchett, G., & Emery-Tiburcio, E. E. (2016). Religious and spiritual struggle: Prevalence and correlates among older adults with depression in the BRIGHTEN Program. *Mental Health, Religion & Culture, 19*(7), 713-721. https://doi.org/10.1080/13674676.2016.1244178

Murray, D. L. (2014). *Pragmatism*. The Floating Press. http://ebookcentral.proquest.com/lib/aut/detail.action?docID=1763374

National Human Rights Commission-Nepal. (2018). *Mid term report on senior citizen home monitoring.* Nepal. http://www.nhrcnepal.org/nhrc_new/doc/newsletter/Mid_Term_Report_on_Senior_Citizen_Home_monitoring_Ashoj_14_2075.pdf

National Human Rights Commission-Nepal. (2019). *Monitoring synopsis of the senior citizens' care centers - 2019*. Lalitpur, Nepal. http://www.nhrcnepal.org/nhrc_new/doc/newsletter/Monitoring_Synopsis_of_the_Senior_Citizens_Care_Centers_2019-min.pdf

Nepal Law Commission. (2006). *Senior Citizens Act, 2063 (2006).* https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/87505/99802/.../NPL87505.pdf

Nepal Law Commission. (2008). *Senior Citizens Rules, 2065 (2008).* http://www.lawcommission.gov.np/en/wp-content/uploads/2018/09/senior-citizens-rules-2065-2008.pdf

Nepali Times. (2017). *A much older tomorrow*. http://archive.nepalitimes.com/article/Nepali-Times-Buzz/need-to-prepare-for-ageing-society,3624

Neuman, W. L. (2014). *Social research methods: Qualitative and quantitative approaches* (7th ed.). Pearson Education Limited.

News18. (2019). Nepal's new law requires children to deposit share of income in parents' bank account. *News18*. https://www.news18.com/news/world/nepals-new-law-requires-children-to-deposit-share-of-income-in-parents-bank-account-1992115.html

Ng, T. P., Nyunt, M. S. Z., Chiam, P. C., & Kua, E. H. (2011). Religion, health beliefs and the use of mental health services by the elderly. *Aging & Mental Health, 15*(2), 143-149. https://doi.org/10.1080/13607863.2010.508771

Norton, M. C., Skoog, I., Franklin, L. M., Corcoran, C., Tschanz, J. A. T., Zandi, P. P., Breitner, J. C. S., Welsh-Bohmer, K. A., Steffens, D. C. (2006). Gender differences in the association between religious involvement and depression: The Cache County (Utah) study. *The Journal of Gerontology: Series B, 61*(3). P129–P136. https://doi.org/10.1093/geronb/61.3.P129

Nursing Council of New Zealand. (2012). *Code of conduct for nurses*. Nursing Council of New Zealand.

O'Brien, M. E. (2004). *A nurse's handbook of spiritual care: Standing on holy ground.* Jones & Bartlett Learning.

O'Brien, M. E. (2011). *Spirituality in nursing: Standing on holy ground* (4th ed.). Jones and Bartlett Learning.

O'Connor, A., Carpenter, B., & Coughlan, B. (2018). An exploration of key issues in the debate between classic and constructivist grounded theory. *Grounded Theory Review, 17*(1), 90-103.

O'Reilly, M., & Parker, N. (2012). 'Unsatisfactory saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 13*(2), 190-197. https://doi.org/10.1177/1468794112446106

Paddock, K., Wilson, C. B., & Walshe, C., Todd, C. (2018). Care home life and identity: A qualitative case study. *The Gerontologist, 59*(4), 655-664. https://doi.org/10.1093/geront/gny090

Paloutzian, R. F., & Ellison, C. W. (1982). Loneliness, spiritual well-being and the quality of life. In L. A. Peplau, & D. Perlman (Eds.), *Loneliness: A source book of current theory, research and therapy* (pp. 224-237). John Wiley & Sons.

Pandya, S. P. (2016). Aging spiritually: Pitamaha Sadans in India. *Cogent Social Sciences, 2*(1). http://dx.doi.org/10.1080/23311886.2016.1219212

Pargament, K. I. (1997). *The psychology of religious coping: Theory, research, and practice.* Guilford Press.

Pargament, K. I., & Mahoney, A. (2012). *Spirituality: The search for the sacred*. Oxford. https://doi.org/10.1093/oxfordhb/9780195187243.013.0058

Parker, S., Khatri, R., Cook, I. G., & Pant, B. (2014). Theorizing aging in Nepal: Beyond the biomedical model. *Canadian Journal of Sociology, 39*(2), 231-254. https://journals.library.ualberta.ca/cjs/index.php/CJS/article/download/22252/16514

Patterson, B. J. (1995). The process of social support: Adjusting to life in a nursing home. *Journal of Advanced Nursing, 21*(4), 682-689. https://doi.org/10.1046/j.1365-2648.1995.21040682.x

Phillippi, J., & Lauderdale, J. (2018). A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research, 28*(3), 381-388. https://doi.org/10.1177/1049732317697102

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52*, 126-136. https://doi.org/10.1037/0022-0167.52.2.126

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine, 17*(6), 642-656. https://doi.org/10.1089/jpm.2014.9427

Rai, S., Khanal, P., & Chalise, H. N. (2018). Elderly abuse experienced by older adults prior to living in old age home in Kathmandu. *Journal of Gerontological and Geriatriatric Research, 7*(1), 460. https://doi.org/10.4172/2167-7182.1000460

Ralph, N., Birks, M., & Chapman, Y. (2015). The methodological dynamism of grounded theory. *International Journal of Qualitative Methods, 14*(4). https://doi.org/10.1177/1609406915611576

Ranjan, S., Bhattarai, A., & Dutta, M. (2014). Prevalence of depression among elderly people living in old age home in the capital city Kathmandu. *Health Renaissance, 11*(3), 213-218. https://doi.org/10.3126/hren.v11i3.9634

Ravanipour, M., Salehi, S., Taleghani, F., Abedi, H. A., Ishaghi, S. R., Schuurmans, M. J., & de Jong, A. (2013). Power resources of older people in Iran. *International Journal of Older People Nursing, 8*(1), 71-79. https://doi.org/10.1111/j.1748-3743.2012.00335.x

Register, M. E., & Scharer, K. M. (2010). Connectedness in community-dwelling older adults. *Western Journal of Nursing Research, 32*(4), 462-479. doi:10.1177/0193945909355997

Regmi, K., Naidoo, J., & Pilkington, P. (2010). Understanding the processes of translation and transliteration in qualitative research. *International Journal of Qualitative Methods, 9*(1), 16-26. https://doi.org/10.1177/160940691000900103

Regmi, R. K. R. (1993). Socio-economic and cultural aspects of ageing in Nepal. *Occasional Papers in Sociology and Anthropology, 3*, 28-46.

Reyes-Ortiz, C. A., Berges, I. M., Raji, M. A., Koenig, H. G., Kuo, Y.F., & Markides, K. S. (2008). Church attendance mediates the association between depressive symptoms and cognitive functioning among older Mexican Americans. *The Journals of Gerontology: Series A, 63*(5), 480-486. https://doi.org/10.1093/gerona/63.5.480

Riedl, M., Mantovan, F., & Them, C. (2013). Being a nursing home resident: A challenge to one's identity. *Nursing Research and Practice, 2013*. https://doi.org/10.1155/2013/932381

Roberts, T., & Bowers, B. (2015). How nursing home residents develop relationships with peers and staff: A grounded theory study. *International Journal of Nursing Studies, 52*(1), 57-67. https://doi.org/10.1016/j.ijnurstu.2014.07.008

Roff, L. L., Durkin, D., Sun, F., & Klemmack, D. L. (2007). Widowhood, religiousness, and self-Assessed well-Being among older adults. *Journal of Religion, Spirituality and Aging, 19*(4), 43-59. https://doi.org/10.1300/J496v19n04_04

Rykkje, L. R., Eriksson, K., & Raholm, M. B. (2013). Spirituality and caring in old age and the significance of religion - a hermeneutical study from Norway. *Scandinavian Journal of Caring Sciences, 27*(2), 275-284. https://doi.org/10.1111/j.1471-6712.2012.01028.x

Ryu, S., & Lee, O. E. K. (2016). Faith, spirituality, and values among Asian-American older adults: An exploratory factor analysis of the multidimensional measures of religion and spirituality. *Mental Health, Religion & Culture, 19*(8), 920-931. https://doi.org/10.1080/13674676.2017.1290593

Sadler, E., & Biggs, S. (2006). Exploring the links between spirituality and 'successful ageing'. *Journal of Social Work Practice, 20*(3), 267-280. doi:10.1080/02650530600931757

Sadler, E., Biggs, S., & Glaser, K. (2013). Spiritual perspectives of Black Caribbean and White British older adults: Development of a spiritual typology in later life. *Ageing and Society, 33*(3), 511-538. http://dx.doi.org/10.1017/S0144686X12000074

Santos, H. P. O., Black, A. M., & Sandelowski, M. (2015). Timing of translation in cross-language qualitative research. *Qualitative Health Research, 25*(1), 134-144. https://doi.org/10.1177/1049732314549603

Sedano, T., Ralph, P., & Peraire, C. (2017). *Lessons learned from an extended participant observation grounded theory study*. [Conference session]. Proceedings of the 5th International Workshop on Conducting Empirical Studies in Industry, Buenos Aires, Argentina. https://doi.org/10.1109/cesi.2017.2

Seicol, S. R. (2005). A pastoral understanding of positive aging. *Journal of Gerontological Social Work, 45*(3), 293-300. https://doi.org/10.1300/J083v45n03_03

Seifert, L. S. (2002). Toward a psychology of religion, spirituality, meaning-search, and aging: Past research and a practical application. *Journal of Adult Development, 9*(1), 61-70. https://doi.org/10.1023/A:1013829318213

Sessanna, L., Finnell, D., & Jezewski, M. A. (2007). Spirituality in nursing and health-related literature:A concept analysis. *Journal of Holistic Nursing, 25*(4), 252-262. https://doi.org/10.1177/0898010107303890

Setta, S. M., & Shemie, S. D. (2015). An explanation and analysis of how world religions formulate their ethical decisions on withdrawing treatment and determining death. *Philosophy, Ethics, and Humanities in Medicine, 10*. https://doi.org/10.1186/s13010-015-0025-x

Shalin, D. N. (1986). Pragmatism and social interactionism. *American Sociological Review, 51*(1), 9-29. https://doi.org/10.2307/2095475

Shaw, R., Gullifer, J., & Wood, K. (2016). Religion and spirituality: A qualitative study of older adults. *Ageing International, 41*, 311-330. https://doi.org/10.1007/s12126-016-9245-7

Sheldrake, P. (2007). *A brief history of spirituality*. Blackwell Publishing.

Shih, S. N., Turale, S., Shih, F. J., & Tsai, J. C. (2010). Religiosity influences on bereavement adjustments of older widows in Taiwan]. *Journal of Clinical Nursing, 19*(5/6), 856-866. https://doi.org/10.1111/j.1365-2702.2009.02947.x

Shrestha, I., & Dahal, B. P. (2007). *Economic and social commission for Asia and the Pacific: High-level meeting on the regional review of the Madrid International Plan of Action on Ageing (MIPAA).* Macao, China. https://www.un.org/esa/socdev/ageing/documents/review_map/Nepal.pdf

Shrestha, S. (2010). *Quality of life among elderly Nepali women*. [Doctoral thesis, The Pennsylvania State University]. https://etda.libraries.psu.edu/files/final_submissions/6086

Shrestha, S., & Zarit, S. H. (2012). Cultural and contextual analysis of quality of life among older nepali women. *Journal of Cross-Cultural Gerontology, 27*(2), 163-182. https://doi.org/10.1007/s10823-012-9167-0

Sikolia, D., Biros, D., Mason, M., & Weiser, M. (2013). Trustworthiness of grounded theory methodology research in information systems. *MWAIS 2013 Proceedings, 16.* http://aisel.aisnet.org/mwais2013/16

Silverman, D. (2013). *Doing qualitative research* (4th ed.). Sage.

Singh, D. R., & Shrestha, S. (2016). Nutritional status of senior citizens living in old age homes of Kathmandu metropolitan municipality. *International Journal of Community Medicine and Public Health 3*(7), 1707-1715. https://doi.org/10.18203/2394-6040.ijcmph20162032

Skarupski, K. A., Fitchett, G., Evans, D. A., & Mendes de Leon, C. F. (2010). Daily spiritual experiences in a biracial, community-based population of older adults. *Aging & Mental Health, 14*(7), 779-789. https://doi.org/10.1080/13607861003713265

Skarupski, K. A., Fitchett, G., Evans, D. A., & Mendes de Leon, C. F. (2013). Race differences in the association of spiritual experiences and life satisfaction in older age. *Aging & Mental Health, 17*(7), 888-895. https://doi.org/10.1080/13607863.2013.793285

Smith, K., & Biley, F. (1997). Understanding grounded theory: Principles and evaluation. *Nurse Researcher, 4*(3), 17-30. https://doi.org/10.7748/nr.4.3.17.s3.

Smith, P., Bond, M., & Kagitcibasi, C. (2006). *Understanding social psychology across cultures: Living and working in a changing world*. Sage.

Soriano, C. A. F., Sarmiento, W. D., Songco, F. J. G., Macindo, J. R. B., & Conde, A. R. (2016). Socio-demographics, spirituality, and quality of life among community-dwelling and institutionalized older adults: A structural equation model. *Archives of Gerontology and Geriatrics, 66*, 176-182. http://dx.doi.org/10.1016/j.archger.2016.05.011

Stefanaki, I. N., Shea, S., Linardakis, M., Symvoulakis, E. K., Wynyard, R., & Lionis, C. (2014). Exploring the association of sense of coherence, and spiritual and religious beliefs in a rural population group on the Island of Crete, Greece. *The International Journal of Psychiatry in Medicine, 47*(3), 207-230. https://doi.org/10.2190/PM.47.3.c

Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. *Image (IN), 12*(1), 20-23. https://doi.org/10.1111/j.1547-5069.1980.tb01455.x

Stern, P. N., & Porr, C. J. (2011). *Essentials of accessible grounded theory*. Routledge. http://ebookcentral.proquest.com/lib/aut/detail.action?docID=5400592

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge University Press.

Strauss, A. L., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage.

Strauss, A. L., & Corbin, J. M. (1997). *Grounded theory in practice*. Sage.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Sage.

Sullivan, G. J., & Williams, C. (2016). Older adult transitions into long-term care: A meta-synthesis. *Journal of Gerontological Nursing, 43*(3), 41-49. https://doi.org/10.3928/00989134-20161109-07

Sun, F., Park, N. S., Roff, L. L., Klemmack, D. L., Parker, M., Koenig, H.G., Sawyer, P., Allman, R.M. (2012). Predicting the trajectories of depressive symptoms among southern community-dwelling older adults: The role of religiosity. *Aging & Mental Health, 16*(2), 189-198. https://doi.org/10.1080/13607863.2011.602959

Tan, H., Wutthilert, C., & O'Connor, M. (2011). Spirituality and quality of life in older people with chronic illness in Thailand. *Progress in Palliative Care, 19*(4), 177-184. https://doi.org/10.1179/1743291X11Y.0000000013

Tariq, S., & Woodman, J. (2013). Using mixed methods in health research. *Journal of the Royal Society of Medicine Short Reports, 4*(6). https://doi.org/10.1177/2042533313479197

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches*. Sage.

Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research, 4*(2), 161-178. https://doi.org/10.1177/1468794104044430

Thapa, N., Paudel, M., Guragain, A. M., Thapa, P., Puri, R., Thapa, P., Aryal, K. K., Paudel, B. K., Thapa, R., & Stray-Pedersen, B. (2019). Status of migration and socio-reproductive impacts on migrants and their families left behind in Nepal. *Migration and Development,* 8(3), 394-417. https://doi.org/10.1080/21632324.2019.1567097

The Himalayan Times. (2017a). *Elderly underfed, neglected at Pashupati old age home*. https://thehimalayantimes.com/kathmandu/elderly-underfed-neglected-pashupati-old-age-home/

The Himalayan Times. (2017b). *Many elderly people forced to live in pitiable conditions*. https://thehimalayantimes.com/kathmandu/many-elderly-people-forced-live-pitiable-conditions/

The Himalayan Times. (2019). Majority of elders at old-age homes deprived of govt allowance. *The Himalayan Times*. Retrieved from https://thehimalayantimes.com/nepal/majority-of-elders-at-old-age-homes-deprived-of-govt-allowance/

Thomas, C. L., & Cohen, H. L. (2006). Understanding spiritual meaning making with older adults. *Journal of Theory Construction & Testing, 10*(2), 65-70.

Timilsina, R., Sherpa, P., & Dhakal, D. (2014). Factors associated with depression among elderly living in old age homes in Kathmandu valley. *Journal of Institute of Medicine, 36*(1), 90-96.

Timonen, V., Foley, G., & Conlon, C. (2018). Challenges when using grounded theory: A pragmatic introduction to doing GT tesearch. *International Journal of Qualitative Methods, 17*(1). https://doi.org/10.1177/1609406918758086

Tomás, J. M., Sancho, P., Galiana, L., & Oliver, A. (2016). A double test on the importance of spirituality, the "forgotten factor", in successful aging. *Social Indicators Research, 127*(3), 1377-1389. https://doi.org/10.1007/s11205-015-1014-6

Tongprateep, T. (2000). The essential elements of spirituality among rural Thai elders. *Journal of Advanced Nursing, 31*(1), 197-203. https://doi.org/10.1046/j.1365-2648.2000.01212.x

Tornstam, L. (2005). *Gerotranscendence: A developmental theory of positive aging*. Springer.

United Nations. (2002). *Political declaration and Madrid international plan of action on ageing*. https://www.un.org/en/events/pastevents/pdfs/Madrid_plan.pdf

United Nations. (2019). *World population ageing 2019 - Highlights*. https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Highlights.pdf

United Nations Human Rights. (1991). *United Nations principles for older persons*. https://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx

Urquhart, C. (2013). *Grounded theory for qualitative research: A practical guide*. Sage.

McCann, T. V., & Clark, E. (2003). Grounded theory in nursing research: Part 2 – Critique. *Nurse Researcher, 11* (2), 19-28. https://doi.org/10.7748/nr2004.01.11.2.19.c5919

Vahia, I. V., Depp, C. A., Palmer, B. W., Fellows, I., Golshan, S., Thompson, W., Allison, M., & Jeste, D. V. (2011). Correlates of spirituality in older women. *Aging & Mental Health, 15*(1), 97-102. https://doi.org/10.1080/13607863.2010.501069

Vahid, Z., Vahid, P., Azad, R., Lynnette, L. C., & Eesa, M. (2016). Older people's experiences involving the decision to transition to an aged care home. *International Journal of Medical Research & Health Sciences, 5*(8), 346-355. https://doi.org/10.7748/nop2011.12.23.10.23.c8838

van Nes, F., Abma, T., Jonsson, H., & Deeg, D. (2010). Language differences in qualitative research: Is meaning lost in translation? *European Journal of Ageing, 7*(4), 313-316. https://doi.org/10.1007/s10433-010-0168-y

Velasco-Gonzalez, L., & Rioux, L. (2014). The spiritual well-being of elderly people: A study of a French sample. *Journal of Religion & Health, 53*(4), 1123-1137. https://doi.org/10.1007/s10943-013-9710-5

Vitorino, L. M., Lucchetti, G., Santos, A. E. O., Lucchetti, A. L. G., Ferreira, E. B., Adami, N. P., & Vianna, L. A. C. (2016). Spiritual religious coping is associated with quality of life in institutionalized older adults. *Journal of Religion and Health, 55*(2), 549-559. https://doi.org/10.1007/s10943-015-0148-9

von Humboldt, S., & Leal, I. (2017). Correlates of adjustment to aging among the young-old and the oldest-old: A comparative analysis. *Educational Gerontology, 43*(4), 175-185. https://doi.org/10.1080/03601277.2016.1272355

Wagner, S. M., Lukassen, P., & Mahlendorf, M. (2010). Misused and missed use — Grounded theory and objective hermeneutics as methods for research in industrial marketing. *Industrial Marketing Management, 39*(1), 5-15. http://dx.doi.org/10.1016/j.indmarman.2008.05.007

Walker, C. A., Curry, L. C., & Hogstel, M. O. (2007). Relocation stress syndrome in older adults transitioning from home to a long-term care facility. Myth or reality? *Journal of Psychosocial Nursing & Mental Health Services, 45*(1), 38-47. https://doi.org/10.3928/02793695-20070101-09

Wallace, M., & O'Shea, E. (2007). Perceptions of spirituality and spiritual care among older nursing home residents at the end of life. *Holistic Nursing Practice, 21*(6), 285-289. https://doi.org/10.1097/01.HNP.0000298611.02352.46

Ward, K., Gott, M., & Hoare, K. (2018). Becoming a team: Findings from a grounded theory study about living with CPAP. *Collegian, 25*(1), 81-88. https://doi.org/10.1016/j.colegn.2017.01.002

Ward, K., Hoare, K. J., & Gott, M. (2015). Evolving from a positivist to constructionist epistemology while using grounded theory: Reflections of a novice researcher. *Journal of Research in Nursing, 20*(6), 449-462. https://doi.org/10.1177/1744987115597731

Welsh, D., Moore, S. L., & Getzlaf, B. A. (2012). Meaning in life: The perspective of long-term care residents. *Research in Gerontological Nursing, 5*(3), 185-194.http://dx.doi.org/10.3928/19404921-20120605-05

World Health Organization. (2011). *Global health and aging* (Report No. 11-7737). https://www.who.int/ageing/publications/global_health/en/

World Health Organization. (2015). *World report on ageing and health*. http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf

WHOQOL SRPB Group. (2006). A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life. *Social Science & Medicine, 62*(6), 1486-1497.http://doi.org/10.1016/j.socscimed.2005.08.001

Wilkes, L., Cioffi, J., Fleming, A., & Lemiere, J. (2011). Defining pastoral care for older people in residential care. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 37*(2), 213-221. https://doi.org/10.5172/conu.2011.37.2.213

Wilkinson, P. J., & Coleman, P. G. (2010). Strong beliefs and coping in old age: A case-based comparison of atheism and religious faith. *Ageing and society, 30*(2), 337-361.http://dx.doi.org/10.1017/S0144686X09990353

Williams, N. (2009). Education, gender, and migration in the context of social change. *Social Science Research, 38*(4), 883-896. https://doi.org/10.1016/j.ssresearch.2009.04.005

Wills, T. A. (1981). Downward comparison principles in social psychology. *Psychological Bulletin, 90*(2), 245-271. https://doi.org/10.1037/0033-2909.90.2.245

Wilson, C. B., Davies, S. , & Nolan, M. (2009). Developing personal relationships in care homes: Realising the contributions of staff, residents and family members. *Ageing and Society, 29*(7), 1041-1063. https://doi.org/10.1017/S0144686X0900840X

Wilson, S. (1997). The transition to nursing home life: A comparison of planned and unplanned admissions. *Journal of Advanced Nursing, 26*(5), 864-871. https://doi.org/10.1046/j.1365-2648.1997.00636.x

Wink, P., Dillon, M., & Prettyman, A. (2007). Religion as moderator of the sense of control-health connection: Gender differences. *Journal of Religion, Spirituality and Aging, 19*(4), 21-41. https://doi.org/10.1300/J496v19n04_03

World Bank Group. (2018). *Male outmigration and women's work and empowernment in agriculture: The case of Nepal and Senegal*. http://documents.worldbank.org/curated/en/653481530195848293/pdf/127755-REVISED-Male-Outmigration-and-Women-s-Work-and-Empowerment-in-Agriculture-The-Case-of-Nepal-and-Senegal.pdf

Xian, H. (2008). Lost in translation? Language, culture and the roles of translator in cross-cultural management research. *Qualitative Research in Organizations and Management, 3*(3), 231-245. https://doi.org/10.1108/17465640810920304

Yadav, U., & Paudel, G. (2016). Prevalence and associated factors of elder mistreatment: A cross sectional study from urban Nepal. *Age and Ageing, 45*(5), 609-613. https://doi.org/10.1093/ageing/afw112

Yadav, U. N., Tamang, M. K., Paudel, G., Kafle, B., Mehta, S., Chandra Sekaran, V., & Gruiskens, J. R. J. H. (2018). The time has come to eliminate the gaps in the under-recognized burden of elder mistreatment: A community-based, cross-sectional study from rural eastern Nepal. *PLoS ONE, 13*(6), e0198410. https://doi.org/10.1371/journal.pone.0198410

Yehya, N. A., & Dutta, M. J. (2010). Health, religion, and meaning: A culture-centered study of druze women. *Qualitative Health Research, 20*(6), 845-858. https://doi.org/10.1177/1049732310362400

Yilmaz, K. (2013). Comparison of quantitative and qualitative research traditions: Epistemological, theoretical, and methodological differences. *European Journal of Education, 48*(2), 311-325. https://doi.org/10.1111/ejed.12014

Yohannes, A. M., Koenig, H. G., Baldwin, R. C., & Connolly, M. J. (2008). Health behaviour, depression and religiosity in older patients admitted to intermediate care. *International Journal of Geriatric Psychiatry, 23*(7), 735-740.

Yoon, D. P. (2006). Factors affecting subjective well-being for rural elderly individuals: The importance of spirituality, religiousness, and social support. *Journal of Religion & Spirituality in Social Work, 25*(2), 59-75. http://dx.doi.org/10.1300/J377v25n02_04

Yoon, D. P., & Lee, E. K. O. (2007). The impact of religiousness, spirituality, and social support on psychological well-being among older adults in rural areas. *Journal of Gerontological Social Work, 48*(3/4), 281-298. https://doi.org/10.1300/J083v48n03_01

You, K. S., Lee, H. O., Fitzpatrick, J. J., Kim, S., Marui, E., Lee, J. S., & Cook, P. (2009). Spirituality, depression, living alone, and perceived health among Korean older adults in the community. *Archives of Psychiatric Nursing, 23*(4), 309-322. https://doi.org/10.1016/j.apnu.2008.07.003

Ysseldyk, R., Haslam, S. A., & Haslam, C. (2013). Abide with me: Religious group identification among older adults promotes health and well-being by maintaining multiple group memberships. *Aging & Mental Health, 17*(7), 869-879. https://doi.org/10.1080/13607863.2013.799120

Zibad, H. A., Shahboulaghi, F. M., Foroughan, M., Rafiey, H., & Rassouli, M. (2016). What is the meaning of spiritual health among older adults? A concept analysis. *Educational Gerontology, 42*(12), 795-808. https://doi.org/10.1080/03601277.2016.1205349

Zibad, H. A., Foroughan, M., Shahboulaghi, F. M., Rafiey, H., & Rassouli, M. (2017). Perception of spiritual health: A qualitative content analysis in Iranian older adults. *Educational Gerontology, 43*(1), 21-32. https://doi.org/10.1080/03601277.2016.1231521

Appendices

Appendix A: Copy of Article Published in *International Journal of Older People Nursing* (Reprinted with Permission)

Received: 17 July 2018 | Accepted: 24 January 2019
DOI: 10.1111/opn.12228

ORIGINAL ARTICLE

WILEY International Journal of Older People Nursing

What is known about the spirituality in older adults living in residential care facilities? An Integrative review

Sital Gautam | Stephen Neville | Jed Montayre

School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand

Correspondence
Jed Montayre, School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand.
Email: jed.montayre@aut.ac.nz

Abstract

Aim: To synthesize evidence regarding the spiritual needs and care of older adults living in residential care facilities from the perspectives of older adults and nurses or caregivers.

Design: Integrative review of literature.

Data sources: Literature search was conducted using CINAHL Plus with Full Text via EBSCO, Scopus, PubMed, PsychInfo, Web of Science, and ProQuest Social Science Databases from March to December 2017.

Review methods: This integrative review utilised the Whittemore and Knafl framework and PRISMA in the selection of eligible articles. Quality of the articles was evaluated using the Mixed Method Appraisal Tool.

Results: Seven articles were reviewed and analysed. There is limited evidence \and no agreed definition of spiritual needs and care of older adults living in residential care facilities. Spiritual needs of older adults in residential care facilities is a psychosocial, religious and existential construct. Spiritual care in residential care facilities is linked to information gathering, religious guidance, maintaining family connections, providing companionship, discussing end of life issues, and providing counseling. Older adults highly value the role of nurses and caregivers in fulfilling their spiritual needs and providing spiritual care. However, nurses and caregivers perceived arranging a referral to a religious advisor as the main aspect of spiritual care. Therefore, nurses', caregivers', and older adults' views on spiritual care differed to some extent.

Conclusion: The practical aspects of spiritual needs assessment and spiritual care provision requires further investigation, which is essential to improve the effectiveness of service delivery in residential care facilities.

KEYWORDS
ageing, caregivers, integrative literature review, nurses, older adults, spiritual care, spiritual needs, spirituality

1 | INTRODUCTION

Once recognised as an exclusive domain of theology and philosophy (Harrington, 2012), spirituality gained increasing recognition in the field of medicine, nursing, and psychology in the late 19th century and remained the focus of some health related literature (Ali, Marhemat, Sara, & Hamid, 2015). Spirituality is a subjective phenomenon and its dimensions can vary among individuals. It has been defined in different ways, yet, two components namely interconnectedness and search for meaning in life (Zibad, Foroughan, Shahboulaghi, Rafiey, & Rassouli, 2017) are central to most definitions of spirituality. For some, spirituality has been described in terms of connections

with higher being/s (De Guzman et al., 2009; Drageset, Haugan, & Tranvåg, 2017; Sadler, Biggs, & Glaser, 2013). However, for others, it has been described as connections with people (Krause & Bastida, 2009).

Spirituality is often used interchangeably with terms such as religion/religiosity/religiousness (Gaskamp, Sutter, & Meraviglia, 2006; Manning, 2012; Molzahn, 2007; Pickard & Nelson-Becker, 2011; Skarupski, Fitchett, Evans, & Mendes de Leon, 2010). However, there is a core difference between the terms spirituality and religion. Religion involves a shared social system of belief and rituals practised by a certain group, whereas spirituality is searching for the meaning of life, which is not necessarily based on religion. Similarly, religiosity/religiousness is used to describe individuals' devotion towards a religion (Koenig, 2012; Zimmer et al., 2016). The key point is that spirituality transcends religion and an individual can be spiritual without being religious (Dunn, 2008; Sessanna, Finnell, & Jezewski, 2007). This makes spirituality a more inclusive term. In this review, the term spirituality will be used in its broadest sense.

Spirituality is a very important aspect of aging. Older adults are more inclined towards spirituality when compared to younger age groups (Lowis, Edwards, & Burton, 2009; Stefanaki et al., 2014). Increasing age can bring profound challenges such as diminished physical functioning, loss of significant others and an associated shrinking of social networks (Yoon, 2006). Older adults seek various resources to enable them to face the challenges associated with aging. Spirituality is considered one of those resources that can assist older adults to deal with the aging process (Momtaz, Ibrahim, Hamid, & Yahaya, 2010; Sun, 2012; Vahia et al., 2011). As people age, they may focus more on maintaining emotional and other important relationships (Shaw, Gullifer, & Wood, 2016). Being connected with others provides older adults with purpose and meaning in life (Register & Scharer, 2010). While some older adults value connections with significant others, others seek connections with higher spiritual being/s. Older adults rely heavily on psychological, social, and religious support to sustain their meaning in life (Hodge & Horvath, 2011; Krause, 2008). Spirituality also provides older adults with a sense of identity, as well as belonging, being involved and affiliated with others (Washington, Moxley, Garriott, & Weinberger, 2009). It is essential that older adults are provided with opportunities to maintain connections and participate in meaningful activities in order to sustain their spirituality.

As the older adult population continues to grow, the increasing demand for long term care is becoming evident worldwide (United Nations, 2016). Long term care for older adults can include community based or residential care. In community based long term care, it is not necessary for older adults to stay permanently in institutional settings (WHO, 2015). Residential care, on the other hand, is "delivered in assisted living facilities and nursing homes, among other locations" (WHO, 2015, p. 129). Residential care has been described in different ways using different terminologies among and within countries on the basis of the level of care (rest home, hospital, dementia, psychogeriatric care) or type of facilities being provided to residents. For instance, while some institutions only provide a basic

What does this research add to existing knowledge in gerontology?

What is already known about the topic

- Spirituality is a very important aspect of aging.
- Transition to residential care facilities is one of the most stressful events for older adults.
- International guidelines recommend that nurses and caregivers working in residential care facilities should identify spiritual needs of residents and provide spiritual support as required.

What this paper adds

This review identifies that:

- Little research has been undertaken focusing specifically on spiritual needs and care of older adults residing in residential care facilities.
- Current research is constrained by the lack of integration of the concepts spiritual practices, needs and care in residential care facilities, which limits our understanding about how older adults maintain their spirituality in residential care facilities.
- Spiritual needs of older adults in residential care facilities is a psycho-social, religious and existential construct.
- Spiritual care in residential care facilities is linked to information gathering, religious guidance, maintaining family connections and companionship, discussing end of life issues and providing counseling.
- Older adults highly value the role of nurses and caregivers in fulfilling their spiritual needs and providing spiritual care. However, nurses' and older adults' views on spiritual care differ.
- Research involving perceptions of both older adults and nurses or caregivers is required to ensure the spiritual needs of older adults is met.

What are the implications of this new knowledge for nursing care with older people?

- Addressing spiritual needs of older adults is crucial in providing spiritual care to older adults in residential care facilities, which impacts on their health and wellbeing.
- The findings of this review will be beneficial for nurses and caregivers to identify areas of improvement in current practice, design effective interventions, thus, improving the effectiveness of service delivery.

How could the findings be used to influence policy or practice or research or education?

- Findings could inform policy makers to develop social and health policies focusing on an inclusive model of providing spiritual care to older adults living in residential care facilities.

level of care and medical support to residents; others can deliver a hospital level of care. In this review, residential care facilities (RCF) refers to any type of institutional setting providing long term care to residents; the level of care ranging from basic to specialized; and including but not limited to assisted living facilities, residential aged care facilities, nursing homes, care homes, specific state residences, and assisted accommodation homes.

Internationally, the transition to RCF has been reported as one of the most stressful life events for older adults (Melrose, 2004; Zamanzadeh, Rahmani, Pakpour, Chenoweth, & Mohammadi, 2017), which has the potential to negatively impact on spirituality. Moving to RCF is not just moving away from family and familiar environments; it involves leaving the psychological and social support system of friends, relatives, and society. It requires establishing new connections with fellow residents, RCF staff, finding new purpose in life, and adjusting to the new environment, which can be emotionally challenging to older adults (Welsh, Moore, & Getzlaf, 2012).

Globally, spiritual needs of older adults have captured the attention of many international organisations. For instance, in 2006, the WHO examined the effect of Spirituality Religion and Personal Beliefs (SPRB) on the Quality of Life (QOL) of 5,087 individuals from 18 different countries. This review concluded that spirituality has a significant effect on QOL and should be routinely included as a major domain of QOL (WHOQOL SRPB Group, 2006). Similarly, the Joint Commission for Accreditation of Health Organizations, which is one of the most distinguished organisations in the United States that sets standards for quality care in national health care settings, has emphasised the importance of addressing spiritual needs of individuals in all health care settings (O'Brien, 2011). Likewise, in 2016, the Australian government developed national guidelines for providing spiritual care to older adults living in RCF. This guideline has identified spirituality as an integral component of wellbeing in older adults living in RCF and nurses need to recognise and respond to spiritual needs (Meaningful Ageing Australia, 2016). New Zealand's Healthy Ageing Strategy has also prioritised that spiritual needs of older adults are met when health services are provided to this group (Ministry of Health, 2016). In spite of the publication of these guidelines and strategies, little is known about the components of spiritual needs and spiritual care in RCF from the perspective of older adults, nurses or caregivers. Therefore, this integrative review synthesises the empirical research on spiritual needs and care from the perspectives of older adults, nurses or caregivers, which is essential to improve the effectiveness of service delivery in RCF. In this review, nurses refer to the registered nursing staff, and caregivers are unregulated staff working in RCF.

2 | REVIEW AIM

The aim of the current integrative review is to synthesise new understandings of older adults and nurses or caregivers perspectives on the spiritual needs and care provided in RCF. The review is guided by the following questions:

1. How is spiritual needs and care of older adults defined in the context of RCF?
2. What are the components of spiritual needs and care in RCF from the perspectives of residents, nurses or caregivers?

3 | METHOD

An integrative review is a method that allows the inclusion of diverse methodologies to provide a broad understanding about the particular phenomenon of interest (Whittemore & Knafl, 2005). Due to limited studies on spiritual needs and care in RCF, it is best to use this review method to develop a comprehensive understanding by combining available empirical research findings. This review follows five stages namely problem identification, literature search, data evaluation, data analysis and presentation of findings along with implications for practice as suggested by Whittemore and Knafl (2005).

3.1 | Search strategy

A search of the literature commenced in March 2017. Initially, a general search around different aspects of the topic was undertaken and later a more focused search was conducted. The general review helped to identify key search terms to be used. Electronic databases such as CINAHL Plus, Scopus, Pubmed, PsycINFO, Web of Science, and ProQuest Social Science Database were accessed. In addition, some articles were accessed from the reference lists of retrieved reports. The search terms used were spiritual* (spirituality, spiritual wellbeing, spiritual health, spiritual needs, spiritual wellness, spiritual coping, spiritual care, spiritual experiences, spiritual practices), relig* (religiosity, religion, religiousness, religious needs, religious coping, religious practices, religious experiences), pastoral* (pastoral care, pastoral counselling), old* (older adults, older, older people, old people, old age), senior, geriatric, aged, aging, advanced age, elderly, elder, elderly people, residential* (residential care, residential homes, residential aged care, residential care facilities), care home, nursing home, long term care, aged care, and assisted living or accommodations. Truncations were used to include all the possible ways of words being used in the literature.

3.2 | Inclusion criteria

- Primary research focusing on the concept of spiritual needs and spiritual care in RCF
- Full-text articles published in English and peer-reviewed journals
- Studies that included older adults aged 60 years and over
- Date of publication: 2006 to 2017

3.3 | Exclusion criteria

- Studies that focus specifically on spirituality of older adults living with chronic illness such as HIV/AIDS, cancer and dementia; older

adults facing disaster, mental health problems, disabilities and older immigrants. These studies were excluded because the main focus was on a particular disease state rather than solely on spirituality.

The inclusion date was set at 2006 when WHO QOL SRPB (Spiritual, Religion and Personal Belief) scale was developed to address the importance of assessing spirituality as an important component of QOL. The publication of this document is considered an important milestone and catalyst for studies on spirituality as a component of overall wellbeing.

3.4 | PRISMA screening and quality appraisal

This integrative review utilised the (Figure 1) Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) in the selection of eligible articles (Moher, Liberati, Tetzlaff, & Altman, 2009). Mixed method Appraisal tool developed by Hong et al. (2018) was used with permission to examine the quality of selected articles (Table 1). Quality appraisal of the selected articles was carried out independently by all three reviewers and consensus reached. Eligible articles having lower quality were still included in the review; however, they contributed less to the analysis and conclusion process.

3.5 | Data abstraction and synthesis

All 7 articles were repeatedly read and data synthesis was undertaken following the integrative review methodology by Whittemore and Knafl (2005). Details of methods, key outcomes and findings related to spiritual needs and care were extracted from primary sources and tabulated in Microsoft Excel to allow for identification of common concepts. Data were grouped according to the research design, sample characteristics, study setting and then coded. A concept map was created after assembling relevant data. After data comparison, similar concepts were regrouped and refined.

4 | RESULTS

4.1 | Study characteristics

The systematic search from electronic online databases using various combinations of keywords and phrases retrieved a total of 259 articles. Only 7 studies were eligible for the review after screening articles using the PRISMA framework. All studies undertaken in older adults (60 years and over) using quantitative, qualitative and mixed methodologies were included in the review. When the inclusion criteria of older adults in the selected articles was closely scrutinized, two articles had mixed older adults living in community and RCF (Rykkje, Eriksson, & Raholm, 2013; Wilkes, Cioffi, Fleming, & Lemiere, 2011). The remaining 5 articles exclusively focused on RCF (Baldacchino, Boneilo, & Debattista, 2014; Blank, Wood, & Egan, 2017; Erichsen & Bussing, 2013; Man-Ging, Oven Uslucan, Fegg, Frick, & Bussing, 2015; Wallace & O'Shea, 2007). Responding to the dearth of information regarding the spiritual needs and care in the context of RCF, the team decided to include those two articles in the review since they included RCF component of long term care. However, caution has been observed in the interpretation of findings from those two studies.

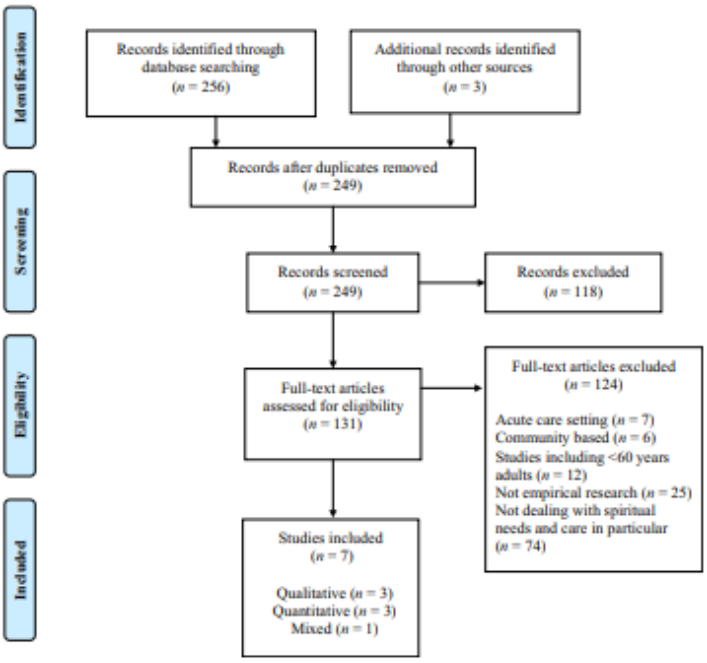


FIGURE 1 Preferred reporting items for systematic reviews and meta-analyses (PRISMA) flowchart

TABLE 1 Quality evaluation of selected articles using MMAT (Hong et al., 2018)

Qualitative Articles	Are there clear research questions?	Do the collected data allow to address the research questions?	Is the qualitative approach appropriate to answer the research question?	Are the qualitative data collection methods adequate to address the research question?	Are the findings adequately derived from the data?	Is the interpretation of results sufficiently substantiated by data?	Is there coherence between qualitative data sources, collection, analysis and interpretation?	Is there clear mention of ethical approval process in the article?
Wilkes et al. (2011)	✓	✓	✓	✓	✓	✓	✓	✓
Rykkje et al. (2013)	✓	✓	✓	✓	✓	✓	✓	✓
Blank et al. (2017)	✓	✓	✓	✓	✓	✓	✓	✓
Quantitative Articles	**Are there clear research questions?**	**Do the collected data allow to address the research questions?**	**Is the sampling strategy relevant to address the research question?**	**Is the sample representative of the target population?**	**Are the measurements appropriate?**	**Is the risk of nonresponse bias low?**	**Is the statistical analysis appropriate to answer the research question?**	**Is there clear mention of ethical approval process in the article?**
Man-Ging et al. (2015)	✓	✓	✓	✓	✓	× not mentioned	✓	× not mentioned
Wallace and O'Shea (2007)	✓	✓	✓	×	✓	× not mentioned	✓	✓
Erichsen and Bassing (2013)	✓	✓	✓	✓	✓	✓	✓	✓
Mixed Method	**Are there clear research questions?**	**Do the collected data allow to address the research questions?**	**Is there an adequate rationale for using a mixed methods design to address the research question?**	**Are the different components of the study effectively integrated to answer the research question?**	**Are the outputs of the integration of qualitative and quantitative components adequately interpreted?**	**Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?**	**Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?**	**Is there clear mention of ethical approval process in the article?**
Part1 Baldacchino, Bonello, et al. (2014) Part2 Baldacchino, Bonello, et al. (2014)	✓	✓	✓	✓	✓	✓	✓	✓

Adapted from MMAT (Hong et al., 2018)

TABLE 2 List of reviewed articles

Author (Year), Country	Aim	Study Design	Setting and sample	Focus and key outcomes	Findings related to spiritual needs/care of older adults
Wilkes et al. (2011), Australia	To explore the meaning of pastoral care from the perspective of older adults, their family members and pastoral care workers.	**Qualitative** Descriptive approach using semi-structured in-depth interviews	2 residential aged care facilities Purposive sampling 18 pastoral care workers (M = 5, F = 13), 9 older adults aged 60 years and over, and 2 family members	Older adults in residential care and community with no cognitive impairment, and receiving pastoral care for at least 6 months were included. Pastoral care workers who had worked in residential aged care facilities for at least 2 years were included. Pastoral care deals with spiritual aspects of life.	Four themes of pastoral care emerged: A trusting relationship, spiritual support, emotional support and practical support.
Rykkje et al. (2013), Norway	To explore older adults' views about spirituality and spiritual care.	**Qualitative** Gadamerian hermeneutical approach using semi-structured interviews	Community and nursing home Purposive sampling 17 older adults (M = 6, F = 11) aged 70 years and over	Exclusion criteria not reported. Included older adults from mixed settings. Spirituality was viewed as connectedness with higher power.	Spiritual care: Being treated as a whole person, having a chance to be out in the nature, take part in meaningful activities (including religious activities), provide and receive love. Older adults perceived that spiritual care include religious support which is important during crisis and end of life. Older adults expect nurses to provide spiritual care to certain extent.
Blank et al. (2017), New Zealand	To explore staff perceptions of spiritual care in residential aged care	**Qualitative** Descriptive approach using semi-structured interviews	4 residential aged-care facilities Purposive sampling 19 staff (8 caregivers, 4 nurse managers, 3 registered nurses, 2 chaplains, 1 house manager, 1activities coordinator)	Deals exclusively with residential aged care facilities. Caregivers had some form of qualification required for aged care support. Work experience of staff ranged from four years to more than 30 years. Four categories of spirituality: Beliefs, values, and preferences; search for meaning or inner well-being; connection with an external force; and religion The perceptions of older adults on spiritual needs and care are not included.	Spiritual care components: Information gathering (formal and informal); facilitation (accessing religious rituals and advisors; maintaining contact with family); companionship, end-of-life care (physical and emotional support); and personal counseling. Barriers in providing spiritual care: Lack of awareness about spirituality, sensitive nature of spirituality, health challenges, lack of staff and time Suggestions to improve spiritual care: Increase number of staff, provide training on spiritual care assessment and regular supervision.
Man-Ging et al. (2015), Germany	To explore spiritual needs of older adults living in residential/ nursing homes.	**Quantitative** Cross-sectional descriptive survey using Spiritual needs Questionnaire (SpNQ)	9 residential/nursing homes and assisted living homes Purposive sampling 100 older adults (M = 24, F = 76) aged 65 years and over	Excluded those with acute physical illness, psychiatric disease and significant dementia. Length of stay is not reported. In the absence of family support, religious activities become a major source of comfort for older adults.	Religious needs were the highest followed by inner peace and giving needs. Most important spiritual needs were chance to pray, reflect on their past, participate in a religious activities, and be dose with nature.

(Continues)

TABLE 2 (Continued)

Author (Year), Country	Aim	Study Design	Setting and sample	Focus and key outcomes	Findings related to spiritual needs/care of older adults
Wallace and O'Shea (2007), United States	To explore nursing home residents' perceptions of spirituality and spiritual care	**Quantitative** Descriptive cross-sectional survey using Spirituality and spiritual care rating scale	Two long term care facilities Purposive sampling 26 older adults (M = 7, F = 19) aged 65 years and over	Included older adults with chronic illness. Residents valued the role of nurses in promoting their spiritual health.	Spiritual care involves organizing visits with religious personnel, treating with respect, kindness, listening to their concerns, allowing time with nature, music and supporting their need for forgiveness.
Erichsen and Bussing (2013), Germany	To explore spiritual needs of older adults living in residential/ nursing homes.	**Quantitative** Cross-sectional descriptive survey using Spiritual Needs Questionnaire (SpNQ)	12 residential/nursing homes and assisted accommodation homes Purposive sampling 100 older adults (M = 18, F = 82) aged 65 years and over	Explored the concept of spiritual needs from the perspective of those older adults who are not necessarily suffering from illness. Excluded those with acute physical illness, psychiatric disease and significant dementia. Length of stay is not reported. More than half of the sample (55%) was independent. 35% described themselves as religious, 56% as not religious and rest undecided.	Need for generativity and inner peace was higher than religious and existential needs. Residents valued the chance to be out in nature, having connections with family and friends, reflecting on their past, being safe and giving back to others. However, fellow residents were unfriendly with each other, and they expressed a lack of social support. They preferred private prayers over group prayers.
Part1 Baldacchino, Bonello, et al. (2014) Part2 Baldacchino, Bonello, et al. (2014), Malta and Australia	To investigate the use of spiritual coping strategies by institutionalized older adults.	**Mixed** Descriptive sequential explanatory design Quantitative: Spiritual Coping Strategies (SCS)scale Qualitative: Face to face interviews and focus groups	Four private homes and two state residences Purposive sampling 137 older adults (M = 34, F = 103) aged 65 years and over Face to face interviews: 42 Focus group: 23	Residents who have lived in the institution for at least 6 months, fully mobile or mobile with aid and those with communication ability were included. Included older adults from mixed settings. The total spiritual coping was higher in women, and residents living in private homes. Themes of spiritual coping strategies: Self-empowerment through a sense of connectedness with self, others, nature and God, acceptance of, and belongingness to, the institution, finding of meaning and purpose in life or a perceived afterlife.	Interconnectedness with family members, staff, fellow residents, and nature was an important aspect for older adults living in that institution. Fulfilment of residents' spiritual needs is very important to increase their acceptance of the institutional life, develop belongingness to the institution and to help them find meaning in life.

The reviewed articles used a wide variety of quantitative, qualitative and mixed methodological approaches. Three studies used qualitative approaches including Gadamerian Hermeneutics and narrative inquiry (Blank et al., 2017; Rykkje et al., 2013; Wilkes et al., 2011). Three studies used quantitative approaches (Erichsen & Bussing, 2013; Man-Ging et al., 2015; Wallace & O'Shea, 2007), and measured spiritual needs and care of older adults using the Spiritual Needs Questionnaire (SpNQ) and Spirituality and Spiritual Care Rating scale (SSCRS). Only one study used a mixed-method design to investigate the use of spiritual coping strategies by institutionalised older adults through questionnaire, individual and focus group interviews (Baldacchino, Bonello, & Debattista, 2014). The majority reported cross-sectional data. The number of participants ranged from 17 (Rykkje et al., 2013) to 137 (Baldacchino, Bonello, et al., 2014). The studies were conducted in the following regions: United States (n = 1), Australia (n = 2), Germany (n = 2), Norway (n = 1), and New Zealand (n = 1).

Five studies included the perspectives of older adults (Baldacchino, Boneilo, et al., 2014; Erichsen & Bussing, 2013; Man-Ging et al., 2015; Rykkje et al., 2013; Wallace & O'Shea, 2007); one interviewed caregivers and nurses (Blank et al., 2017); and one integrated the viewpoints of both older adults and caregivers (Wilkes et al., 2011). Female participants outnumbered male in all studies. Most of the studies included older adults who were at least 65 years, and the mean age of the majority was mid-eighties. The characteristics of older adults varied in different studies. Two studies excluded older adults who had significant health problems, dementia, and acute psychiatric illness (Erichsen & Bussing, 2013; Man-Ging et al., 2015), whereas Wallace and O'Shea (2007) included frail older adults. While Baldacchino, Boneilo, et al. (2014) included older adults based on their mobility, Rykkje et al. (2013) didn't mention the exclusion criteria of older adults, making it difficult to synthesize findings. Some studies didn't mention the length of stay in RCF (Erichsen & Bussing, 2013; Man-Ging et al., 2015; Rykkje et al., 2013), yet, the average length of stay ranged from 6 months to 3 years in the remaining studies. A comprehensive summary of the selected studies is presented in Table 2. Based on the aims of this review, the concept of spiritual needs, spiritual care, and components of spiritual needs and care were analysed in detail.

4.2 | Conceptualisation of spiritual needs and spiritual care

Spiritual need is a highly subjective construct and confining spiritual need to a single definition is complex. The concept of spiritual needs has been expressed using different dimensions in different articles. However, there is consensus that spiritual needs of older adults encompass their psychological, social, religious and existential requirements (Erichsen & Bussing, 2013; Man-Ging et al., 2015). The clearest conceptualisation of spiritual needs is found in the work of Erichsen and Bussing (2013). According to these authors, spiritual needs have four interconnected dimensions; namely connection, peace, meaning/purpose, and transcendence. The articles measuring spiritual needs quantitatively have presented spiritual needs under the categories of religious needs, existential needs, inner peace needs and giving needs (Erichsen & Bussing, 2013; Man-Ging et al., 2015). Therefore, spiritual needs, in general, can best be described as a combination of religious, psycho-social and existential constructs.

Spiritual care, on the other hand, has been described as compassionate, respectful, and incorporating a holistic approach (Blank et al., 2017; Rykkje et al., 2013). Establishing trusting relationships and providing spiritual, emotional, and practical support have been identified as major attributes of spiritual care (Wilkes et al., 2011). In general, spiritual care of older adults means taking into account the importance of their spiritual needs as identified by them. As a result of this review it is clear that the concept of spiritual needs and care specifically in the context of RCF needs further exploration.

4.3 | Components of spiritual needs: Perspectives of older adults vs. nurses or caregivers

Older adults living with their family/friends and who participate in society might have easy access to resources to fulfil their psychosocial and religious needs but maintaining spirituality can be challenging for those who live in RCF (Rykkje et al., 2013). In the absence of family support and the ability to participate in religious activities becomes a major source of spiritual comfort for older adults (Man-Ging et al., 2015). Substantial research has been published on spiritual needs of hospitalised older adults (Hodge, Salas-Wright, & Wolosin, 2016; Hodge, Wolosin, & Bonifas, 2013; Monod, Rochat, Bula, & Spencer, 2010). However, there is limited knowledge on spiritual needs of those residing in RCFs (Wilkes et al., 2011). Older adults living in RCF value the chance to be out in nature, maintaining strong connections with family and friends, reflecting on their past, being safe and giving back to others (Erichsen & Bussing, 2013). Similarly, the need for prayer, inner reflection, participation in religious activities and seeking connections with higher beings ranked highest among the spiritual needs of older adults living in RCF (Man-Ging et al., 2015). One component common to both studies was the need for connection either with self, family, friends, higher being or nature. Fulfilment of residents' spiritual needs is very important to assist acceptance to living in an institutional environment, developing belongingness to the institution and to help older adults find meaning in life (Baldacchino, Boneilo, et al., 2014).

4.4 | Components of spiritual care: Perspectives of older adults vs. nurses or caregivers

Nurses and caregivers can make a significant difference to the life of older adults by providing spiritual care in a variety of ways. Addressing spiritual needs, however, does not only imply joining in prayer with older adults or reading religious books with them. Responding to spiritual needs requires being sensitive, open to all perspectives of the older adults' life and being there for them. Blank et al. (2017) explored the concept of spiritual care from the perspectives of nurses, caregivers, chaplains, managers, and coordinators

of RCF. They linked spiritual care to information gathering, religious guidance, maintaining family connections, providing companionship, discussing end of life issues, and providing counseling. In addition, the study identified that each of these functions requires different skills, knowledge, and levels of commitment from each staff member. It is important to note that referring residents to religious advisor was considered as the main component of spiritual care provided by nurses and caregivers. On the other hand, older adults consider spiritual care as being treated in a holistic and dignified way. For example, Rykkje et al. (2013) recruited older adults from both nursing home and the community to explore their views about spiritual care. Opportunities to take part in meaningful events such as religious ceremonies, visiting religious places, reading religious books, having social interactions, being treated as a whole person, experiencing nature, love and belongingness were integral to the provision of appropriate spiritual care. Similarly, older adults perceived spiritual care as the establishment of a trusting relationship with nurses, caregivers and fellow residents. Additionally, the emotional support provided during challenging life events such as loss of family members and fulfillment of physical and practical needs were also considered important aspects associated with the provision of spiritual care (Wilkes et al., 2011).In summary, older adults highly value the role of nurses and caregivers in fulfilling their spiritual needs and providing spiritual care. However, nurses and caregivers perceived arranging a referral to a religious advisor as the main aspect of spiritual care. Therefore, nurses', caregivers, and older adults' views on spiritual care differed to some extent. Integrating the perspectives of both nurses or caregivers' and older adults' in practice is therefore very important.

4.5 | Barriers and enablers to spiritual care

Only one of the reviewed articles identified barriers and enablers to spiritual care. Lack of awareness, the sensitive nature of addressing spirituality, fear of going beyond the personal and professional boundaries, prevalence of dementia, lack of a trusting relationship between staff and residents, workloads, task-oriented model of care, lack of staff, time, and referral mechanisms have also been reported as barriers to spiritual care in RCF. Conversely, providing regular staff education sessions on the importance of addressing spiritual needs, what spirituality is and how to undertake a spiritual assessment, as well as ongoing supervision and support to staff has been identified as enablers to the successful provision of spiritual care in RCF (Blank et al., 2017).

5 | DISCUSSION

Analysis of the 7 papers in this review identified limited empirical evidence related to the spiritual needs of older adults living in RCFs, and how nurses or caregivers perceive and respond to those spiritual needs. Little is known about how older adults maintain spirituality in RCF. Two reviewed studies mixed the perceptions of community dwelling older adults and residents (Rykkje et al., 2013; Wilkes et al., 2011). Spiritual needs are important whether they live in their own community or in RCFs. However, spiritual needs of older adults living in RCF can differ from those who are living in their own community. Community-dwelling older adults express their spiritual needs as the importance of having connections with friends, family, and other people; having something to aim for; and a chance to be involved in religious activities (Register & Scharer, 2010). The context, sources of connection, and access to resources, however, can vary in RCF. Therefore, an exclusive focus on the residents living in RCF is vital. Similarly, the findings from the studies included in this review represent a diverse sample of older adults living in RCFs. For instance, Wallace and O'Shea (2007) included frail older adults in their study whereas other studies excluded older adults with acute physical or psychiatric conditions (Baldacchino, Boneilo, et al., 2014; Erichsen & Bussing, 2013; Man-Ging et al., 2015; Wilkes et al., 2011). Consequently, residents who are not acutely ill may have different spiritual needs and care demands when compared to those who are frail (Erichsen & Bussing, 2013).

The reviewed studies only investigated either the concept of spiritual needs or spiritual care. Therefore, investigating how spiritual practices, needs and care of older adults is provided is needed so as to gain a comprehensive understanding of how older adults maintain their spirituality in RCF. Likewise, with the exception of one study (Wilkes et al., 2011), the other studies included the views of either older adults or nurses or caregivers (Baldacchino, Boneilo, et al., 2014; Blank et al., 2017; Erichsen & Bussing, 2013; Man-Ging et al., 2015; Rykkje et al., 2013; Wallace & O'Shea, 2007). It is therefore essential to synthesise both older adults' and nurses' or caregivers' views to determine the spiritual care provided in RCF. Even though the provision of spiritual care to patients is acknowledged by many as an important component of nursing care in general (Akgün Şahin & Kardaş Özdemir, 2016; Cockell & McSherry, 2012; McSherry & Jamieson, 2011; Melhem et al., 2016; Mónica, Lucy Muñoz de, Claudia, & Sandra, 2016), there is limited evidence specific to spiritual care of older adults, particularly those living in RCF. Furthermore, practical aspects of spiritual needs assessment and spiritual care provision remain underexplored. For example, only one article in the review have identified the barriers and enablers to spiritual care (Blank et al., 2017). Although, Jackson, Doyle, Capon, and Pringle (2016) have suggested taking an organisational approach to spiritual care in RCF, further investigation into the significance of this approach as it relates to the delivery of care is warranted. In addition, the articles measuring spiritual needs quantitatively were based on predetermined responses (Erichsen & Bussing, 2013; Man-Ging et al., 2015; Wallace & O'Shea, 2007).

Spirituality is a complex construct (Yoon & Lee, 2007), therefore, quantitative measurements might not fully reflect older adults' conceptualisation of what constitutes spiritual needs and care (Molzahn, 2007). These studies would have been more relevant if they had incorporated older adults' viewpoints on spiritual needs using qualitative methods (Dorji, Dunne, Seib, & Deb, 2017; Harris, Allen, Dunn, & Parmelee, 2013; Tan, Wutthilert, & O'Connor, 2011). Moreover, most of the qualitative studies used only individual or focus group

interviews to explore spiritual needs or care, which limits our understanding about actions, interactions and interpretations involved in the process of maintaining spirituality. Therefore, research that incorporates observation along with interviews would be useful.

6 | LIMITATIONS

This integrative review did not include grey or theoretical literature since the aim was to collect empirical findings on the topic. The initial search was comprehensive so as to gain a broad understanding of the topic; however, the search was then narrowed through applying inclusion and exclusion criteria. A limited number of studies were conducted exclusively in RCF. Consequently, the inclusion of samples from community setting in two reviewed articles made it difficult to synthesise some of the results. The quality of some of the articles such as lack of explanation about inclusion and exclusion criteria of older adults and small sample sizes particularly in the quantitative studies were also limitations (Rykkje et al., 2013; Wallace & O'Shea, 2007).

7 | CONCLUSION

This is the first integrative review of spirituality in older adults living in RCF. This review has identified the spiritual needs and care in RCF from older adults' and nurses' or caregivers' perspective. Maintaining spirituality in residents should be the prime focus of nurses and caregivers working in RCF since it has been directly linked to the overall wellbeing of older adults (Koenig, 2012; Zimmer et al., 2016). However, current research is constrained by the lack of integration of the concepts: spiritual practices, needs and care in RCF, which limits our understanding of how older adults maintain their spirituality in RCF. Addressing the topic through the perspective of either service provider or service recipient may overlook some practical aspects of maintaining spirituality in RCF. As a result, research involving opinions of both older adults and nurses or caregivers is required to ensure the effective delivery of spiritual care to older adults living in RCF.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ORCID

Stephen Neville https://orcid.org/0000-0002-1699-6143
Jed Montayre https://orcid.org/0000-0002-2435-8061

REFERENCES

Akgün Şahin, Z., & Kardaş Özdemir, F. (2016). Spirituality and spiritual care: A descriptive survey of nursing practices in Turkey. *Contemporary Nurse*, *52*(4), 454–461. https://doi.org/10.1080/10376178.2016.1221324

Ali, J., Marhemat, F., Sara, J., & Hamid, H. (2015). The relationship between spiritual well-being and quality of life among elderly people. *Holistic Nursing Practice*, *29*(3), 128–135. https://doi.org/10.1097/HNP.0000000000000081

Baldacchino, D., Bonello, L., & Debattista, C. (2014). Spiritual coping of older persons in Malta and Australia (part 2). *British Journal of Nursing*, *23*(15), 843–846. https://doi.org/10.12968/bjon.2014.23.15.843

Baldacchino, D., Bonello, L., & Debattista, C. (2014). Spiritual coping of older people in Malta and Australia (part 1). *British Journal of Nursing*, *23*(14), 792–799. https://doi.org/10.12968/bjon.2014.23.14.792

Blank, M., Wood, S., & Egan, R. (2017). Layers of engagement: Staff perceptions of spiritual care in residential aged care. *Journal of Religion, Spirituality & Aging*, 1–21. https://doi.org/10.1080/15528030.2017.1301844

Cockell, N., & McSherry, W. (2012). Spiritual care in nursing: An overview of published international research. *Journal of Nursing Management*, *20*(8), 958–969. https://doi.org/10.1111/j.1365-2834.2012.01450.x

De Guzman, A. B., Dalay, N. J. Z., De Guzman, A. J. M., De Jesus, L. L. E., De Mesa, J. B. C., & Flores, J. D. D. (2009). Spirituality in nursing: Filipino elderly's concept of, distance from, and involvement with God. *Educational Gerontology*, *35*(10), 929–944. https://doi.org/10.1080/03601270902717962

Dorji, N., Dunne, M. P., Seib, C., & Deb, S. (2017). Quality of life among senior citizens in Bhutan. *Asia Pacific Journal of Public Health*, *29*(1), 35–46. https://doi.org/10.1177/1010539516685609

Drageset, J., Haugan, G., & Tranvåg, O. (2017). Crucial aspects promoting meaning and purpose in life: Perceptions of nursing home residents. *BMC Geriatrics*, *17*, 254. https://doi.org/10.1186/s12877-017-0650-x

Dunn, K. S. (2008). Development and psychometric testing of a new geriatric spiritual well-being scale. *International Journal of Older People Nursing*, *3*(3), 161–169. https://doi.org/10.1111/j.1748-3743.2007.00107.x

Erichsen, N.-B., & Bussing, A. (2013). Spiritual needs of elderly living in Residential/Nursing homes. *Evidence-Based Complementary and Alternative Medicine*, *2013*, 1–10. https://doi.org/10.1155/2013/913247

Gaskamp, C., Sutter, R., & Meraviglia, M. (2006). Evidence-based guideline: Promoting spirituality in the older adult. *Journal of Gerontological Nursing*, *32*(11), 8–13.

Harrington, A. (2012). A beginning understanding of caregivers' spiritual needs when relinquishing a loved one to a palliative care setting. *Journal of Religion, Spirituality & Aging*, *24*(1–2), 131–145. https://doi.org/10.1080/15528030.2012.633055

Harris, G. M., Allen, R. S., Dunn, L., & Parmelee, P. (2013). "Trouble won't last always": Religious coping and meaning in the stress process. *Qualitative Health Research*, *23*(6), 773–781. https://doi.org/10.1177/1049732313482590

Hodge, D. R., & Horvath, V. (2011). Spiritual needs in health care settings: A qualitative meta-synthesis of clients' perspectives. *Social Work*, *56*(4), 306–316.

Hodge, D. R., Salas-Wright, C. P., & Wolosin, R. J. (2016). Addressing spiritual needs and overall satisfaction with service provision among older hospitalized inpatients. *Journal of Applied Gerontology*, *35*(4), 374–400. https://doi.org/doi:10.1177/0733464813515090

Hodge, D. R., Wolosin, R. J., & Bonifas, R. P. (2013). Addressing older Latinos' spiritual needs in hospital settings: Identifying predictors of satisfaction. *Advances in Social Work*, *14*(1), 65–81.

Hong, Q., Pluye, P., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., … Vedel, I. (2018). Mixed Methods Appraisal Tool (MMAT), version 2018 (1148552). Canada. Retrieved from http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

Jackson, D., Doyle, C., Capon, H., & Pringle, E. (2016). Spirituality, spiritual need, and spiritual care in aged care: What the literature says. *Journal of Religion, Spirituality & Aging*, *28*(4), 281–295. https://doi.org/10.1080/15528030.2016.1193097

Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *International Scholarly Research Notices Psychiatry*, 2012, 1–33. https://doi.org/10.5402/2012/278730

Krause, N. (2008). The social foundation of religious meaning in life. *Research on Aging*, *30*(4), 395–427. https://doi.org/10.1177/0164027508316619

Krause, N., & Bastida, E. (2009). Core religious beliefs and providing support to others in late life. *Mental Health, Religion & Culture*, *12*(1), 75–96. https://doi.org/10.1080/13674670802249753

Lowis, M., Edwards, A., & Burton, M. (2009). Coping with retirement: Well-being, health, and religion. *Journal of Psychology: Interdisciplinary and Applied*, *143*(4), 427–448. https://doi.org/10.3200/JRLP.143.4.427-448

Man-Ging, C. I., Oven Uslucan, J., Fegg, M., Frick, E., & Bussing, A. (2015). Reporting spiritual needs of older adults living in Bavarian residential and nursing homes. *Mental Health, Religion & Culture*, *18*(10), 809–821. https://doi.org/10.1080/13674676.2015.1100159

Manning, L. K. (2012). Spirituality as a lived experience: Exploring the essence of spirituality for women in late life. *International Journal of Aging & Human Development*, *75*(2), 95–113. https://doi.org/10.2190/AG.75.2.a

McSherry, W., & Jamieson, S. (2011). An online survey of nurses' perceptions of spirituality and spiritual care. *Journal of Clinical Nursing*, *20*(11–12), 1757–1767. https://doi.org/10.1111/j.1365-2702.2010.03547.x

Meaningful Ageing Australia. (2016). National guidelines for spiritual care in aged care. Retrieved from https://meaningfulageing.org.au/wp-content/uploads/2016/08/National-Guidelines-for-Spiritual-Care-in-Aged-Care-DIGITAL.pdf

Melhem, G. A. B., Zeilani, R. S., Zaqqout, O. A., Aljwad, A. I., Shawagfeh, M. Q., & Al-Rahim, M. A. (2016). Nurses' perceptions of spirituality and spiritual care giving: A comparison study among all health care sectors in Jordan. *Indian Journal of Palliative Care*, *22*(1), 42–49. https://doi.org/10.4103/0973-1075.173949

Melrose, S. (2004). Reducing relocation stress syndrome in long-term care facilities. *The Journal of Practical Nursing*, *54*(4), 15–17.

Ministry of Health. (2016). *Health of older people strategy: Consultation draft*. Wellington, New Zealand: Ministry of Health.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Molzahn, A. E. (2007). Spirituality in later life: Effect on quality of life. *Journal of Gerontological Nursing*, *33*(1), 32–39.

Momtaz, Y. A., Ibrahim, R., Hamid, T. A., & Yahaya, N. (2010). Mediating effects of social and personal religiosity on the psychological well being of widowed elderly people. *Omega: Journal of Death & Dying*, *61*(2), 145–162. https://doi.org/10.2190/om.61.2.d

Mónica, V.-G., Lucy Muñoz de, R., Claudia, G.-A., & Sandra, M.-R. (2016). The importance of spiritual care in nursing practice. *Journal of Holistic Nursing*, *35*(2), 118–131. https://doi.org/10.1177/0898010115626777

Monod, S., Rochat, E., Bula, C., & Spencer, B. (2010). The spiritual needs model: Spirituality assessment in the geriatric hospital setting. *Journal of Religion, Spirituality & Aging*, *22*, 271–282. https://doi.org/10.1080/15528030.2010.509987

O'Brien, M. E. (2011). *Spirituality in nursing: Standing on holy ground* (4th ed.). Sudbury, MA: Jones and Bartlett Learning.

Pickard, J. G., & Nelson-Becker, H. (2011). Attachment and spiritual coping: Theory and practice with older adults. *Journal of Spirituality in Mental Health*, *13*(2), 138–155. https://doi.org/10.1080/19349637.2011.565239

Register, M. E., & Scharer, K. M. (2010). Connectedness in community-dwelling older adults. *Western Journal of Nursing Research*, *32*(4), 462–479. https://doi.org/10.1177/0193945909355997

Rykkje, L., Eriksson, K., & Raholm, M.-B. (2013). Spirituality and caring in old age and the significance of religion - A hermeneutical study from Norway. *Scandinavian Journal of Caring Sciences*, *27*(2), 275–284. https://doi.org/10.1111/j.1471-6712.2012.01028.x

Sadler, E., Biggs, S., & Glaser, K. (2013). Spiritual perspectives of Black Caribbean and White British older adults: Development of a spiritual typology in later life. *Ageing and Society*, *33*(3), 511–538. https://doi.org/10.1017/S0144686X12000074

Sessanna, L., Finnell, D., & Jezewski, M. A. (2007). Spirituality in nursing and health-related literature. *Journal of Holistic Nursing*, *25*(4), 252–262. https://doi.org/10.1177/0898010107303890

Shaw, R., Gullifer, J., & Wood, K. (2016). Religion and spirituality: A qualitative study of older adults. *Ageing International*, *41*(3), 311–330. https://doi.org/10.1007/s12126-016-9245-7

Skarupski, K. A., Fitchett, G., Evans, D. A., & Mendes de Leon, C. F. (2010). Daily spiritual experiences in a biracial, community-based population of older adults. *Aging & Mental Health*, *14*(7), 779–789. https://doi.org/10.1080/13607861003713265

Stefanaki, I. N., Shea, S., Linardakis, M., Symvoulakis, E. K., Wynyard, R., & Lionis, C. (2014). Exploring the association of sense of coherence, and spiritual and religious beliefs in a rural population group on the Island of Crete, Greece. *The International Journal of Psychiatry in Medicine*, *47*(3), 207–230. https://doi.org/doi:10.2190/PM.47.3.c

Sun, F. (2012). Predicting the trajectories of depressive symptoms among southern community-dwelling older adults: The role of religiosity. *Aging & Mental Health*, *16*(2), 189–198. https://doi.org/10.1080/13607863.2011.602959

Tan, H., Wutthilert, C., & O'Connor, M. (2011). Spirituality and quality of life in older people with chronic illness in Thailand. *Progress in Palliative Care*, *19*(4), 177–184. https://doi.org/10.1179/1743291X11Y.0000000013

United Nations. (2016). Briefing Paper: Growing Need for Long-Term Care: Assumptions and Realities. Retrieved from https://www.un.org/esa/socdev/ageing/documents/un-ageing_briefing-paper_Long-term-care.pdf

Vahia, I. V., Depp, C. A., Palmer, B. W., Fellows, I., Golshan, S., Thompson, W., & Jeste, D. V. (2011). Correlates of spirituality in older women. *Aging & Mental Health*, *15*(1), 97–102. https://doi.org/10.1080/13607863.2010.501069

Wallace, M., & O'Shea, E. (2007). Perceptions of spirituality and spiritual care among older nursing home residents at the end of life [Article]. *Holistic Nursing Practice*, *21*(6), 285–289. https://doi.org/10.1097/01.HNP.0000298611.02352.46

Washington, O. G. M., Moxley, D. P., Garriott, L., & Weinberger, J. P. (2009). Five dimensions of faith and spirituality of older african american women transitioning out of homelessness. *Journal of Religion and Health*, *48*(4), 431–444. https://doi.org/10.1007/s10943-008-9198-6

Welsh, D., Moore, S. L., & Getzlaf, B. A. (2012). Meaning in Life: The perspective of long-term care residents. *Research in Gerontological Nursing*, *5*(3), 185–194. https://doi.org/10.3928/19404921-20120605-05

Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing*, *52*(5), 546–553. https://doi.org/10.1111/j.1365-2648.2005.03621.x

WHO. (2015). World report on ageing and health. Retrieved from http://apps.who.int/iris/bitstream/10665/186463/1/9789240694811_eng.pdf

WHOQOL SRPB Group. (2006). A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life. *Social*

Science & Medicine, *62*(6), 1486–1497. https://doi.org/10.1016/j.socscimed.2005.08.001

Wilkes, L., Cioffi, J., Fleming, A., & Lemiere, J. (2011). Defining pastoral care for older people in residential care. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *37*(2), 213–221. https://doi.org/10.5172/conu.2011.37.2.213

Yoon, D. P. (2006). Factors affecting subjective well-being for rural elderly individuals: The importance of spirituality, religiousness, and social support. *Journal of Religion & Spirituality in Social Work*, *25*(2), 59–75. https://doi.org/10.1300/J377v25n02_04

Yoon, D. P., & Lee, E.-K. O. (2007). The impact of religiousness, spirituality, and social support on psychological well-being among older adults in rural areas. *Journal of Gerontological Social Work*, *48*(3–4), 281–298. https://doi.org/10.1300/J083v48n03_01

Zamanzadeh, V., Rahmani, A., Pakpour, V., Chenoweth, L. L., & Mohammadi, E. (2017). Psychosocial changes following transition to an aged care home: Qualitative findings from Iran. *International Journal of Older People Nursing*, *12*(2), e12130. https://doi.org/10.1111/opn.12130

Zibad, H. A., Foroughan, M., Shahboulaghi, F. M., Rafiey, H., & Rassouli, M. (2017). Perception of spiritual health: A qualitative content analysis in Iranian older adults. *Educational Gerontology*, *43*(1), 21–32. https://doi.org/10.1080/03601277.2016.1231521

Zimmer, Z., Jagger, C., Chiu, C.-T., Ofstedal, M. B., Rojo, F., & Saito, Y. (2016). Spirituality, religiosity, aging and health in global perspective: A review. *SSM - Population Health*, *2*, 373–381. https://doi.org/10.1016/j.ssmph.2016.04.009

How to cite this article: Gautam S, Neville S, Montayre J. What is known about the spirituality in older adults living in residential care facilities? An Integrative review. *Int J Older People Nurs*. 2019;14:e12228. https://doi.org/10.1111/opn.12228

Appendix B: Participant Information Sheet for Residents

Participant Information Sheet

Copies of this participant information sheet are available in Nepali language and English

Residents

Date Information Sheet Produced:

20th September 2017

Project Title

Spirituality in older adults living in selected residential care facilities in Kathmandu, Nepal

An Invitation

Namaste! My name is Sital Gautam and I am a nurse and PhD student at Auckland University of Technology with a special interest in residents' spirituality. My supervisors Associate Professor Stephen Neville and Dr Jed Montayre have a special interest in issues related to older adults. Dr Sarala Joshi is my field supervisor for this project.

You are invited to participate in this study which will explore the spiritual needs of residents. Your participation in this research project is voluntary (it is your choice), and you have full authority to withdraw your participation at any time without question. If you choose to withdraw from the study, then any data that is identifiable as belonging to you will be removed. However, once the findings have been produced, removal of your data may not be possible. The researchers have no involvement in any community or health services for residents; therefore you will not be advantaged or disadvantaged in any way if you choose to participate or not.

What is the purpose of this research?

I want to understand the spiritual needs of older adults living in residential care facilities in Nepal. The findings of this study will be beneficial for nurses and caregivers to design effective interventions according to identified needs, thus, improving the effectiveness of service delivery. Similarly, it could inform policy makers to develop social and public health policies to improve the provision of care to older adults living in residential care facilities. This research will help me gain PhD qualification. Different national, international presentations and publications are likely to result from the research. Furthermore, this study will advance knowledge in the care of older adults living in residential care facilities, which can be the basis for future studies

How was Iidentifiedand why am I being invited to participate in this research?

You will have either responded to an advertisement about the study on a noticeboard at your residential care facilities, or have picked up the information after an information session about the study. You are eligible to volunteer if you are 60 years or older, and have lived in the residential care facilities for 6 months or more. Conversational Nepali language will be spoken during the study, so you do not need to worry about the language. The nature of the proposed study and time might not be suitable to elicit the perceptions of residents living with cognitive impairment or who are having an acute episode of ill health.

How do I agree to participate in this research?

If you wish to participate, please inform me directly. I will be available in the residential care facility. I will first check whether you are eligible to participate in this study. You will then be asked to sign the consent form in our first appointment. If you cannot sign the consent form, the verbal consent will be audio-recorded. We will then arrange the time for our next meeting, which will be according to your choice.

What will happen in this research?

Interviews will be undertaken regarding spirituality (meaningful living and connectedness) in residential care facilities. Interviews will be digitally recorded and field notes will be taken during interviews. You will be allowed to ask questions during the interview. You will not be pressured to complete the whole interview session or forced to answer any question. If you are not comfortable with the presence of the researcher, the researcher will leave the facility and postpone interviews. I will not be involved in any professional nursing activities. The data gained from the study will be typed, analysed, and used for academic purposes only.

What are the discomforts and risks?

It is not anticipated that you will experience any significant discomfort or embarrassment and it is not our intention to ask questions that may cause you any discomfort. It is possible, however, that you may experience minor emotional distress when discussing your life in residential care facilities.

How will these discomforts and risks be alleviated?

You may choose at any time to not answer a question, to stop the recording or to leave the interview.

A professional Nepalese counsellor (not involved with this residential care facility) is able to offer three free sessions of confidential counselling support for participants of this research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access this service, you will need to:

- Make an appointment by calling +977 9851181928 or sending email (pradeep_sant1@hotmail.com). Let them know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

What are the benefits?

By participating in this study, you may experience personal benefits from sharing your experience about the needs of older adults living in residential care facilities, which can inform nurses, caregivers, and policy makers. Eventually, it can improve the services offered in residential care facilities in Nepal.

How will my privacy be protected?

Privacy will be maintained by collecting data from each resident separately in a quiet place or separate room according to your convenience. Maintaining your confidentiality is of utmost importance to me. You will be invited to choose a pseudonym (fictitious name) for use in the interview transcripts and when referring to any information from the study in research reports or published articles. No material which could personally identify you will be used in any reports on this study. If necessary, confidentiality will be maintained by changing any identifying details in the transcripts and any reports, presentations, or publications arising from the research.

All material pertaining to the study, including digital recordings, transcripts of the interview, memos, consent forms, and field notes will be stored in a locked filing cabinet at the Auckland University of Technology for six years, then destroyed. During the study, only the researcher and supervisors will have access to the information.

What are the costs of participating in this research?

There will be no financial cost to you for participating in this study. Participating will take up to 2 hours of your time, which includes the time required to explain the details of the study, warm up question and major questions. In addition, once the process of spirituality in residential care facilities emerges from the data, you will be asked to confirm whether it has covered your major concerns. In addition, you may choose to spend few minutes listening to the summary report of the research.

What opportunity do I have to consider this invitation?

You have up to two weeks to consider volunteering for the study. You may contact me directly to ask any questions or to indicate your interest in volunteering. I will be available in the residential care facility after two weeks.

Will I receive feedback on the results of this research?

Yes, you will get a summary of the results of this research.

What do I do ifI have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Stephen Neville, stephen.neville@aut.ac.nz, +64 09 921 9999 Ext. 9379.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , +64 921 9999 ext6038.

Whom do I contact for further information about this research?

Please keep this information sheet and a copy of the consent form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Sital Gautam, gautamsital@hotmail.com, +977 9841676324

Project Supervisor Contact Details:

Associate Professor Stephen Neville, stephen.neville@aut.ac.nz, +64 09 921 9999 Ext. 9379.

Approved by the Auckland University of Technology Ethics Committee on *11/12/2017*, AUTEC Reference number 17/413.

Participant Information Sheet

(सहभागि सूचना शीट)

यो सहभागि सूचना शीटको प्रतिलिपी नेपली तथा अंग्रेजी भाषामा उपलब्ध छ।

वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरु(Residents)

सहभागि सूचना शीट बनेको मिती:

09/20/2017

अनुसंधानको शीर्षक

नेपालको वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको आध्यात्मिकता बारे

निमन्त्रणा

नमस्कार! मेरो नाम सितल गौतम हो र म अकल्याण्ड युनिभरसिटी अफ टेकनोलोजीबाट पीएच.डी. गर्दै गरेको नर्स हु। मेरो विशेष जिज्ञासाको बिषय वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको आध्यात्मिक जरुरतहरुको बारेमा हो। मेरो अनुसंधानको सुपरभाईजर अस्सोसीयट प्रोफेसर स्टेफेन नेविल तथा डा जेड मोंतेथर को विशेष रुचि वृद्धअवस्तामा आउने समस्याहरुको हल खोज्नु हो। यस अनुसंधानको क्षेत्र सुपरभाईजर डा. सरला जोशी हुनु हुन्छ।

यो अनुसंधानको लागि तपाईहरुको सहभागिता मेरो लागि अमुल्य हुने भएकोले यसमा मलाई साथ दिनु हुन्छ भन्ने आश गरेको छु। यस अनुसंधानमा सहभागिताको निर्णय स्वयं तपाईको हुनेछ र चाहेमा यो अनुसंधानबाट कुनै पनि समयमा कुनै प्रश्न बिना सहभागिता हटाउन सक्नु हुनेछ। यस अनुसंधानबाट सहभागिता हटाउदा तपाईसंग सम्बन्धित तथ्य हटाइने छ तर अनुसंधानको नतिजा निस्किषपछि सो तथ्य हटाउन संभव हुने छैन। यस अध्ययनको अनुशंधानकर्ताहरु वृद्धाश्रमसंग सम्बन्धित कुनै पनि सामुदायीक वा स्वास्थ्य सेवाहरूमा संलग्न नभएको हुदा, तपाइ सहभागि हुनु वा नहुनुले तपाइलाई कुनै फाइदा वा नोक्सान हुने छैन।

यो अनुसंधानको मुख्य उदेश्य के हो?

मेरो मुख्य उदेश्य नेपालको वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको सामाजिक, मानसिक तथा धार्मिक जरुरतहरुको बारेमा बुझ्नु हो। यस अनुसंधानको नतिजाले सेवा सुधार्न अनि प्रभावकारि बनाउन नर्स तथा सहायकहरुलाई मदत गर्नेछ। त्यसै गरि नतिजाले वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको सेवा अनि स्याहार सुधार्न सामाजिक तथा सार्वजनिक नीतिहरू बनाउनको लागि मदत गर्न सक्छ। यो अध्ययनले मलाई शैक्षिक योग्यता(पीएच.डी.) हासिल गर्न महत गर्नेछ। यस अनुसंधानको परिणाम विभिन्न राष्ट्रिय तथा अन्तराष्ट्रिय प्रस्तुति तथा प्रकाशनमा देखिन सक्ने छ। त्यस वाहेक यो अनुसंधानले वृद्धमानुभावहरुको स्याहार सुसारको ज्ञानमा सुधार ल्याउछ र यस्तै अरु अनुसंधान गर्ने आधार बनाउछ।

म कसरी यो अनुसंधानको लागि भेटिएको र यसमा भाग लिन मलाई किन निमन्त्रणा दिएको हो?

तपाईले यो अनुसंधानको लागि गरिएको विज्ञापन नोटिस बोर्डमा देख्नु भएको वा यस विषयमा भएको बिस्तृत जानकारी सेसनबाट सुन्नु भएको हुनु सक्छ। यदी तपाई साठी वर्ष वा माथि पुग्नु भयो र तपाई यहाँ बसेको छ महिना वा त्यो भन्दा बडी भयो भने तपाईले यो अनुसंधानमा भाग लिन सक्नु हुन्छ।यो अध्ययनको समयमा बोलचालको नेपाली भाषा प्रयोग हुने भएको हुदा भाषा सम्बन्धि कुनै आपति हुने छैन। यस अनुसंधानको प्रकृति र समयको कारणले गर्दा संज्ञानात्मक क्षमतामा कमि भएको तथा कुनै तीव्र रोगले ग्रस्थ वृद्धमानुभावहरुको संलग्नता उपयूक्त नहुन सक्छ।

मैले यो अनुसंधानमा भाग लिन कसरि सहमति जनाउन सक्छु?

यो अनुसंधानमा भाग लिन मन भए कृपया मलाई सीधा सम्पर्क गर्नुहोला। म वृद्धाश्रमको परिसर मा हुने छु। तपाई यो अध्ययनको लागि योग्य प्रतिनिधी हुनु हुन्छ कि हुन्न भन्ने कुरा पहिले निरुपण गरिनेछ र योग्य भएमा तपाइलाई हाम्रो पहिलो भेटमा सूचित सहमति फारम भर्न लगाइनेछ। तपाईले हस्ताक्षर गर्न नसकेमा तपाईको मौखिक सहमति रेकोर्ड गरिनेछ। त्यस पछिको भेटको समय तपाईको इच्छा अनुसार निर्धारित गरिनेछ।

यो अनुसंधानमा के गरिनेछ?

नेपालको वृद्धाश्रममा बस्नु हुने वृद्धहरुको जिन्दगि के कुराले सार्थक बनाइ रहेको छ र आफ्नोपन, सम्बन्ध तथा निकटता कसरि कायम राख्नु भएको छ भन्ने बारेमा अन्तर्वार्ता लिथिनेछ। अन्तर्वार्ता लिने क्रममा बोलेको कुरा रेकोर्ड तथा गरेको गतिबिधिहरु नोट गरिनेछ। तपाईले अन्तर्वार्ताको समयमा कुनै पनि प्रश्न सोध्न सक्नु हुनेछ। तपाईलाई अन्तर्वार्ता पूरा गर्न कुनै किसिमको दबाब दिईने छैन र कुनै प्रश्न को उत्तर दिन मननलागेमा केहि आप्पत्ति हुने छैन। कुनै बेला तपाईलाई अनुसंधानकर्ताको उपस्थितिले असहज बनाएमा अनुसंधानकर्ता वृद्धाश्रमबाट निस्किने र अन्तर्वार्ता स्थगित गरिनेछ। म एउटा अनुसंधानकर्ता मात्र भएको नाताले, कुनै किसिमको नर्सिंग कार्यमा सहभागी हुन नसक्ने जानकारी दिन चाहान्छु। यस अध्ययनबाट निस्केको तथ्य टाइप अनि निरिक्षण गरि पढाईको लागि मात्र प्रयोग गरिनेछ।

यस अनुसंधानमा भाग लिदा हुन सक्ने असुविधा र जोखिमहरु?

यस अनुसंधानमा कुनै किसिमको असुविधा र जोखिमको अपेक्षा गरिएको छैन र हाम्रो आशय कुनै हालतमा पनि तपाइलाई असुविधा पुर्याउने होइन। तपाई कुनै प्रश्नको उत्तर दिने बेलामा भावुक हुने सम्भावना भने हुन सक्छ।

तेस्तो असुविधा र जोखिमहरुलाई कसरि कम गरिनेछ?

यदि कुनै प्रश्नको उत्तर दिन उचित नलागेमा त्यस प्रश्नलाई छोड्न पनि सक्नु हुनेछ, रेकर्डिंग रोक्न मन लागे रोक्न पनि सक्नु हुनेछ र चाहेमा अन्तर्वार्ता रोकेर जान पनि सक्नु हुनेछ।

यस अनुसंधानमा सहभागि हुनेहरुको निम्ति ३ ओटा निशुल्क र गोपनीय व्यावसायिक परामर्शको बेवस्था गरिएको छ। परामर्श दिने व्यक्तिको यो वृद्धाश्रममा कुनै संलग्नता हुने छैन। यो सेवा केवल ति मुद्दाहरूको लागि उपलब्ध छन् जुन सिधै अनुसन्धानमा सहभागिताको परिणाम स्वरुप उत्पन्न भएको हो र अन्य सामान्य परामर्श को निम्ति यो सेवा उपलब्ध हुने छैन । यो सेवाको लागि तपाईले:

- +977 9851181928 मा फोन गरेर वा pradeep_sant1@hotmail.com मा इमेल पठाएर भेटघाटको समय निश्चित गर्न सक्नु हुनेछ। फोन गर्दा वा इमेल पठाउदा आफु एस अनुसंधानमा सहभागी भएको जानकारी दिएर अनुसंधानको शीर्षक, मेरो नाम र सम्पर्क विवरण (यस सहभागि सूचना शीट मा दिए अनुसार) उल्लेख गर्दिनु होला।

यस अनुसंधानबाट कस्तो फाइदा हुन सक्छ?

यस अनुसंधानमा भाग लिएर तपाईले आफ्नो अनुभव सुनाउन पाउदा आफैलाई सन्तुष्टि मिल्न सक्छ । तपाईले दिएको जानकारीले अरु नर्स, सहायक, र निती बनाउनेहरुलाई त्यहाँ बस्नुहुने वृद्धमानुभावहरुको आवश्यकताको बारेमा सूचित गराउन सक्छ। यस जानकारीले नेपालको हरेक वृद्धाश्रममा दिईने सुविधा र स्याहारमा सुधारको कार्यक्रमहरु ल्याउन मदत गर्नेछ।

मेरो गोपनियता कसरी सुरक्षा गरिनेछ?

तपाईको गोपनियताको सुरक्षा गर्नको लागि हरेक वृद्धमानुभावसंग छुट्टै ठाउँमा तपाईको इच्छा अनुसार अन्तर्वार्ता गरिनेछ। तपाईको गोपनियताको सुरक्षा गर्नु मेरो लागि धेरै महत्वपूर्ण छ। तपाईको परिचय कहिलै खुलाईने छैन र यो कुरा सुनिश्चित राख्नको लागि तपाईलाई एउटा काल्पनिक नाम छान्न लगाईनेछ। अन्तर्वार्ता प्रतिलेख र रिपोर्ट बनाउदा काल्पनिक नाम प्रयोग हुने हुदा पछि गरिने प्रस्तुति तथा प्रकाशनमा तपाईको गोपनियेता सुनिस्चित हुनेछ।

यस अध्ययनमा प्रयोग गरिने रेकर्डिङ, अन्तर्वार्ता प्रतिलेख , मेमोज , सूचित सहमति फारम , र नोटहरु अकल्याण्ड युनिभरसिटी अफ टेकनोलोजीको लकरमा ६वर्ष सम्मको लागि राखिने छ र त्यस पछि विनाश गरिनेछ।यो अध्ययनको तथ्यहरुमा केवल अनुसन्धानकर्ता र सुपरभाईजरको मात्र पहूच हुनेछ।

यो अनुसंधानमा भाग लिन कति लागत लाग्छ?

यो अनुसंधानमा भाग लिन तपाईलाई कुनै किसिमको पैसा लाग्दैन। यो अनुसंधानमा भाग लिन तपाइले आफ्नो

दुई घण्टाको समय निकाल्नु पर्ने हुन्छ,जसमा यो अध्ययनको बारेमा बिस्तृत जानकारी दिईनेछ, मुख्य प्रश्नहरु सोधिनेछ, र पछि यो अध्ययनको सारांश दिईनेछ ।साथ साथै आध्यात्मिकताको प्रकृया थाहा भए पछि फेरी फर्किएर तपाईलाई पुष्टि गराईनेछ। तपाईको इच्छा अनुसार तपाईले केहि समय रिपोर्टको सारांश सुन्न समेत सक्नु हुनेछ।

यो निमन्त्रणा स्वीकार गर्न मसंग कति समय हुन्छ?

यो निमन्त्रणा स्वीकार गर्न तपाईसंग २ हप्ताको समय हुन्छ। कुनै प्रश्न भए मलाई सीधा सम्पर्क गर्नुहोला। म वृद्धाश्रमको परिसर मा २ हप्ता पछि हुने छु।

यो अनुसंधानको नतिजाको सारांश मैले हेर्न सक्छु?

हजुर! तपाईले यो अनुसंधानको नतिजाको सारांश हेर्नपाउनु हुनेछ।

मलाई यो अनुसंधानको बारेमा चासो भए मैले के गर्न मिल्छ?

यो अनुसंधानको प्रकृतिको बारेमा कुनै जिज्ञासा भए तपाईले अनुसंधानको सुपरभाईजर, अस्सोसीयट प्रोफेसर स्टेफेन नेविल, stephen.neville@aut.ac.nz, +६४०९९२१९९९९ Ext.९३७९ लाई सम्पर्क गर्न सक्नु हुनेछ।

यो अनुसंधानको आचरणबारेमा कुनै जिज्ञासा भए तपाईले अकल्याण्ड युनिभरसिटी अफ टेकनोलोजी एथिक्स कमिटिको कार्यकारी सचिव केट कोनोर ethics@aut.ac.nz , +६४९२१९९९९ext६०३८ लाई सम्पर्क गर्न सक्नु हुनेछ।

यो अनुसंधानको बारेमा थप जानकारी पाउन मैलेको संग सम्पर्क गर्नु पर्छ?

कृपया यो शीट तथा सूचित सहमति फारमको प्रतिलिपी आफुसंग राख्नु होला। तपाईले तल दिईएको टिमलाई सम्पर्क गर्न सक्नु हुनेछ।

अनुसंधानकर्ता:

सितल गौतम, gautamsital@hotmail.com, 977 9841676324

अनुसंधानको सुपरभाईजर:

अस्सोसीयट प्रोफेसर स्टेफेन नेविल, stephen.neville@aut.ac.nz, +६४०९९२१९९९९ Ext.९३७९

अकल्याण्ड युनिभिरसटी अफ टेकनोलोजी एथिक्स कमिटबाट 11/12/2017 ग ते अनुमोदित गरिएको
ए.उ.ट.इ.सी रेफरेन्स नम्बर 17/413.

Appendix C: Participant Information Sheet for Nurses and Caregivers

Participant Information Sheet

Copies of this participant information sheet are available in Nepali language and English

Nurses and caregivers

Date Information Sheet Produced:

20th September, 2017

Project Title

Spirituality in older adults living in selected residential care facilities in Kathmandu, Nepal

An Invitation

Namaste! My name is Sital Gautam and I am a nurse and PhD student at Auckland University of Technology with a special interest in residents' spirituality. My supervisors Associate Professor Stephen Neville and Dr Jed Montayre have a special interest in issues related to older adults. Dr Sarala Joshi is my field supervisor for this project.

You are invited to participate in this study which will explore spiritual needs of residents. Your participation in this research project is voluntary (it is your choice), and you have full authority to withdraw your participation at any time without question. If you choose to withdraw from the study, then any data identified to be belonging to you will be removed. However, once the findings have been produced, removal of your data may not be possible. The researchers have no involvement in any community or health services for residents; therefore you will not be advantaged or disadvantaged in any way if you choose to participate or not.

What is the purpose of this research?

I want to understand the spiritual needs of older adults living in residential care facilities in Nepal. The findings of this study will be beneficial for nurses and caregivers to design effective interventions according to identified needs, thus, improving the effectiveness of service delivery. Similarly, it could inform policy makers to develop social and public health policies to improve the provision of care to older adults living in residential care facilities. This research will help me gain my PhD qualification. Different national, international presentations and publications are likely to result from the research. Furthermore, this study will advance knowledge in the care of older adults living in residential care facilities, which can be the basis for future studies.

How was Iidentifiedand why am I being invited to participate in this research?

You will have either responded to an advertisement about the study on a noticeboard at your residential care facility or have picked up the information after an information session about the study. You are eligible to volunteer if you are a registered nurse or formal caregiver, and have worked in the residential care facility for 6 months or more. Conversational Nepali language will be spoken during the study, so you do not need to worry about the language.

How do I agree to participate in this research?

If you wish to participate, please contact me through email or phone. I will first check whether you are eligible to participate in this study. You will then be asked to sign the consent form at our first appointment. We will then arrange the time for our next meeting, which will be according to your choice.

What will happen in this research?

Interviews will be undertaken regarding the spiritual needs of older adults living in residential care facilities, challenges to fulfil those needs and changes you would like to see in the delivery of care. Interviews will be digitally recorded and field notes will be taken during interviews. You will be allowed to ask questions during the interview. You will not be pressured to complete the whole interview session or forced to answer any question.If you are not comfortable with the presence of the researcher, the researcher will leave the facility and postpone interviews.I will not be involved in any professional nursing activities. The data gained from the study will be typed, analysed, and used for academic purposes only.

What are the discomforts and risks?

It is not anticipated that you will experience any significant discomfort or embarrassment and it is not our intention to ask questions that may cause you any discomfort. It is possible, however, that you may experience minor emotional distress.

How will these discomforts and risks be alleviated?

You may choose at any time to not answer a question, to stop the recording or to leave the interview.

A professional Nepalese counsellor (not involved with this residential care facility) is able to offer three free sessions of confidential counselling support for participants of this research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access this service, you will need to:

- Make an appointment by calling +977 9851181928 or sending email (pradeep_sant1@hotmail.com). Let them know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information sheet.

What are the benefits?

By participating in this study, you may experience personal benefits from sharing your experience about the needs of older adults living in residential care facilities, which can inform nurses, caregivers, and policy makers. Eventually, it can improve the services offered in residential care facilities in Nepal.

How will my privacy be protected?

Privacy will be maintained by collecting data from each nurse or caregiver separately in a quiet place or separate room according to your convenience. Maintaining your confidentiality is of utmost importance to me. You will be invited to choose a pseudonym (fictitious name) for use in the interview transcripts and when referring to any information from the study in research reports or published articles. No material which could personally identify you will be used in any reports on this study. If necessary, confidentiality will be maintained by changing any identifying details in the transcripts and any reports, presentations, or publications arising from the research.

All material pertaining to the study, including digital recordings, transcripts of the interview, memos, consent forms, and field notes will be stored in a locked filing cabinet at the Auckland University of Technology for six years, then destroyed. During the study, only the researcher and supervisors will have access to the information.

What are the costs of participating in this research?

There will be no financial cost to you for participating in this study. Participating will take up to 2 hours of your time, which includes the time required to explain the details of the study, warm up question and major questions. In addition, once the process of spirituality in residential care facilitiesemerges from the data, you will be asked to confirm whether it has covered your major concerns. In addition, you may choose to spend few minutes listening to the summary report of the research.

What opportunity do I have to consider this invitation?

You have up to two weeks to consider volunteering for the study. You may contact me to ask any questions or to indicate your interest in volunteering.

Will I receive feedback on the results of this research?

Yes, you will get a summary of the results of this research.

What do I do ifI have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Stephen Neville, stephen.neville@aut.ac.nz, +64 09 921 9999 Ext. 9379.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , +64 921 9999 ext6038.

Whom do I contact for further information about this research?

Please keep this information sheet and a copy of the consent form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Sital Gautam, gautamsital@hotmail.com, +977 9841676324

Project Supervisor Contact Details:

Associate Professor Stephen Neville, stephen.neville@aut.ac.nz, +64 09 921 9999 Ext. 9379.

Approved by the Auckland University of Technology Ethics Committee on *11/12/2017* AUTEC Reference number 17/413.

Participant Information Sheet

(सहभागि सूचना शीट)

यो सहभागि सूचना शीटको प्रतिलिपी नेपली तथा अंग्रेजी भाषामा उपलब्ध छ।

नर्स तथा सहायकहरु (Nurses and Caregivers)

सहभागि सूचना शीट बनेको मिती:

09/20/2017

अनुसंधानको शीर्षक

नेपालको वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको आध्यात्मिकता बारे

निमन्त्रणा

नमस्कार! मेरो नाम सितल गौतम हो र म अकल्याण्ड युनिभरसिटी अफ टेकनोलोजीबाट पीएच.डी. गर्दै गरेको नर्स हु। मेरो विशेष जिज्ञासाको बिषय वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको आध्यात्मिक जरुरतहरुको बारेमा हो। मेरो अनुसंधानको सुपरभाईजर अस्सोसीयट प्रोफेसर स्टेफेन नेविल तथा डा जेड मोंतेयर को विशेष रुचि वृद्धअवस्तामा आउने समस्याहरुको हल खोज्नु हो। यस अनुसंधानको क्षेत्र सुपरभाईजर डा. सरला जोशी हुनु हुन्छ।

यो अनुसंधानको लागि तपाईहरुको सहभागिता मेरो लागि अमुल्य हुने भएकोले यसमा मलाई साथ दिनु हुन्छ भन्ने आशा गरेको छु। यस अनुसंधानमा सहभागिताको निर्णय स्वयं तपाईको हुनेछ र चाहेमा यो अनुसंधानबाट कुनै पनि समयमा कुनै प्रश्न बिना सहभागिता हटाउन सक्नु हुनेछ। यस अनुसंधानबाट सहभागिता हटाउदा तपाईसंग सम्बन्धित तथ्य हटाइने छ तर अनुसंधानको नतिजा निस्किसकपछि सो तथ्य हटाउन संभव हुने छैन। यस अध्ययनको अनुशंधानकर्ताहरु वृद्धाश्रमसंग सम्बन्धित कुनै पनि सामुदायीक वा स्वास्थ्य सेवाहरूमा संलग्न नभएको हुदा, तपाइ सहभागि हुनु वा नहुनुले तपाइलाई कुनै फाइदा वा नोक्सान हुने छैन।

यो अनुसंधानको मुख्य उदेश्य के हो?

मेरो मुख्य उदेश्य नेपालको वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको सामाजिक, मानसिक तथा धार्मिक जरुरतहरुको बारेमा बुझ्नु हो। यस अनुसंधानको नतिजाले सेवा सुधार्न अनि प्रभावकारि बनाउन नर्स तथा सहायकहरुलाई मदत गर्नेछ। त्यसै गरि नतिजाले वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको सेवा अनि स्याहार सुधार्न सामाजिक तथा सार्वजनिक नीतिहरू बनाउनको लागि मदत गर्न सक्छ। यो अध्ययनले मलाई शैक्षिक योग्यता(पीएच.डी.) हासिल गर्न महत गर्नेछ। यस अनुसंधानको परिणाम विभिन्न राष्ट्रिय तथा अन्तराष्ट्रिय प्रस्तुति तथा प्रकाशनमा देखिन सक्ने छ। त्यस वाहेक यो अनुसंधानले वृद्धमानुभावहरुको स्याहार सुसारको ज्ञानमा सुधार ल्याउछ र यस्तै अरु अनुसंधान गर्ने आधार बनाउछ।

म कसरी यो अनुसंधानको लागि भेटिएको र यसमा भाग लिन मलाई किन निमन्त्रणा दिएको हो?

तपाईले यो अनुसंधानको लागि गरिएको विज्ञापन नोटिस बोर्डमा देख्नु भएको वा यस विषयमा भएको बिस्तृत जानकारी सेसनबाट सुन्नु भएको हुनु सक्छ। यदी तपाई रेजिसस्टर नर्स वा वृद्ध मानुभावहरुको हेरचाह गर्ने सहायक कामदार हुनु हुन्छ र साथै तपाईले यहाँ काम गर्नु भएको छ महिना वा त्यो भन्दा बडी भयो भने तपाईले यो अनुसंधानमा भाग लिन सक्नु हुन्छ।यो अध्ययनको समयमा बोलचालको नेपाली भाषा प्रयोग हुने भएको हुदा भाषा सम्बन्धि कुनै आपति हुने छैन।

मैले यो अनुसंधानमा भाग लिन कसरि सहमति जनाउन सक्छु?

यो अनुसंधानमा भाग लिन मन भए कृपया मलाई दिईएको इमेल डेगाना वा फोन नम्बरमा सम्पर्क गर्नुहोला। तपाई यो अध्ययनको लागि योग्य प्रतिनिधी हुनु हुन्छ कि हुन्न भन्ने कुरा पहिले निरुपण गरिनेछ र योग्य भएमा तपाइलाई हाम्रो पहिलो भेटमा सूचित सहमति फारम भर्न लगाइनेछ। त्यस पछिको भेटको समय तपाईको इच्छा अनुसार निर्धारित गरिनेछ।

यो अनुसंधानमा के गरिनेछ?

नेपालको वृद्धाश्रममा बस्नु हुने वृद्धहरुको विशेष आवश्यकताहरु, त्यसलाई पुरा गर्न के कस्ता चुनौतीहरू सामना गर्नु पर्ने र स्याहार तथा सुविधाहरुमा कुनै किसिमको परिवर्तन ल्याउन सकिन्छ कि भन्ने बारेमा अन्तर्वार्ता लिथिनेछ। अन्तर्वार्ता लिने क्रममा बोलेको कुरा रेकोर्ड तथा गरेको गतिबिधिहरु नोट गरिनेछ। तपाईले अन्तर्वार्ताको समयमा कुनै पनि प्रश्न सोध्न सक्नु हुनेछ। तपाईलाई अन्तर्वार्ता पूरा गर्न कुनै किसिमको दबाब दिईने छैन र कुनै प्रश्न को उत्तर दिन मननलागेमा केहि आप्यत्ति हुने छैन। कुनै बेला तपाईलाई अनुसंधानकर्ताको उपस्थितिले असहज बनाएमा अनुसंधानकर्ता वृद्धाश्रमबाट निस्किने र अन्तर्वार्ता स्थगित गरिनेछ। म एउटा अनुसंधानकर्ता मात्र भएको नातले, कुनै किसिमको नर्सिंग कार्यमा सहभागी हुन नसक्ने जानकारी दिन चाहान्छु। यस अध्ययनबाट निस्केको तथ्य टाइप अनि निरिक्षण गरि पढाईको लागि मात्र प्रयोग गरिनेछ।

यस अनुसंधानमा भाग लिदा हुन सक्ने असुविधा र जोखिमहरु?

यस अनुसंधानमा कुनै किसिमको असुविधा र जोखिमको अपेक्षा गरिएको छैन र हाम्रो आशय कुनै हालतमा पनि तपाइलाई असुविधा पुर्याउने होइन। तपाई कुनै प्रश्नको उत्तर दिने बेलामा भावुक हुने सम्भावना भने हुन सक्छ।

तेस्तो असुविधा र जोखिमहरुलाई कसरि कम गरिनेछ?

यदि कुनै प्रश्नको उत्तर दिन उचित नलागेमा त्यस प्रश्नलाई छोड्न पनि सक्नु हुनेछ, रेकर्डिंग रोक्न मन लागे रोक्न पनि सक्नु हुनेछ र चाहेमा अन्तर्वार्ता रोकेर जान पनि सक्नु हुनेछ।

यस अनुसंधानमा सहभागि हुनेहरुको निम्ति ३ ओटा निशुल्क र गोपनीय व्यावसायिक परामर्शको बेवस्था गरिएको छ। परामर्श दिने व्यक्तिको यो वृद्धाश्रममा कुनै संलग्नता हुने छैन। यो सेवा केवल ति मुद्दाहरूको लागि उपलब्ध छन् जुन सिधै अनुसन्धानमा सहभागिताको परिणाम स्वरुप उत्पन्न भएको हो र अन्य सामान्य परामर्श को निम्ति यो सेवा उपलब्ध हुने छैन । यो सेवाको लागि तपाईले:

- +977 9851181928 मा फोन गरेर वा pradeep_sant1@hotmail.com मा इमेल पठाएर भेटघाटको समय निश्चित गर्न सक्नु हुनेछ। फोन गर्दा वा इमेल पठाउदा आफु एस अनुसंधानमा सहभागी भएको जानकारी दिएर अनुसंधानको शीर्षक, मेरो नाम र सम्पर्क विवरण (यस सहभागि सूचना शीट मा दिए अनुसार) उल्लेख गर्दिनु होला।

यस अनुसंधानबाट कस्तो फाइदा हुन सक्छ?

यस अनुसंधानमा भाग लिएर तपाईले आफ्नो अनुभव सुनाउन पाउदा आफैलाई सन्तुष्टि मिल्न सक्छ । तपाईले दिएको जानकारीले अरु नर्स, सहायक, र निती बनाउनेहरुलाई त्यहाँ बस्नुहुने वृद्धमानुभावहरुको आवश्यकताको बारेमा सूचित गराउन सक्छ। यस जानकारीले नेपालको हरेक वृद्धाश्रममा दिईने सुविधा र स्याहारमा सुधारको कार्यक्रमहरु ल्याउन मदत गर्नेछ।

मेरो गोपनियता कसरी सुरक्षा गरिनेछ?

तपाईको गोपनियताको सुरक्षा गर्नको लागि हरेक नर्स तथा सहायकसंग छुट्टै ठाउँमा तपाईको इच्छा अनुसार अन्तर्वार्ता गरिनेछ। तपाईको गोपनियताको सुरक्षा गर्नु मेरो लागि धेरै महत्वपूर्ण छ। तपाईको परिचय कहिलै

खुलाईने छैन र यो कुरा सुनिश्चित राख्नको लागि तपाईलाई एउटा काल्पनिक नाम छान्न लगाईनेछ। अन्तर्वार्ता प्रतिलेख र रिपोर्ट बनाउदा काल्पनिक नाम प्रयोग हुने हुदा पछि गरिने प्रस्तुति तथा प्रकाशनमा तपाईको गोपनियेता सुनिश्चित हुनेछ।

यस अध्ययनमा प्रयोग गरिने रेकर्डिङ, अन्तर्वार्ता प्रतिलेख , मेमोज , सूचित सहमति फारम , र नोटहरु अकल्याण्ड युनिभरसिटी अफ टेकनोलोजीको लकरमा ६वर्ष सम्मको लागि राखिने छ र त्यस पछि विनाश गरिनेछ।यो अध्ययनको तथ्यहरुमा केवल अनुसन्धानकर्ता र सुपरभाईजरको मात्र पहूच हुनेछ।

यो अनुसंधानमा भाग लिन कति लागत लाग्छ?

यो अनुसंधानमा भाग लिन तपाईलाई कुनै किसिमको पैसा लाग्दैन। यो अनुसंधानमा भाग लिन तपाइले आफ्नो दुई घण्टाको समय निकाल्नु पर्ने हुन्छ,जसमा यो अध्ययनको बारेमा बिस्तृत जानकारी दिईनेछ, मुख्य प्रश्नहरु सोधिनेछ, र पछि यो अध्ययनको सारांश दिईनेछ ।साथ साथै आध्यात्मिकताको प्रकृया थाहा भए पछि फेरी फर्किएर तपाईलाई पुष्टि गराईनेछ। तपाईको इच्छा अनुसार तपाईले केहि समय रिपोर्टको सारांश सुन्न समेत सक्नु हुनेछ।

यो निमन्त्रणा स्वीकार गर्न मसंग कति समय हुन्छ?

यो निमन्त्रणा स्वीकार गर्न तपाईसंग २ हप्ताको समय हुन्छ। कुनै प्रश्न भए तल दिईएको नम्बरमा सम्पर्क गर्न सक्नु हुनेछ।

यो अनुसंधानको नतिजाको सारांश मैले हेर्न सक्छु?

हजुर! तपाईले यो अनुसंधानको नतिजाको सारांश हेर्नपाउनु हुनेछ।

मलाई यो अनुसंधानको बारेमा चासो भए मैले के गर्न मिल्छ?

यो अनुसंधानको प्रकृतिको बारेमा कुनै जिज्ञासा भए तपाईले अनुसंधानको सुपरभाईजर, अस्सोसीयट प्रोफेसर स्टेफेन नेविल, stephen.neville@aut.ac.nz, +६४०९९२१९९९९ Ext.९३७९ लाई सम्पर्क गर्न सक्नु हुनेछ।

यो अनुसंधानको आचरणबारेमा कुनै जिज्ञासा भए तपाईले अकल्याण्ड युनिभरसिटी अफ टेकनोलोजी एथिक्स कमिटिको कार्यकारी सचिव केट कोनोर ethics@aut.ac.nz , +६४९२१९९९९ext६०३८ लाई सम्पर्क गर्न सक्नु हुनेछ।

यो अनुसंधानको बारेमा थप जानकारी पाउन मैलेको संग सम्पर्क गर्नु पर्छ?

कृपया यो शीट तथा सूचित सहमति फारमको प्रतिलिपी आफुसंग राख्नु होला। तपाईले तल दिईएको टिमलाई सम्पर्क गर्न सक्नु हुनेछ।

अनुसंधानकर्ता:

सितल गौतम, gautamsital@hotmail.com, 977 9841676324

अनुसंधानको सुपरभाईजर:

अस्सोसीयट प्रोफेसर स्टेफेन नेविल, stephen.neville@aut.ac.nz, +६४०९९२१९९९९ Ext.९३७९

अकल्याण्ड युनिभरिसटी अफ टेकनोलोजी एथिक्स किमिटबाट 11/12/2017 गते अनुमोदित गरिएको ए.उ.ट.इ.सी रेफरेन्स नम्बर 17/413.

Appendix D: Consent Form

Consent Form

Face to Face Interviews

Copies of this consent form are available in Nepali and English language

Project title: *Spirituality in older adults living in selected residential care facilities in Kathmandu, Nepal*

Project Supervisor: *Associate Professor Stephen Neville, Dr Jed Montayre*

Researcher: *Sital Gautam*

- O I have read and understood the information provided about this research project in the Information Sheet dated _____.
- O I have had an opportunity to ask questions and to have them answered.
- O I am not suffering from cognitive impairment or an acute episode of ill health.
- O I understand that interviews will be digitally-recorded and transcribed.
- O I understand that field notes will be taken regarding my activities during interviews.
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then any data that is identifiable as belonging to me will be removed. However, once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 11/12/2017 AUTEC Reference number 17/413.

Note: The Participant should retain a copy of this form.

Consent Form

(सूचित सहमति फारम)

मौखिक अन्तर्वार्ता

यो सूचित सहमति फारमको प्रतिलिपी नेपली तथा अंग्रेजी भाषामा उपलब्ध छ।

अनुसंधानको शीर्षक: नेपालको वृद्धाश्रममा बस्नु हुने वृद्धमानुभावहरुको आध्यात्मिकता बारे
अनुसंधानको सुपरभाईजर: अस्सोसीयट प्रोफेसर स्टेफेन नेविल,डा जेड मोंतेयर
अनुसंधानकर्ता: सितल गौतम

- यस अनुसंधानसंग सम्बन्धित बिबिध जानकारी _____गते प्राप्तभएको डाटाशीट पढेर बुझेको छु।
- यस अनुसंधानको बारेमा प्रर्याप्त प्रश्न सोध्ने त्यसबारे खुलस्त उत्तर पाउने मौका पाएको छु।
- म कुनै तीव्र रोग वा संज्ञानात्मक हानीबाट ग्रस्थ छैन।
- यस अन्तर्वार्ताको समयमा मैले बोलेको कुरा रेकोर्ड गरिन्छ, मेरो गतिबिधिहरु नोट गरिन्छ र पछि प्रतिलेखन गरिन्छ भन्ने बारे जानकारी पाएको छु।
- यस अनुसंधानमा सहभागिताको निर्णय स्वयं म आफैले लिएको हो र चाहेमा यो अनुसंधानबाट कुनै पनि समयमा कुनै बेफाइदा नभइ सहभागिता हटाउन सक्छु भन्ने बारे जानकारी पाएको छु।
- यस अनुसंधानबाट आफुले सहभागिता हटाउदा मसंग सम्बन्धित तथ्य हटाइने तर अनुसंधानको नतिजा निस्किसकपछि सो तथ्य हटाउन संभव नहुने जानकारी पाएको छु।
- यस अनुसंधानमा भाग लिन म तयार छु।
- यस अनुसंधानको नतिजाको सारांश पाउने आशा गरेको छु (एउटामा चिन्ह लगाउनु होला): हो○ होइन○

सहभागीको सहि:_____
सहभागीको नाम:_____
सहभागीको ठेगाना:_____

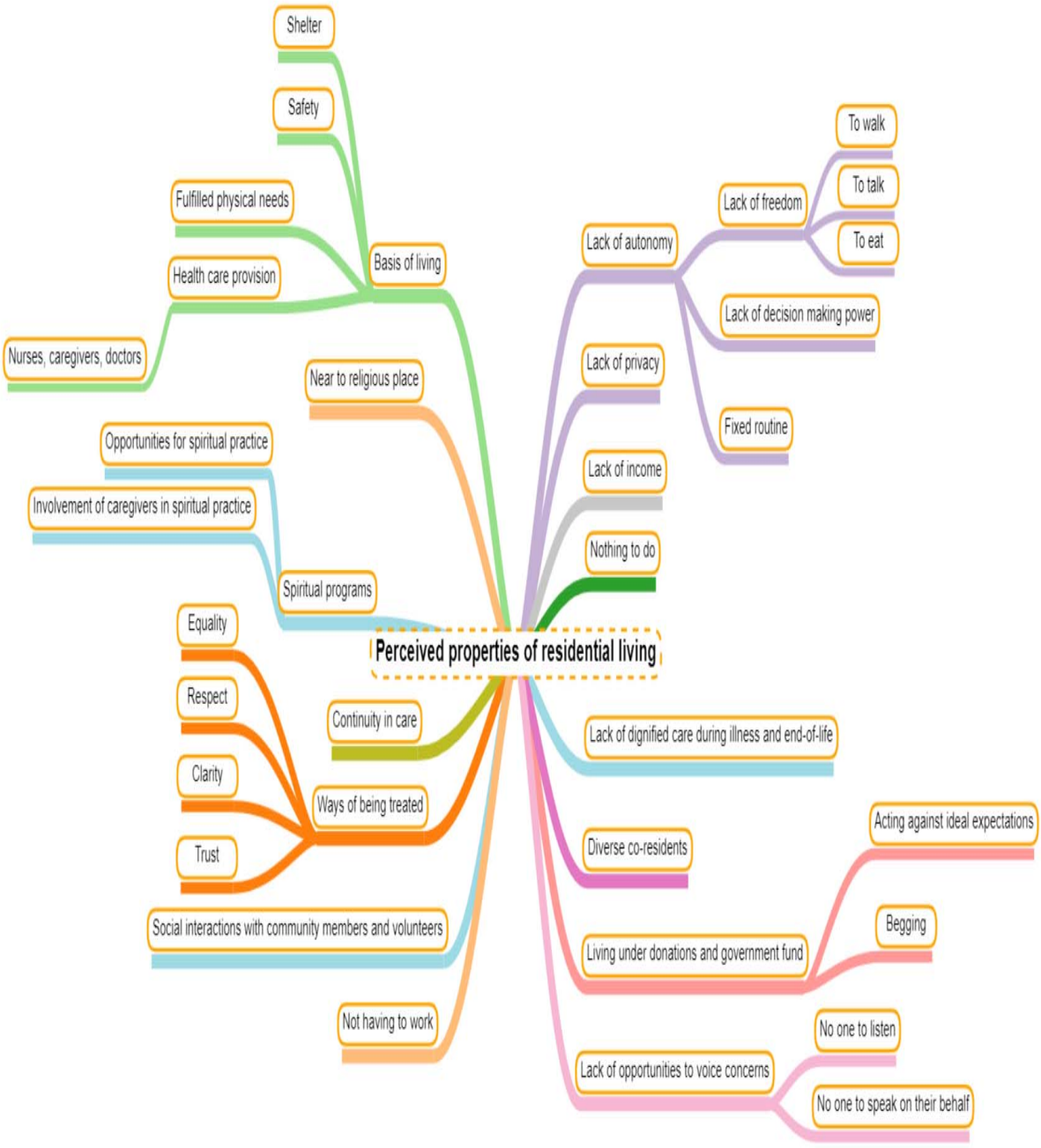
मिति:

अकल्याण्ड युनिभरिसटी अफ टेकनोलोजी एथिक्स कमिटबाट 11/12/2017 गते अनुमोदित गरिएको ए.उ.ट.इ.सी रेफरेन्स नम्बर 17/413.
नोट :सहभागिताहरुले यस फारमको एक प्रतिलिपी राख्नु पर्ने

Appendix E: Translation and Back Translation: Determining the Conceptual Equivalence of the Translated Transcript

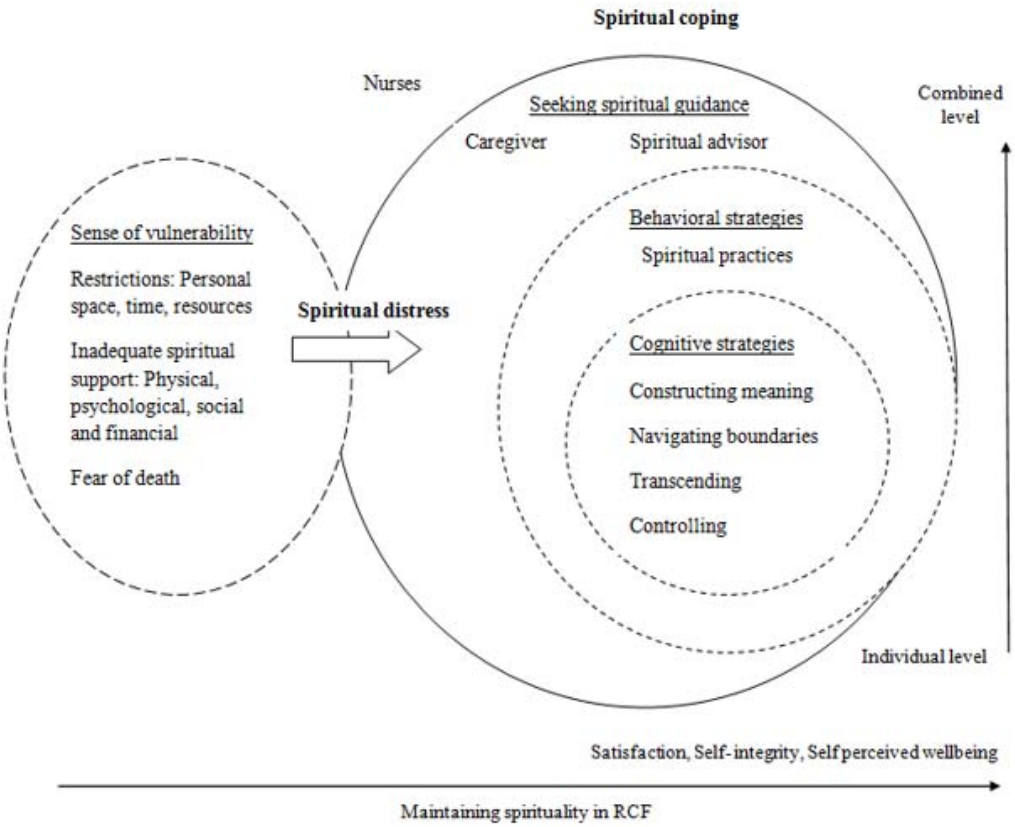
Interview	Transcribed in Nepali language by the researcher	Translated from Nepali to English by main bilingual translator	Back translated into Nepali by another bilingual translator
1	साथी त थिए वरपरका त्यो कोठा बेग्लै हुन्थे । लाटी सँग थिए, लाटी चाहि अलि बदमास थिई। कुट्ने पिट्ने गर्थी। हाकिमलाइ भन्दा खेरि हजुर एस्तो गर्छे यो के गरेर बस्नु म भने हैन ? भित्ता फर्किनु, सुत्नु भै हाल्छ नि भन्नु हुन्थ्यो उहा चाही अनि १० महिना बसे तल सिडीमा। अनि माथि हाकिमले लग्देको क्या। …अनि २-४ दिन भए पछि आमा तपाईलाइ कस्तो लाग्यो यहाँ भन्नु भयो उहाले सोध्नु भयो क्या। हजुर भर्खर पो काठमाडौँ आएछु म त भन्न आए छ। (हाँसे)	There were friends but in different rooms. I was with lati (having cognitive impairment). She was terrible and used to abuse by hitting me physically. I told the manager that she does that and asked how to live with her? The manager used to tell me, face walls of the room and sleep. I stayed downstairs for 10 months and then I was transferred upstairs by the manager. …After two-four days, they asked me how I felt living upstairs. I said now I feel like I am living in Kathmandu. (Laughs)	साथीहरु त थिए तर उनीहरु अर्कै कोठामा थिए। म लाटी (बुझ्न नसक्ने) सँग थिए। त्यो साह्रै खराब थिई तेस्ले मलाई कुट्ने गर्थी। मैले यो बारेमा हाकिमलाई बताए एस्तो गर्छे म कसरि बसु भने। उहाले मलाई तपाई भित्ता पट्टि फर्केर सुत्नु केहि हुन्न भन्नु भयो। म त्यहाँ तल १० महिना बसे, त्यसपछि हाकिमले मलाई माथिल्लो तल्लामा सारे। … उनीहरुले म माथि सरेको २-४ दिन पछि तपाईको बसाइ कस्तो हुदै छ त माथि भनेर सोधे। मैले भने मलाई अहिले चाही काठमाडौँ बसेको अनुभूति भै रहेको छ।(हाँसे)
2	नयाँ सम्बन्ध! त तै एउटा साथी थ्यो गुमिहाल्यो, धेरै असाद्धै मिलनसार साथी थियो। ऐले छ एक जना।अ मिल्ने । ऐले भनौ भने कोहि कोहि मात्र हो । त्यति सारो म अरु संग त्यति झगडा गरेर निहु खोजेर म कोहि संग नि छैन। कसै कसैले नभाको झुटो आरोप लाउछन्, लाओ मैले गरया छैन तिमिहरुले गर्या तिमीहरु भोग्छौ भन्छु। म तेता पट्टि जान्छु।	New relation! I had one friend but I lost her. She was very friendly. I have one at this moment. Am friendly. I have to say that I have only few of them. Usually, I don't fight with others. Few of them blame me for the thing that I haven't done. I let them blame me, I haven't done anything, they will have to suffer for things they have done. I think that way.	नयाँ सम्बन्ध! मेरो एकजना साथी थियो तर मैले उनलाइ गुमाए। उनि साह्रै मिलनसार थिइन। मसँग अहिले एक जना मात्र छ मिल्ने । मैले भन्नु पर्छ थोरै मात्र छन्. साधारणतया म अरुसँग झगडा गर्दिन। कोहिले चाँही मैले जे गरेको छैन तेसैमा दोष लगाउछन्। म दोष लगाउन दिन्छु उनिहरुले गरेको कुराको दुख उनीहरुले सहनु पर्नेछ। म यसरी सोच्छु।
3	एकचोटी इंडिया मा छँदा पागल खाना गाथिए, पागल खाना मा जाँदा तेस्तै गर्थे। यो वृद्धाश्रम त मलाइ थाहा थिएन।पागल खाना पो हो रैछ कि क्या हो (हाँसे) हेतेरी! याँहा अब के गर्नु भन्दा बिहान उठेर त्यो एउटा आइमाईलाइ सोधे, यो आइमाई किन कराउछ भन्दा, " बौलाइ हो त्यो मान्छे, त्यो पनि बौला हो। यो बृद्धाश्रम हो कि पागलखाना हो भन्दा खेरी पागलखाना हैन बृद्धाश्रम हो भनिन । (हाँसे)	Once I went to the mental asylum in India, they used to do the same thing. I did not know about this RCF, is it a mental asylum? (Laughs). Unfortunately! What should I do here now? Then, I woke up in the morning and asked with a woman why the other woman was shouting. She told me that those are mentally ill. I asked whether it is a mental asylum or RCF, then she said, "it is a RCF, not a mental asylum." (Laughs)	म एक पटक भारतको पागल केन्द्रमा गाथि । तिनीहरु त्यहाँ पनि तेस्तै गर्ने गर्दथे। मलाई थाहा थिएन यो बृद्धाश्रमको बारेमा। के यो पागल केन्द्र हो कि? (हाँसे) दुर्भाग्यबस ! म के गरौ अहिले याँहा? अनि म बिहानै उठें र अर्को महिला किन हल्ला गरिरहेको हो भनेर सोधे। अनि उनले मलाई बताइन यिनी हरु मानसिक रोगि हुन्। यो पागल केन्द्र हो कि बृद्धाश्रम हो त भनेर मैले उन्लाई सोधे अनि उन्ले भनिन्,"यो एउटा बृद्धाश्रम हो पागल केन्द्र हैन" (हाँसे)

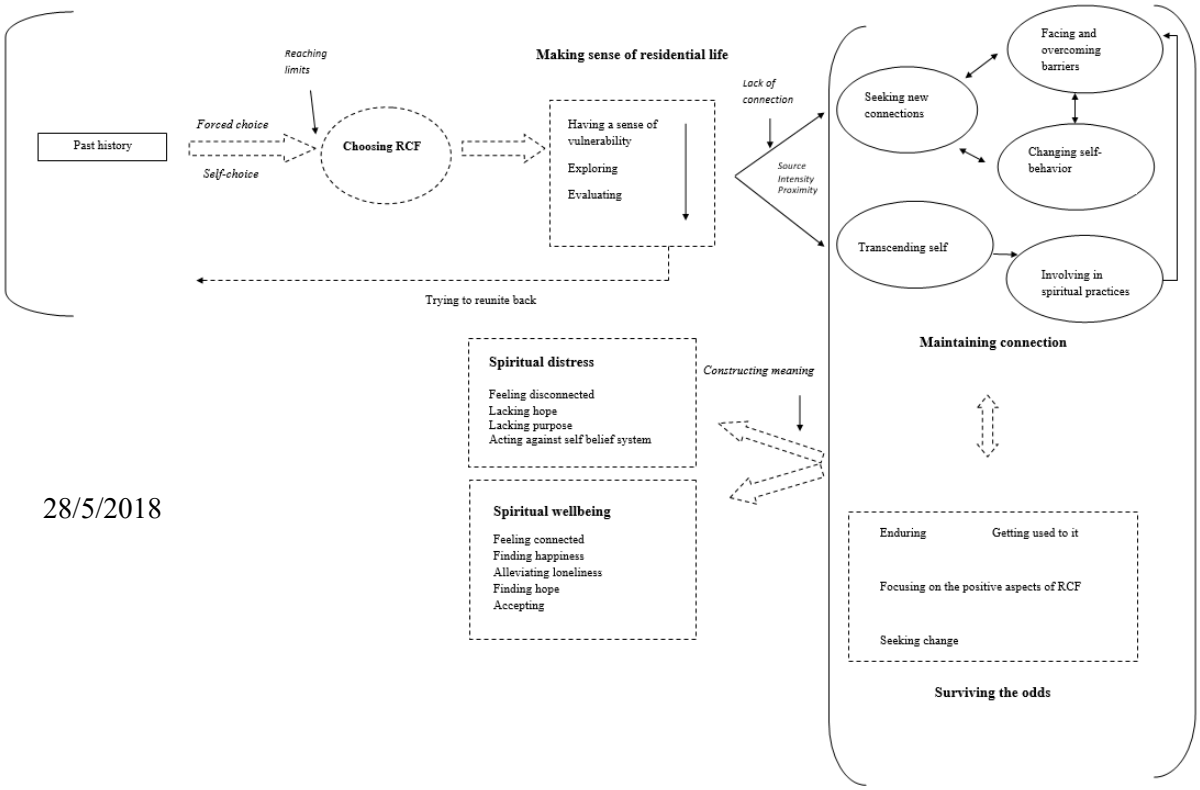
Appendix F: Brain Map to Record Dimensions of Residential Living as Reported by Participants



Appendix G: Evolved Diagram of Developing Theory

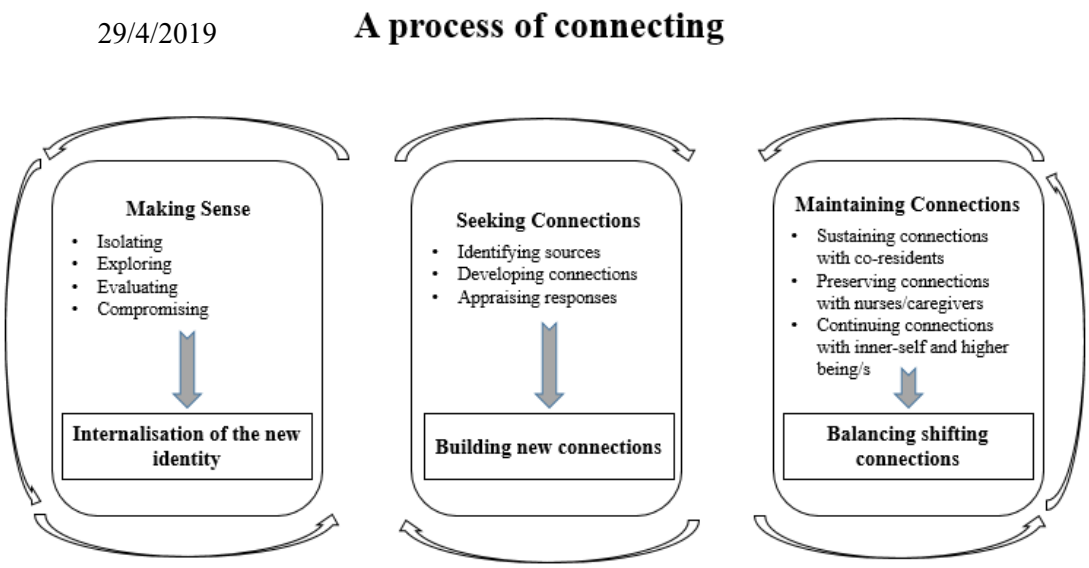
20/2/2018





28/5/2018

29/4/2019



Appendix H: Ethics Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

11 December 2017

Stephen Neville
Faculty of Health and Environmental Sciences

Dear Stephen

Re Ethics Application: **17/413 Spirituality in older adults living in residential care facilities in Nepal**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 11 December 2020.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: gautamsital@hotmail.com; Jed Montayre; Barbara McKenzie-Green

Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 1189

28 November 2017

Ms. Sital Gautam
Principal Investigator, Auckland University of Technology
New Zealand

Subject: Approval of research proposal entitled **Spirituality in older adults living in selected residential care facilities in Kathmandu, Nepal**

Dear Ms. Gautam,

It is my pleasure to inform you that the above-mentioned proposal submitted on **13 November 2017** (**Reg.no. 460/2017** please use this Reg. No. during further correspondence) has been approved by NHRC Ethical Review Board on **26 November 2017**.

As per NHRC rules and regulations, the investigator has to strictly follow the protocol stipulated in the proposal. Any change in objective(s), problem statement, research question or hypothesis, methodology, implementation procedure, data management and budget that may be necessary in course of the implementation of the research proposal can only be made so and implemented after prior approval from this council. Thus, it is compulsory to submit the detail of such changes intended or desired with justification prior to actual change in the protocol before the expiration date of this approval. Expiration date of this study is **February, 2020.**

If the researcher requires transfer of the bio samples to other countries, the investigator should apply to the NHRC for the permission. The researchers will not be allowed to ship any raw/crude human biomaterial outside the country; only extracted and amplified samples can be taken to labs outside of Nepal for further study, as per the protocol submitted and approved by the NHRC. The remaining samples of the lab should be destroyed as per standard operating procedure, the process documented, and the NHRC informed.

Further, the researchers are directed to strictly abide by the National Ethical Guidelines published by NHRC during the implementation of their research proposal **and submit progress report in between and full or summary report upon completion.**

As per your research proposal, the total research amount is **USD 4,928.00** and accordingly the processing fee amount to **USD 100.00.** It is acknowledged that the above-mentioned processing fee has been received at NHRC.

If you have any queries, please feel free to contact the Ethical Review M & E section of NHRC.

Thanking you.

Prof. Dr. Anjani Kumar Jha
Executive Chairman

Tel: +977 1 4254220, Fax: +977 1 4262469, Ramshah Path, PO Box: 7626, Kathmandu, Nepal
Website: http://www.nhrc.org.np, E-mail: nhrc@nhrc.org.np

Appendix I: Confidentiality Agreement

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Confidentiality Agreement

Back translation of interview transcripts from English to the Nepali language

Copies of this confidentiality agreement are available in Nepali language and English

Project title: *Spirituality in older adults living in selected residential care facilities in Kathmandu, Nepal*

Project Supervisor: *Associate Professor Stephen Neville and Dr Jed Montayre*

Researcher: *Sital Gautam*

- ○ I understand that all the material I will be asked to translate is confidential.
- ○ I understand that the contents of the transcripts can only be discussed with the researcher.
- ○ I will not keep any copies of the translations nor allow third parties access to them.

Translator's signature: .....

Translator's name: .....

Translator's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

Associate Professor Stephen Neville, stephen.neville@aut.ac.nz, +64 09 921 9999 Ext. 9379.

Approved by the Auckland University of Technology Ethics Committee on 11/12/2017 AUTEC Reference number 17/413.

Note: The Translator should retain a copy of this form.