Degree of privacy afforded in long-term care

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DEGREE OF PRIVACY AFFORDED IN LONG TERM CARE

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Lynn Marie Givens
Jesse Ornelas
June 2008
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ABSTRACT

The purpose of this study was to assess the level of privacy among the elderly living in long-term nursing and communal facilities. The data were collected through a probability sampling at the Veterans Home of California, in Barstow. All participants' confidentiality was observed by omitting personal information. Participation was strictly voluntary and the residents were under no obligation to participate. The selected participants completed a survey that revealed both positive and negative factors that may raise privacy awareness in long-term care facilities. The data have been analyzed through quantitative methods. The analyses focused on levels of privacy using descriptive statistics, including frequencies, and measures of central tendencies and dispersion. Correlations determined the strength of the association between the independent variables and the dependent variable. The immediate benefit to the participants was the opportunity to express their privacy experiences and concerns. The study concluded that the location of residency and the dates of military service were significant in determining a low level of privacy. The research can be used to formulate privacy guidelines to improve quality of life for long-term care residents.
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CHAPTER ONE

INTRODUCTION

Problem Statement

A study completed by the Center on Aging Studies at the University of Missouri-Kansas City (2005, para. 1) concluded that slightly over 5 percent of the 65+ population occupy congregate care, assisted living, and board-and-care homes, and about 4.2 percent are in nursing homes at any given time. Many of these aging individuals have no family support systems to advocate for their privacy and intimate concerns. The living arrangements in these facilities usually consist of a room with a window, two beds, and one bathroom. Some rooms might have a curtain divider, but others do not have any form of privacy.

Privacy is seen as a set of conditions that protects an individual’s life, dignity, personal space, and is defined by society as the “right to be left alone.” Privacy is a concern, particularly among the elderly because of the aging process. As an individual ages so does their body. These changes may be difficult for the aging individual and without privacy to accept the
changes, they may be embarrassed and develop feelings of depression or low self-esteem. If they were given more privacy in their rooms for dressing, bathing, and grooming they would have a better opportunity to accept the aging process.

The aging process may also cause the aging individual to develop physical, mental, and emotional disabilities. In addition to the aging process, life experiences may have created physical deformities and difficulties for some individuals. Unfortunately, birth defects have also left some people with scars, bruises, missing limbs, or illnesses that have caused physical limitations. Accidents resulting in a physical or mental injury can also be an overwhelming situation.

Everyone is born into a different life style and they depend on their families to teach them their culture and religion. As an individual grows and matures, they integrate their taught values with their personal beliefs and develop their own opinions. When two elderly people with different ethnicities, religions, or cultures are living in one room and sharing a bathroom, privacy may become limited, leaving no privacy for activities such as meditation or religious rituals.
Regardless of age, everyone needs love, touch, companionship, and intimacy (Kamel, 2004). Zastrow and Kirst-Ashman (2005, p. 286) define intimacy as the capacity to experience an open, tender, supportive relationship with another person, without fear of losing one's own identity in the process of growing close. Emotional intimacy is a feeling of trust and closeness between partners. It is when two people can be themselves and share their deepest thoughts, feelings and emotions, without being afraid their partner will laugh or judge them. Physical intimacy is the openness of sharing and touching with trust and respect. In general, intimacy is an important key to a healthy relationship.

Love, attachment, friendship, and companionship are cherished feelings of well-being for elders. In fact, research has shown that touch is the most important aspect of intimacy (Hooyman & Kiyak, 2002). Denying elders the opportunity to express intimacy can have negative effects. Lack of intimacy may cause elderly individuals to experience feelings of depression and worthlessness, which can lead to more serious problems.

Current social work practice regarding nursing and communal home privacy follows the National Association of
Social Workers' standards for social work services in long-term care facilities. The standards require establishment and administration of a social work program that provides high-quality care and services reflective of professional standards of practice and in compliance with all federal, state, and local laws (NASW, 2003, p. 12).

Federal law requires that all skilled nursing facilities provide medically related social services to attain or maintain the highest practicable resident physical, mental, and psychosocial well-being (NASW, 2007, para. 3). Nursing homes with more than 120 beds are required to employ a full-time social worker with at least a bachelor's degree in social work or similar professional qualifications (NASW, 2007, para. 3). Facilities with 120 beds or fewer must still provide social services, but do not need to have a full-time social worker on staff (NASW, 2007, para. 3).

The data collection for this study was conducted in California at a state facility. California has laws, rules and regulations in place to ensure the proper delivery of state aid. State agencies have used the California Constitution as a guide to create public
assistance. Article 1, Section 1 (Declaration of Rights), of the California Constitution states that all people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy (California State Constitution, 2006, para. 1).

The state of California provides its residents with supportive services throughout the state. The California Health and Human Services Agency (CHHSA) is the central agency that administers state and federal programs for health care, social services, public assistance and rehabilitation (State of California, 2007, para. 1). Another branch within the CHHSA is the California Department of Health Services (CDHS), one of the largest departments in the state government. The mission of the CDHS is “to protect and improve the health of all Californians” (State of California, 2007, p. 1).

Within the CDHS there is a Licensing and Certification Program that provides material designed to assist a resident in understanding Nursing Home Residents’ Rights. There are two privacy policies that are relevant to this study, the right to privacy and
personal privacy. The right to privacy includes privacy during guest visits, phone calls, and sending and receiving mail. Personal privacy involves resident protection by staff members including knocking on a residents' door before entering, closing the door during assistance with personal care, providing personal care so the residents' unclothed body will never be exposed, and assuring all health and financial records are kept confidential (State of California, 2004).

Purpose of the Study

The purpose of this study was to assess the level of privacy among the elderly veterans (residents) at the Veterans Home of California in Barstow (VHCB). The VHCB provides and maintains a privacy policy for all residents residing at the facility. The residents are required to follow and respect the policy at all times. Through the evaluation process of the generalist model of social work practice, this study has evaluated the current privacy afforded at the VHCB. The data that were collected sought explanations as to why there is or is not privacy.

Off Interstate-15 in Barstow, California sits a quiet veteran's home with a lot of vacancies. The VHCB
opened to veterans in February, 1996. Veterans desiring to reside at VHCB must be a resident of California, age 62 or older (or younger if disabled), and have served honorably in the military. Unfortunately, it is not free to live at the VHCB; each resident is required to pay a percentage of their monthly income. Their rent includes room, utilities, food, and any medical services needed. They are responsible for purchasing their clothing, hygiene products, and any other personal items they may need. There are also daily activities and outings in which they can participate.

There are two levels of care, intermediate care and independent living. Residents who are unable to perform activities of daily living (ADL'S), including eating, bathing, dressing, grooming, working, and homemaking; usually reside in the intermediate care facility (ICF). Most residents residing in the ICF have a roommate and are being continuously monitored by the nursing staff. The residents who are able to care for themselves without problems are placed in independent living where they reside in a domiciliary, which they call "the doms." The majority of the residents residing in the doms also have roommates and many of them dislike sharing a room;
fortunately married couples get to share a room. Most of the veterans reside at the VHCB because they cannot afford a home of their own, they have no family to care for them, or they need a higher level of care than their families can provide.

The data for this study were collected in the form of a survey. The residents of the VHCB were the ultimate data source, as they were the ones who were and were not satisfied with their privacy. There were 166 residents within the facility and 55 of them were chosen by systematic random sampling to participate in the study. Since some of the residents had vision problems, the surveys were conducted with a researcher present to help eliminate resident confusion.

Significance of the Study for Social Work

Zastrow and Kirst-Ashman (2005, p. 572) define gerontology as the scientific study of the aging process from physiological, pathological, psychological, sociological, and economic points of view. Gathering data from individuals who are experiencing the aging process can be beneficial to caregivers, social workers, medical staff, researchers, and gerontologists.
Social workers have a desire to provide support and advocate for those who are vulnerable and oppressed. The social work department at the VHCB is concerned because they want to help the residents improve their lives so they can properly function in their environment. If the residents are unable to function properly because they lack privacy, then the social work department must assess the privacy issues and create a plan to offer the appropriate assistance. Thus the question is asked, "Are the residents of the VHCB satisfied with their privacy?"

The aging process is real; ready or not here it comes. Research needs to focus on what will make the aging process easier. If providing more privacy to the elderly population will help their dignity remains intact, then it needs to be done because they deserve it.
CHAPTER TWO
LITERATURE REVIEW

Introduction

The need for privacy among nursing home residents worldwide was a major concern in gerontology evidenced by a growing body of research. Studies revealed, explored, and debated some of the common problems and solutions associated with perceptions regarding elderly quality of living standards centered on their need for privacy and their well being (Kane et al. 2001; Kelly, 2001; Hooyman, & Kiyak, 2002; McKinley & Alder, 2005; Roach, 2004; Wiley, 1996).

Quest for Privacy

Aizenberg, Weizman, and Barak, (2002) found that nursing home residents in Tel Aviv, Israel particularly men, were moderately in favor of addressing their sexual concerns. Aizenberg et al. (2002) study looked at a 1200 bed facility from which only 15 men and 16 women were chosen to be interviewed and to fill out a Likert scale that ranged from very important to very unimportant in terms of their sexual needs being met.
Aizenberg et al. found that cultural, specifically sample size, and using only cognitively functioning individuals limited the generalizability of the study; nevertheless, the findings were informative and paralleled other research on the subject matter.

Majercsik (2004) found in a study conducted at St. Margaret Hospital, Geriatric Department, Budapest, Hungary that the hierarchy of needs proved opposite to the general hypothesis of Maslow's theory. This study involved 70 females and 25 males geriatric patients to assess the hierarchy of needs using psychometric measurements (Majercsik, 2004). Study suggests a shift from overtly physiological care to esteem and self-actualization needs of the elderly (Majercsik, 2004). In other words Maslow's theory is not invalidated; however, there is more importance placed on esteem and self actualization by elderly than on their physiological needs (Majercsik, 2004). It is logical to assume that the age of the population influenced a tendency to reflect back on life and searched for purpose in their accomplishments, failures, regrets, and hopes for the future. Thus, most of their emphasis would probably be on self-actualization, not their physical immediate needs.
Quality of Life Considerations

Kane et al. (2001) found that participants from eleven nursing homes in Florida, New Jersey, and Minnesota considered nursing home resident quality of life significant. Kane et al. found that participants were registered and licensed nurses (RNs and LVNs), certified nursing assistants (CNAs), activities personnel, social workers, physicians, residents, and family members. Kane et al. found that consideration for quality of life lessened with the population who were regarded as cognitively impaired. Despite staff justifications for providing less consideration for the elderly who have cognitive impaired functions, federal and state law does not specify unequal treatment.

Feldkamp's (2003) findings revealed that elderly living in certified Medicare and/or Medicaid nursing home facilities have a number of protected rights, as defined by federal and state law. Those rights include privacy, confidentiality, and needs related to sexuality (Feldkamp, 2003). Privacy can be both visual and auditory (Feldkamp, 2003). Furthermore, nursing facilities are required to provide a high standard of care that is
consistent with high quality of physical, mental, and psychosocial well being (Feldkamp, 2003).

Another quality of life study found that nursing home residents listed privacy as one of the main needs in enhancing their quality of living (McKinley & Alder, 2005). This study used open-ended questions with focus groups from three northwest Iowa rural communities (McKinley & Alder, 2005). Each focus group consisted of four to seven participants and gathered the data through discussion and collaborative information sharing (McKinley & Alder, 2005).

A Need for Privacy Reform

Lack of intimacy was a consistent finding in the majority of the literature reviewed thus far (Hooyman & Kiyak, 2002; Roach, 2004). Privacy policy was largely affected by a conservative administrative culture which discouraged elderly intimacy (Roach, 2004). A need for privacy reform was demonstrated by teasing, bans on pornographic material, lack of conjugal visit, lack of private rooms or their unpractical location in the facility, no accommodation for non-traditional relationships, and the lack of education provided to
residents, line staff, and practitioners (e.g., Hooyman & Kiyak 2002; Richardson, & Lazur, 1995; Roach, 2004).

In response to lack of intimacy, a sexual revolution was spawned at the Hebrew Home for the Aged, a 1,200 bed nursing home and Alzheimer staff research center in the Riverdale section of the Bronx (Kelly, 2001). Their policy stated that residents have the right seek out and engage in sexual expression and the right to obtain material with sexuality explicitly content, including books, magazines, and videos (Kelly, 2001). Intimacy and privacy are intertwined ideas; one cannot limit one without affecting the other.

In a more practical yet unorthodox approach, a nursing home in Denmark provided pornographic programming "to ease resident tension" (Edwards, 2003). This approach indicated that humor served as an effective intervention tool to break the ice and cleared up misconceptions about elders not having sexual desires (Edwards, 2003).

Implications and Gaps in Privacy

The consequences of denying elderly self-expression of their sexuality in twenty thousand nursing homes can have negative effects (Kamel, 2004). Kelly (2001) claimed
that sexual activity dissatisfaction is related to
depression and feelings of worthlessness, which in turn
discouraged further intimate behavior. By law nursing
homes are required to provide services that meet
physical, mental, and psychosocial needs of elders,
including sexual needs under the Nursing Home Reform Act
(NHRA) of 1987 (McKinley & Alder, 2005).

There were gaps apparent in research not adequately
addressing privacy. For example, there was a lack of data
or support for alternative life styles in long-term care
specifically for male homosexuals, lesbians, bisexuals,
and others. However, there was some current research that
depicted the effectiveness of intimacy educational
interventions (Aja & Self, 1986). This study found
implicit and explicit treatment groups had significantly
higher scores than the control group on the Sexual
Knowledge and Attitude Test (SKAT). Participants in the
implicit group viewed films and slides that were
non-graphically depictive of sexual behavior. The same
materials were presented to the participants in the
explicit treatment group except for a film that portrayed
sexual behavior of live actors.
A process similar to the Sexual Attitudes Reassessment (SAR) developed the National Sex Forum found that sexual education was more effective with the explicit sexual education group in meeting the working goals: to become more knowledgeable about sexual matters, to develop more tolerant sexual attitudes, and to explore and state one's attitude and values regarding human sexual activity (Aja & Self, 1986).

The lack of research in these areas suggested that intimacy was considered a delicate subject area that researchers had managed to overlook. In addition, the literature review revealed one current study on the effectiveness of Nursing Home Reform Act (NHRA) of 1987 (McKinley & Alder, 2005). Focus groups were conducted to analyze quality of life in nursing homes. During the focus groups four major themes emerged as important: generativity, spirituality well being, homelike environment, and privacy (McKinley & Alder, 2005). There were disparities between quality of care in the NHRA's directives and the quality of life themes that emerged from the four focus groups in the study. In addition, there was a need for a policy that truly supported quality of life that requires that all staff be trained
to understand the meaning of quality of life. Thus, more studies were needed to reveal if in fact NHRA or the Omnibus Budget Reconciliation Act (OBRA) of 1987 privacy standards were being enforced in certified nursing facilities (McKinley & Alder, 2005; Umoren, 1992).

There was a need for more studies in the United States like those done in Budapest, Hungary and Tel Aviv, Israel. These studies could assess the validity of a hierarchy needs approach so that professionals can better serve the geriatrics population who lack family support or advocates. Furthermore, studies that focus on correlations between level of sex education and openness to express intimacy needs could also reveal a wealth of knowledge on the subject.

The literature showed consensus among gerontologist who believed that everyone regardless of age needs love, touch, companionship, and intimacy (Kane et al. 2001; Kelly, 2001; Hooyman, & Kiyak, 2002; McKinley & Alder, 2005; Roach, 2004).

Theories Guiding Conceptualization

Guiding the conceptualization of the study were theories, frameworks, and perspectives intended to help
understand the aging process by looking through a multiplicity of lenses (Hooyman & Kiyak, 2002). For instance, continuity theory suggested that elders have a need for intimacy, which remains consistent with age regardless of cohort, gender, race, and ethnicity (Hooyman & Kiyak, 2002).

Finchum and Weber (2000) also made reference to continuity theory as long established behavioral patterns which are expressed in elders. For example, intimacy dynamics changed in degree but not in lifestyle. Residents in nursing homes continued to seek friendships that provided companionship, assistance, and emotional support regardless of their age (Finchum & Weber, 2000). This suggested that humans were continuity seeking creatures who sought to express their needs by connecting with others at various levels.

In addition, Finchum and Weber (2000) postulated that continuity was maintained by internal and external factors. Internal continuity was maintained and expressed by residents in long-term care by their day to day living (Finchum & Weber, 2000). The elderly’s internal continuity was a reflection of their ability to continue to have time to be by themselves to reflect on their
life, to watch a movie alone, and to please themselves with out being interrupted (Finchum & Weber, 2000).

On the other hand, the dynamics of external continuity relied on maintaining involvement in familiar activities and friendships (Finchum & Weber, 2000). For example, when long-term care residents were not allowed to make private phone calls, not able to talk to a friend in private, and were not able to be intimate with their partner it jeopardized their external continuity (Finchum & Weber, 2000). Disruption of their disposition for external continuity inhibited privacy elements that allowed residents to express their need for privacy and dignity which is contradictory to Maslow’s hierarchy of needs (Finchum & Weber, 2000).

Maslow’s hierarchy theory was utilized to explain elderly development and to assess their psychological needs in nursing homes. Research findings of Aizenberg, Weizman, and Barak, (2002) were consistent with Maslow’s hierarchy of needs which were experienced in ascending order as described by Maslow. Aizenberg et al. (2002) found that Maslow’s hierarchy of needs people generally will progress in an ascending order making a pyramid:
physiological, safety, social and sense of belonging, self-esteem, and self-actualization.

Majercsik (2004) found in a different study that Maslow's hierarchies of needs were inconsistent with the original ascending order and placed physiological needs last. Elderly residents are likely to be concerned more with Erickson's last two stage of psychosocial development Generativity vs. stagnation and integrity vs. despair; thus, their primary focus is on self actualization, not physiological needs (Majercsik, 2004). Umoren (1992) also contended that Maslow's hierarchy of needs shifted from the lower to the higher needs in the pyramid suggesting that their lower needs for shelter, food, and water were already met; thus, they were more concerned with esteem and self actualization. Nonetheless, the Majercsik study suggests that privacy in long-term care is important even if the order happens to be reversed (Majercsik, 2004).

Umoren's (1992) interpretation of his research pointed out that Maslow's hierarchy of needs paralleled Omnibus Budget Reconciliation Act (OBRA) which implied an appropriate mix of needs to improve elderly's quality of life in the higher stages involving self esteem and self
actualization. Umoren (1992) proposed that elderly higher needs can be met by complying with OBRA and taking a resident-centered approach, not just meeting the federal and state regulations on paper.

Summary

Maslow’s hierarchy theory and continuity theory were used to conceptualize and understand the aging process that illustrated multi dimensional aspects of privacy in nursing homes. Disparities in the implementation of privacy policy demonstrated a negative impact on nursing home residents; thus, a need for privacy reform was recommended to enhance quality of life by enforcing existing policies on privacy. Gaps in research also revealed a need for further research indicating that there are subculture populations within the nursing homes such as male homosexuals, lesbians, bisexuals, and others. Lack of education about privacy increased risk factors associated with limited quality of life in nursing homes such as feelings of depression. Educating professionals and the elderly population on the subject provided a knowledge base that facilitated the use of evidenced based interventions with respect to privacy.
issues of dissatisfaction. The literature also showed consensus among gerontologist who believed that everyone regardless of age needs love, touch, companionship, and intimacy (Kane et al. 2001; Kelly, 2001; Hooyman, & Kiyak, 2002; McKinley & Alder, 2005; Roach, 2004).
CHAPTER THREE

METHODS

Introduction

In this chapter, an overview of the research methods utilized in the study of Veterans Home of California, Barstow residents' privacy was presented in hope of shedding light on the topic. The abovementioned was accomplished by formulating and discussing in detail a study design, sampling methods, data collection process, procedures, protection of human subjects, and data analysis.

Study Design

This study explored the Veterans Home of California Barstow (VHCB) residents' need for privacy by examining their current level of privacy. Research data was used to illustrate the degree of privacy afforded in long-term care specifically at the VHCB. The purpose of the research was to raise privacy awareness in long-term care, resulting in dialogue and potentially improving their current privacy policies. This study utilized a probability sampling research method approach.
A systematic probability sample was selected due to the large population size at the (VHCB), time constraints, and the power of sampling logic which allowed data gathering efficiency. The research question was: What degree of privacy is afforded to residents at VCHB?

Sampling

A list of Intermediate Care Facility (ICF) and Domiciliary (doms) residents was provided by the VHCB Chief of Social Work Services. After reviewing the residents' medical records and conferring with the LCSW and the Psychiatric Social Worker (PSW) that interacts with the residents daily, it was concluded that all residents were cognitively able to complete the survey. Since no residents were eliminated for cognitive deficiencies the original resident list was used.

There were 166 potential participants who did not exhibit any significant cognitive impairment that would exclude them from this study. A systematic random sampling method was used to select every third resident from an alphanumeric list. Thirty-two people were randomly selected from the doms and twenty-three from the
ICF. Domiciliary had nine participants that were never located, eight refusals, and two hospitalizations. Intermediate Care Facility had three refusals and one person who transferred to higher level of care.

Residents were assessed in the introduction phase of the survey and during the response portion as well. This consisted of clarifying any ambiguous survey question responses that did not encompass or account for their current living condition. For instance, some questions were not applicable. For example, VHCB does not provide room phones and not all veterans can afford cellular phones. Therefore, many veterans do not have the options of using a phone in private. Consequently, answers were factored into their total survey score for those particular questions that did not apply.

Data Collection and Instruments

A survey was used to collect data by Jesse Ornelas and Lynn Givens. An instrument was constructed to measure the level of privacy at VCHB. Jesse Ornelas and Lynn Givens, CSUSB MSW students, developed a eight-item five point Likert scale to measure the level of privacy, with response options ranging from "never", "rarely", "somewhat", "often", and "always". 

"sometimes", "often", to "frequently" (Appendix A). For example: 1. Can you make private phone calls in your room?

1........2........3........4........5

Residents circled one of the numbers that best corresponded to the frequency of private phone call in their room, for example. Privacy scores ranged from minimum of eight to a maximum of forty points contingent on residents' answers from the eight privacy questions. It was logically assumed that the closer the outcome was to forty the higher the level of privacy afforded and the closer the number to eight the lower privacy afforded to veterans at the VCHB.

This instrument was developed by considering the following criteria: simple language, clear and short close ended questions, instrument construction and appearance, questions order, organization of content, questions relevance, questions sensitivity, and questions order. The main reason for having chosen this type of research method was external validity that allowed for generalization to other long-term care facilities.

The independent variables (IVS) were demographics influencing the dependent variable (DV) of privacy afford
to veterans at the VHBC. The DV utilized an interval level of measurement. All demographics used a nominal level of measurement with the exception of education and age. Education used an ordinal level of measurement and age used an interval level of measurement. The demographics analyzed were branch of services, combatant status, disability, education, ethnicity, gender, residence, and time frame of military service.

Procedures

The sample of residents chosen were approached and informed of the study. When they chose to participate, they marked an informed consent (Appendix B) before they completed the survey. The participant chose a location to complete the survey that allowed them to feel comfortable, either a vacant office or their personal room. Surveys were conducted with the researchers present and lasted approximately 20 minutes. This method was chosen so the researcher could read and complete the survey for any participants with a vision loss. After each survey was completed, the participant was given a debriefing statement (Appendix C) informing them of the
study in which they participated. Data collection was completed by June 7, 2007.

Protection of Human Subjects

Protecting the confidentiality of the residents was a priority of the researchers. The residents of the VHCB have private meetings with staff members on a daily basis, so conducting a survey with one resident did not draw concern from other residents. Participants were asked to mark an informed consent (Appendix B) before they completed the survey. The surveys did not ask for any identifiable information from the participants, but were labeled with an identification number so the data could be processed in a statistical computer program. The data were only viewed by the researchers and their research advisor. The list of participants involved in the study and the data that were collected was kept in a locked drawer at the VHCB throughout the study.

Participants were assured that participation was strictly voluntary and they were under no obligation to participate. They were informed that they had the right to withdraw anytime during the research process and that their answers would remain confidential. Upon completion
of the survey each participant was given a debriefing statement (Appendix C) informing them of the study in which they participated. After the study was completed all lists of participants, surveys, and data were destroyed.

Data Analysis

The data were analyzed through quantitative methods. Descriptive statistics were used to describe the demographics of participants. The analysis focuses on the level of privacy by using descriptive statistics, including frequencies and measures of central tendency, and dispersion.

The level of measurement for the dependent variable was interval, allowing the level of privacy to be measured using a score from eight to 40. The independent variables were the demographics of the participants. Age was measured at an interval level. Gender, ethnicity, location of residency, branch of service, dates of military service, combat status, and service connected disability status were all measured at a nominal level. Education was measured at an ordinal level. The analysis required correlations that determined the relationship
between the participants' privacy scores and their age and education level. The analysis also suggested that t-tests be completed to compare the different demographic nominal categories.

Summary

In summary, the purpose of this study was to assess privacy at the VHCB. Participants were systematically selected and completed a survey pertaining to privacy within the VHCB. The participants were assured of their confidentiality. The data were analyzed using quantitative data methods which determined the relationships between the level of privacy and the demographic characteristics of the participants. The immediate benefit to the participants was to allow them to express their privacy experiences and concerns. Long-term research benefits were tentative finding and may be used to formulate privacy guidelines to improve quality of life at the Veterans Home of California in Barstow.
they care for themselves, and 15 (46.87%) participants resided in the intermediate care facility (ICF), where they receive assistance with their activities of daily living (ADL's).

The study determined there were 8 categories of branches of service because two participants served in two different branches within their military career. Ten (31.25%) participants served in the Army, 6 (18.75%) in the Marines, 6 (18.75%) in the Navy, 3 (9.38%) in the Air Force, one (3.12%) in the Coast Guard, one (3.12%) in the Navy and Army, one (3.12%) in Army Air Corp, one (3.12%) in the Coast Guard and Marines, and three (9.38%) participants did not offer their branch of service.

Military service dates were broken into two separate categories, 1940 to 1949 was considered peacetime and 1950 to 1980 was the Korean Conflict and Vietnam era. Eleven (34.37%) participants served during peacetime, 16 (50.00%) served during the Korean Conflict and Vietnam, and five (15.63%) participants did not provide military service dates.

Not all military personnel experience war combat during their military service. Nine (28.12%) participants experienced combat, 22 (68.75%) did not, and one (3.13%)
participant chose not to give that information. Several residents at the VHBC are disabled, whether it is from aging, previous accidents, illnesses, or being wounded while serving in the military. Ten (31.25%) participants reported having a service connected disability, 20 (62.50%) did not, and two (6.25%) participants did not provide an answer.

The privacy survey consisted of eight questions totaling five points each. Each survey score ranged from 40 to 8 points. Some participants chose not to provide answers to some survey questions, causing an inconsistent score. Privacy scores for the total sample were converted into a percent for the analysis by deducting unanswered questions, resulting in a new score. Then the new scores were divided by those participants’ highest possible score, resulting in a percentage (see Table 1).
Table 1. Percent of Privacy Afforded At the Veterans Home of California in Barstow

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Percent of Afforded Privacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>93%</td>
</tr>
<tr>
<td>3</td>
<td>90%</td>
</tr>
<tr>
<td>1</td>
<td>85%</td>
</tr>
<tr>
<td>1</td>
<td>84%</td>
</tr>
<tr>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>1</td>
<td>75%</td>
</tr>
<tr>
<td>1</td>
<td>73%</td>
</tr>
<tr>
<td>1</td>
<td>70%</td>
</tr>
<tr>
<td>1</td>
<td>69%</td>
</tr>
<tr>
<td>1</td>
<td>53%</td>
</tr>
<tr>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>1</td>
<td>44%</td>
</tr>
<tr>
<td>1</td>
<td>31%</td>
</tr>
<tr>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td><strong>TOTAL 32</strong></td>
<td><strong>82.27% OVERALL</strong></td>
</tr>
</tbody>
</table>

The findings have determined that three (9.37%) participants felt they had less than 50% of the measured aspects of privacy afforded to them, whereas 29 (90.63%) participants felt they had more than 50%. Eleven (34.38%) participants felt they had complete privacy within the VHCB.
The relationship between the dependent variable (privacy) and the independent variables (age, education, and branch of service) were examined using Pearson's correlation coefficient. All variables had a low correlation with a p-value greater than .05. The correlation between the variables was not significant to this study, but might be in a larger sample.

The relationship between the dependent variable (privacy) and the independent variables (gender, ethnicity, location of residency, dates of service, combat status, and service disability) were examined using a t-test. The results concluded that location of residency and military dates of service were significant within the study (see Table 2 & Table 3).

Table 2. Independent Samples Test between Privacy and Residency of Participants

<table>
<thead>
<tr>
<th>Residency of Participants</th>
<th>Independent T-Test</th>
<th>P-Value (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy at the VHBC</td>
<td>2.879</td>
<td>.007</td>
<td>32</td>
</tr>
</tbody>
</table>
The relationship between residency and privacy was examined using a t-test. Participants living in the domiciliary had higher mean privacy scores (90.1176) than those living in the ICF (70.2000) \( (t = 2.879, \ df = 30) \). The p-value is .007, less than .05, which indicates that there is a significant relationship between residency and privacy at the VHCB.

Table 3. Independent Samples Test between Privacy and Military Date of Service

<table>
<thead>
<tr>
<th>Privacy at the VHBC</th>
<th>Military Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Independent T-Test 2.964</td>
</tr>
<tr>
<td></td>
<td>P-Value (2-tailed) .007</td>
</tr>
<tr>
<td></td>
<td>N 27</td>
</tr>
</tbody>
</table>

The relationship between dates of service and privacy was examined using a t-test. Participants serving in the military from 1940 thru 1949 have a higher mean privacy score (92.1818) than those serving from 1950 thru 1980 (69.0000) \( (t = 2.964, \ df = 25) \) The p-value is .007, less than .05, which indicates that there is a
significant relationship between dates of service and privacy at the VHCB.

Summary

This chapter provided an overview of the findings from the study. The results determined that the place of residency and dates of military service were associated with a decreased amount of privacy at the VHCB. Overall, the findings have concluded that the residents, on average, are afforded 82.27% of the measured aspects of privacy while residing at the VHCB.
CHAPTER FIVE
DISCUSSION

Introduction

In terms of major findings the significance of the study results, alternative explanations, limitations and strengths of the study were explored. Social Work contributions and the relevance of the study were also discussed in terms of implications regarding the elderly, considered a vulnerable population. Future studies suggestions were also provided to promote the expansion of current knowledge that could increase awareness on privacy matters.

Major Findings of the Study

Place of residence was statistically significant in relation to whether veterans lived in the Domiciliary (doms) or the Intermediate Care Facility (ICF). Essentially the mean scores suggest that veterans living in the ICF experienced a lower level of privacy than those living in the doms. Additionally, dates of services were also statistically significant. The study suggests that veterans who served during the Korean Conflict and Vietnam era experienced less privacy than those who
served prior to 1950. The correlation between advanced ages showed greater privacy approaching significance. There was no correlation between education and privacy, and age and privacy. The t-tests also did not demonstrate any statistically significant relationship between gender and privacy, ethnicity and privacy, combatant status and privacy, and services connected disability and privacy.

Discussion

Meaning and Significance of Findings

Logically speaking, doms veterans experience more independence and inversely fewer intrusions from nursing staff. Intermediate Care Facility residents, on the other hand, have less mobility and more restrictions due to requiring a higher level of care. Veterans in the ICF, for example, experience more health needs promulgated by medical complications and their inability to carry out everyday activities.

Clinically speaking veterans’ well-being might be influenced by their current level of privacy. Thus, a privacy measure that considers installing partitions in their rooms may be an option. However, some veterans
oppose the previous suggestion due to VHCB being an income based facility. For example, some veterans stated they are entitled to a larger area of the room since they pay more than their peers.

It would also be prudent to provide clinical attention to veterans who are experiencing more health issues and behavioral problems who might want more privacy consideration. Privacy tailored interventions specific to individual’s need can be provided to improve their quality of life at VHCB. For example, a veteran who is suffering from an acute medical condition can request from a social worker and nursing staff to be placed with a roommate who can show consideration for his or her medical condition.

Alternative Explanations

An alternative explanation to place of residence determining privacy might be related to veterans’ health deteriorating; therefore, they are less concerned with privacy matters, which are supported by the age correlation. Instead, they are more preoccupied with end of life questions that might stem from being stuck in Erickson's Psychosocial Stages of Development. For example, a veteran who might be estranged from family and
has strained social support might be self-absorbed and feel little connection to others. This could mean that ICF veterans might be going through a situation where they find themselves in the stagnation or despair stage of development. Consequently, veterans are possibly experiencing self-rejectivity, which can potentially lead to despair and dread of dying.

A possible explanation for service dates being associated with privacy is that the Korean Conflict and Vietnam era veterans who experienced combat where likely to also suffer from trauma, for example Post Traumatic Stress Disorder (PTSD). In others words, Korean Conflict and Vietnam veterans experienced less privacy than those who served prior to 1950 because of possible negative associations with war. After the Vietnam War, veterans were in essence re-living hostile experiences from images of death and dying portrayed by the media and rejection when they returned back home to find anti-war protest rallies. In addition, during the Vietnam era there was a high use of narcotics, especially heroine, among veterans. Thus, it's likely that some veterans from this era suffered from Post Stress Traumatic Stress Disorder and substance abuse. This study suggests that veterans
who served during the Korean Conflict and Vietnam experienced less privacy at the VHCB than peace time veterans who served prior to 1950.

Limitations

One of the chief limitations of the study was the lack of quantitative measuring instruments available in the literature that addressed specific privacy needs in long-term facilities. In response to this lack, a new instrument had to be designed. Consequently, measurements of validity and reliability were not available.

The faculty supervisor of the study and LCSW Chief of Social Work at VHCB provided their expertise and guidance in the development of the instrument. Thus, consideration was given to content validity, face validity, criterion validity, construct validity, internal validity, and external validity. A pretest was also conducted and completed by April 13, 2007, to evaluate the use of the instrument.

A test-retest method, alternative-forms method, and split half method were not established to test for reliability due to time constraints. The instrument
developed, was also not assessed for concurrent and predictive validity.

On the other hand, having developed a nonstandardized instrument was a major advantage in measuring specific demographic characteristics of the target population at VCHB (Appendix A).

Other potential limitations included potential untruthful, disgruntled, and inapplicable responses. For instance, some veterans randomly chosen could attempt to please social work interns due to already established rapport. On a negative note, some residents did not consider their opinions matter based on their skepticism for change while others showed a lack of interest in the survey. On a more practical matter, some of the questions on the survey were not applicable to residents who were not able to assess whether they had privacy because they did not own a TV or a cellular phone, and had no special friend (Appendix A).

Recommendations for Social Work Practice, Policy, and Research

In the broader scope of social work practice privacy in long-term care is a topic that needs further attention and advocacy from professional social workers in the
field. Evidence based research on privacy illustrates the need for enhanced privacy in nursing homes. In addition privacy is multifaceted and needs to be addressed in all it’s aspects on educating professions and the elderly population they serve.

In terms of policy development and implementation, VHCB and nursing homes nationwide and abroad would benefit from residents’ serving on their board. Collaborative input from veterans would allow for more balanced policies and genuine implementations of privacy regulations.

For instance, an instrument could be developed to assess privacy satisfaction at VHCB. Assessing privacy satisfaction would likely determine if doms residents and pre-Korean Conflict and Vietnam veterans are actually experiencing higher levels of privacy satisfaction. A correlation between privacy and satisfaction could support the current findings at the VHCB. Privacy satisfaction feedback could be utilized to suggest privacy improvements by addressing lack of privacy where the need is greater. For example, those who have experienced wartime can receive more privacy consideration. Implementation of privacy consideration
can enhance quality of care for those who score lower on the satisfaction survey.

Conclusion

In conclusion, privacy for veterans who are fragile and vulnerable both mentally and physically needs to be reconsidered. Veterans in the Intermediate Care Facility at the Veterans Home of California, Barstow and elderly living in other nursing homes across the globe deserve more privacy considerations. This means reevaluating privacy policy and practice to ensure that the elderly’s dignity is protected. Privacy and well-being of the elderly are intertwined.
APPENDIX A

SURVEY
Privacy Satisfaction Survey

Part 1:
The following questions are designed to understand how satisfied are you with the currently level of privacy afford to you. It is not a test, so there is no right or wrong answers. Please answer each item as carefully and accurately by circling your answer.

1. Can you make private phone call in your room?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

2. Can you have a private conversation in your room?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

3. Can you watch a movie in private without worrying about what nurses or staff will say?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

4. Can you spend private time in your room without being interrupted?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

5. Do you feel comfortable bringing a special friend to your room without worrying about what your roommate will say?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

6. Do you feel comfortable bringing a special friend to your room without worrying about what nurses or staff will say?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

7. Can you watch a movie in private without worrying about what your roommate will say?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often

8. Is there a place in the facility where you can meet in private with another resident?
   1-Never  2-Rarely  3-Sometimes  4-Frequently  5-Often
**Part 2: Background**

In this section, I would like to ask you a few questions about yourself. Please circle your answer.

A1. How old are you? _______

A2. What is your gender?
   1. Male
   2. Female

A3. What is your ethnicity?
   1. White
   2. African American
   3. Hispanic
   4. Asian/Pacific Islander
   5. Native-American
   6. Other (Please Specify) _______________

A4. What was the highest level of Education obtained?
   1. High School
   2. 2 year college
   3. University
   4. Graduate School

A5. Where do you live?
   1. Domiciliary
   2. (ICF) Intermediate Care Facility

A6. Branch of Service? __________

A7. Dates of Services? __________

A8. Combat Status?
   1. War Time Veteran
   2. Peace Time Veteran

A9. Service Connected Disability Status?
   1. Yes
   2. No
APPENDIX B

INFORMED CONSENT
This study in which you are being asked to participate will assess the satisfaction regarding privacy and intimacy among veterans living in retirement homes. This study is being conducted by Lynn Givens and Jesse Ornelas under the supervision of Professor Rosemary McCaslin, Ph.D. at California State University, San Bernardino (CSUSB). This study has been approved by the Department of Social Work Sub-Committee of the Institutional Review Board, California State University, San Bernardino.

In this study you will be asked to respond to several privacy and intimacy questions. The questionnaire should take about 15 to 20 minutes to complete. All of your responses will be held in the strictest of confidence by the researchers. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion in September, 2008, at the John M. Pfau Library located on the campus of CSUSB or the Veterans Home of California, Barstow.

Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. There are no foreseeable risks in participating. When you have completed the questionnaire, you will receive a debriefing statement describing the study in more detail. The immediate benefit of this study is that it allows you to express your experiences and concerns about privacy and intimacy. The long-term benefits may be used to formulate guidelines that will create more privacy in nursing and retirement homes.

If you have any questions or concerns about this study, please feel free to contact Dr. Rosemary McCaslin at (909) 537-5507.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate.
APPENDIX C

DEBRIEFING STATEMENT
DEBRIEFING STATEMENT

Study of Privacy at the Veterans Home of California, Barstow

The study you have just completed was about your level of privacy satisfaction. We are interested in finding out what levels of privacy have been offered as well as how often you have exercised them. We hope that this finding will show the present level of privacy satisfaction that is being given at Veterans Home of California. Research results will be shared with the Chief of Social Work Service in hope of instilling a more progressive understanding of privacy satisfaction among the residents at Veterans Home of California.

Thank you for your participation in this study. If you have any questions about the study, please feel free to contact Dr. McCaslin at 909-537-5507. The findings will be made available at Veterans of California Barstow after the summer 2008. LCSW Chief of Social Work Services Bill Rigole can be reached at 760-252-6241.
REFERENCES


ASSIGNED RESPONSIBILITIES

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Group Effort: Lynn Givens & Jesse Ornelas

2. Data Entry and Analysis:
   Assigned leader: Lynn Givens
   Assisted by: Jesse Ornelas

3. Writing Report and Presentation of Findings:
   a. Introduction
      Assigned leader: Lynn Givens
      Assisted by: Jesse Ornelas
   b. Literature Review
      Assigned leader: Jesse Ornelas
      Assisted by: Lynn Givens
   c. Methods
      Group Effort: Lynn Givens & Jesse Ornelas
   d. Results
      Assigned leader: Lynn Givens
      Assisted by: Jesse Ornelas
   e. Discussion
      Assigned leader: Jesse Ornelas
      Assisted by: Lynn Givens